LGBTI+ Youth in Ireland and across Europe:

A two-phased Landscape and Research Gap Analysis

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Introduction

Individuals who identify as lesbian, gay, bisexual, trans or intersex, or belong to other sexual or gender minorities (LGBTI+) have worse health and life outcomes than those who identify as heterosexual and/or whose sex assigned at birth and gender identity are aligned to each other. These inequalities have been confirmed by examination of the lived experiences of, and scientific research with, sexual and gender minority (SGM) people. Since the 1980s, in many countries there has been a growing tolerance and acceptance towards LGBTI+ persons, yet many SGM people face rejection, harassment or physical violence and stigmatisation. It seems that their poor health indicators can at least partly be attributed to chronic minority stress and its negative consequences. Many SGM people report that they began to recognise their sexual orientation or gender identity during adolescence. Due to developmental-psychological reasons, this is the life stage where they are the most vulnerable to negative health outcomes from adverse experiences such as bullying, harassment, and social exclusion by their peers or others. While warm, caring and accepting families can, to some extent, buffer the negative impact of such experiences, many LGBTI+ individuals also report negative relationships within their families. Adverse childhood and adolescent experiences, through stigmatisation and minority stress, have a long-lasting impact on SGM people. Research also demonstrates that many SGM individuals encounter a lack of understanding and respect in educational, health and social services. Providers of such services, in turn, often report that they lack adequate information and training on LGBTI+ issues.

Research shows that these effects are embedded within a complex network of psychosocial determinants, including socio-economic status. They are interwoven with other dimensions of inequality, including gender, ethnic or cultural background, residence, immigration, or chronic conditions. For instance, SGM adults are more likely than heterosexual and cisgender people to live in poverty and have poor health status. People with multiple, intersecting minority statuses are more likely than others to face inequalities. The normative and developmental stress of adolescence is further increased if somebody identifies as SGM: this is the effect we refer to as 'additionality' in this report. Decision-makers need to consider these complexities and facilitate evidence-based initiatives that help SGM young people live in more understanding and tolerant societies which are attentive to their specific needs.

It is important to recognise that many SGM young people report warm and loving parents and family, supportive friends and teachers, and have a full and healthy life. Therefore a merely 'victimising' narrative is not helpful in understanding their experiences. It should be recognised that SGM youth "can flourish when they have consistently positive interactions with those around them and supportive experiences in the services with which they most engage" (DCYA, 2018, p. IV).

In 2018, the Department of Children and Youth Affairs of Ireland published the *LGBTI+ National Youth Strategy 2018-2020*, the world's first governmental strategy document that aims to improve the lives of LGBTI+ young people. It was built on the foundations of Better Outcomes, Brighter Futures, the national policy framework for young people in Ireland. It is an action-oriented plan built around three goals.

These goals are further broken down to 15 objectives, and each objective contains one or more concrete actions. They are aligned with the *Irish Better Outcomes, Brighter Futures* (BOBF) national youth policy framework. The three overarching goals and the 15 objectives of the strategy and their alignment with the BOBF national outcomes are presented in **Table 1**. The actions assigned to the individual objectives are presented in the introductory parts of Subsections 3.1–3.15.

Altogether these constitute a comprehensive action plan that involves legislative changes and policy development as well as allocating additional financial resources to provide training, create or enhance interventions, develop or transform curricula, and strive for a more accepting and inclusive society. The objectives and actions were generated through consultations with LGBTI+ young people as well as various other stakeholder groups and were based on the best available scientific evidence.

Table 1. Goals and objectives of the *LGBTI+ National Youth Strategy 2018-2020* and their alignment with the *Better Outcomes Brighter Futures* national youth policy framework

National LGBTI+ Youth Strategy 2018-2020		Better Outcomes Brighter Futures
Goal	**Objective**	**National Outcome**
Goal 1: Create a safe, supportive and inclusive environment for LGBTI+ young people	**Objective 1:** Create a more supportive and inclusive environment for LGBTI+ young people in formal education settings	**Outcome 2:** Achieving full potential in all areas of learning and development
	Objective 2: Create safe environments for LGBTI+ young people	**Outcome 3:** Safe and protected from harm
	Objective 3: Make all youth services more inclusive of LGBTI+ young people and provide accessible LGBTI+ youth services nationally	**Outcome 3:** Safe and protected from harm
	Objective 4: Ensure equal employment opportunity and an inclusive work environment for LGBTI+ young people	**Outcome 4:** Economic security and opportunity
	Objective 5: Provide a more supportive and inclusive environment that encourages positive LGBTI+ representation and participation in culture, society, and sport, and reduces LGBTI+ stigma	**Outcome 5:** Connected, respected and contributing to their world
	Objective 6: Expand and develop supports to parents and families of LGBTI+ young people	**Outcome 5:** Connected, respected and contributing to their world
	Objective 7: Provide capacity building measures among service providers to improve their understanding of, and ability to engage with, LGBTI+ young people	Cross-cutting objective
	Objective 8: Address gaps in current legislation and policies, and ensure inclusion of LGBTI+ young people in future legislation and policy development	Cross-cutting objective

National LGBTI+ Youth Strategy 2018-2020		Better Outcomes Brighter Futures
Goal	**Objective**	**National Outcome**
	Objective 9: Address fragmentation in funding and support networking of organisations to work collaboratively	Cross-cutting objective
	Objective 10: Provide an inclusive physical environment for transgender and intersex young people	Cross-cutting objective
Goal 2: Improve the physical, mental and sexual health of LGBTI+ young people	**Objective 11:** Respond effectively to the mental health needs of LGBTI+ young people	**Outcome 1:** Active and healthy; physical and mental wellbeing
	Objective 12: Strengthen sexual health services and education to respond to the needs of LGBTI+ young people, including in the area of sexual consent	**Outcome 1:** Active and healthy; physical and mental wellbeing
	Objective 13: Improve the physical and mental health of transgender young people	**Outcome 1:** Active and healthy; physical and mental wellbeing
	Objective 14: Improve the understanding of, and the response to, the physical and mental health needs of intersex young people	**Outcome 1:** Active and healthy; physical and mental wellbeing
Goal 3: Develop the research and data environment to better understand the lives of LGBTI+ young people	**Objective 15:** Enhance the quality of LGBTI+ data and commission research to ensure evidence-informed policy and service delivery	Cross-cutting objective

However, such evidence is scarce and uneven. It is noted in the strategy that "Research and data-gathering mechanisms for LGBTI+ people in Ireland and internationally remain in their infancy and require substantial development" (p. 7). While there is ample evidence on the health and lived experiences of SGM young people, the overwhelming majority of these studies were conducted in North America. It remains to be investigated whether their conclusions can be generalised to Ireland or other European countries. Scholars in the area of SGM research note this imbalance and highlight the need for more studies in European countries. The strategy also notes that the impact of any new programmes and interventions on LGBTI+ youths' health and well-being should be carefully monitored.

Aims

This report presents a Landscape and Knowledge Gap Analysis which systematically maps research evidence on SGM youth in Ireland and other European countries. We examine which objectives of the *LGBTI+ National Youth Strategy 2018-2020* are well supported with scientific evidence, where there are information gaps and where additional research is needed. The overall goal is to inform decision-makers on the disparities in gender and sexual minority young people that should be investigated in depth. Additional aims are:

1. To examine protective factors and positive aspects, in order to balance the predominant 'victimising' narrative on SGM youth.

2. Based on the synthesised evidence, provide recommendations to decision-makers and other stakeholder groups, including SGM young people's families and friends/ allies; teachers and school staff; educational, social and healthcare providers.

Method

In the first phase of the study, the landscape analysis, a scoping review technique was applied to identify, organise and evaluate research conducted with SGM youth in Ireland and other European countries. This phase followed the guidelines of the Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) checklist.

Five different sources of information were used. These comprised scientific databases, contacting researchers and stakeholder associations as well as utilising our

international Health Behaviour in School-aged Children (HBSC) research network, a World Health Organization collaborative cross-national study. We applied a systematic search for research outputs in peer-reviewed scientific journals and grey or unpublished literature.

We searched for all findings with a combination of keywords that contained different descriptors of LGBTI+ and SGM, descriptors of adolescents, children or young people, and keywords describing the five overarching dimensions (Outcomes) of the Irish *Better Outcomes, Brighter Futures* national youth policy framework. Thus, five systematic searches were conducted (the search terms for these are given in Appendix B). These were aligned to the BOBF outcomes, to which the fifteen objectives of the *LGBTI+ National Youth Strategy 2018-2020* are linked. This approach was taken so as to gather literature which would broadly speak to the LGBTI+ NYS objectives, while also producing a manageable amount of data within the infrastructural and financial constraints of the project.

The following inclusion criteria were used:

1. Primary studies and datasets from within the geographical boundaries of the European Union and synthesised evidence (including systematic and other type reviews and meta-analyses) without geographical confines.
2. Primary studies and evidence syntheses published between January 2000 and September 2019, and datasets between January 2010 and September 2019.
3. Material published in English.
4. Studies where the majority of the participants were 26 years old or younger.

All identified evidence was entered into a web application for systematic reviews, and two researchers independently screened them against these inclusion criteria. In case of conflicting evaluation and ambiguity on whether a publication should be included in the analysis, it was discussed with a third researcher until consensus was reached.

All publications and data sets that met the inclusion criteria were mapped and entered onto a spreadsheet containing various types of information on each output, including their source, country, bibliographical details, digital identifiers as well as details on

the study such as design, research questions or hypotheses, characteristics of the sample, dependent and independent variables, methods of analysis, main findings, and practical and policy implications.

In the second phase, the knowledge gap analysis, pieces of the mapped evidence were analysed for strength, quality and applicability. The material was critically appraised for quality and to inform recommendations on what areas of LGBTI+ youth research should be adapted and/or improved. A range of methods were used for quality assessment. Applicability of the international findings/indicators in the Irish context was assessed on the basis of sampling, method(s), and indicators and whether they were coherent with the goals and objectives of the LGBTI+ National Youth Strategy. Strengths and weaknesses of the materials were analysed with special regard to this aspect. Summarising the knowledge gap phase, each piece of evidence was evaluated on a six-tier scale:

1. No further action needed, as high quality evidence exists in Ireland which directly speaks to the *LGBTI+ National Youth Strategy 2018-2020*.
2. Research needs in Ireland are covered, but either data from Ireland is part of the international comparison, or the given need is already addressed by existing and well-documented research in Ireland.
3. Research in Ireland needs to be improved.
4. International research is high quality and should be adapted.
5. International research could be adapted with modifications.
6. The given international evidence, regardless of its strength or quality, is not relevant or applicable in an Irish context.

Results

Applying the methods and the inclusion criteria outlined above, we initially identified 4,603 records, of which 126 were included into the landscape and knowledge gap spreadsheet. Each record was assigned to the fifteen objectives in the *LGBTI+ National Youth Strategy 2018-2020*. A single record, on average, was relevant to 3.31 objectives. The extent to which each objective was covered by evidence was illustrated by a density map. This map (see **Figure 1**) shows that the distribution of

the evidence was uneven across objectives. Some objectives were relatively well represented, for example creating a more supportive and inclusive environment for LGBTI+ young people in formal education (15%) and creating safe environments for them (14%). Others, such as responding effectively to the mental health needs of LGBTI+ young people (11%), providing a supportive and inclusive environment that encourages LGBTI+ representation and participation (10%), providing capacity building for service providers (9%) and improving the physical and mental health of transgender youth (8%), had a moderate number of relevant pieces of evidence. There are some objectives, however, that were poorly covered. For instance, LGBTI+ inclusivity of youth services (6%), supports for parents and families of LGBTI+ youth (5%), and inclusive environment for transgender and intersex young people (5%) were scarcely represented. A low number of studies (3%) spoke to Objective 15, enhancing the quality of LGBTI+ data and commissioning of research to ensure evidence-informed policy and service delivery. Ensuring equal employment opportunities and an inclusive work environment for LGBTI+ young people (2%), understanding and addressing specific needs of intersex youth (2%) and tackling the fragmentation in funding and support networking in organisations to work collaboratively (1%) were only sporadically mentioned in the evidence base.

The landscape of research with LGBTI+ youth is varied and diverse in terms of scope, aims, research questions, design and methods, investigated populations and outcomes. While we have identified single-site research from many European countries, only a small number (8%) compared data from more than one country or region. There was large variation in the quality of evidence. Many studies had a rigorous methodological approach; others had weaknesses. Most studies analysed data from sexual minority (lesbian, gay and bisexual) young people, based on their self-identified sexual orientation. There were fewer studies which observed other dimensions of sexuality, including romantic attraction, sexual behaviour, or gender of the romantic/sexual partners. Gender minority young people were also less frequently studied, and most investigations classified them based on their self-identified transgender status.

A large number of outputs presented research on bullying victimisation and exclusion of LGBTI+ youth, while studies relevant to mental health were largely focused on poor mental health outcomes. The majority of these concerned minority stress and depression. The findings suggest that SGM status is moderately but significantly

associated with stress and adverse mental health. Sexual minority young people experience significantly more bullying and victimisation than their heterosexual peers. Hostile school climates, lack of sense of belonging to school, and poor family and peer support are linked to higher levels of bullying and victimisation. These negative experiences have been associated with externalising and behavioural problems, mental health problems and suicide attempts among sexual minority youth. Gender minority young people seem to face even larger inequalities than their sexual minority peers. However, the evidence on positive and protective factors, as well on prevention and amelioration of adverse health effects is less well-developed.

Various intersections have been observed in the reviewed evidence. In studies that involved gender, a general finding was that girls fared worse than boys. Where such a distinction was employed, bisexual youth had poorer outcomes than heterosexual or lesbian/gay participants. While (lesbian, bisexual and trans) girls were more likely to be seen as sexualised and objectified, gay and bisexual boys were more likely to face hostility and status-based competitive pressure. Other intersecting dimensions in the evidence-base were age, ethnicity or race, socio-economic status, religion, or disability. Some studies included language, citizenship, school type, care experience, health status, other reason(s) for discrimination, or considered specific subgroups (e.g. black lesbian, gay or bisexual students).

Many pieces of evidence demonstrated that minority stresses associated with being LGBTI+ have direct effects on SGM individuals' health, and these inequalities can be traced back to their adolescence. However, the causal mechanisms underlying these health disparities are not fully understood. The life-course approach could be helpful in better understanding these developmental trajectories and improving the experiences of SGM youth.

Research on gender minority adolescents is considerably sparser and less developed than that on their sexual minority peers. There is an urgent need for a better understanding of their complex health and social needs. Evidence on medical interventions to assist gender transitioning of trans young people, especially that on pubertal blocking and administration of cross-sex hormones, is very scarce, and the long-term impact on cognitive and physical development, fertility or on other outcomes remains largely unknown. Research on young people with intersex variations is extremely limited. We were unable to identify any international studies on

intersex young people that met the inclusion criteria for the landscape analysis. This signifies the pressing need to conduct studies that tap into the specific needs of youth with intersex variations.

While we identified a large number of research outputs documenting bullying, exclusion, rejection, lack of understanding and acceptance, much fewer studies were found on how SGM youth develop resilience in the face of bullying, and what enables them to employ adaptive coping strategies. There are a number of protective factors, or positive developmental assets, that have shown to promote healthy developmental outcomes and reduce risk behaviours among the general population of adolescents. These include supportive and nurturing family relationships, supportive friends, having other caring adults such as teachers and coaches, school connectedness, and religiosity or spirituality. There is robust evidence that establishing Gender-Sexuality Alliances (formerly known as Gay-Straight Alliances) in schools reduce bullying-victimisation and related mental health burden in SGM youth. Such alliances appear to have a positive impact even on heterosexual students. A Gender-Sexuality Alliance, however, is not sufficient on its own, and may not suit all schools (for instance those with a very low overall number of students). Enabling health-promoting, inclusive and safe environments for SGM young people can only be created by adopting a comprehensive approach that considers different determinants of well-being, characteristics of the given setting, and the pre-existing attitudes and needs of all stakeholders. For instance, a school in a highly urbanised neighbourhood with a large number of students, where there are openly out LGBTI+ students, will need different types of interventions than a school in rural setting, with a low number of students, where LGBTI+ students have less visibility.

School-based interventions to improve the lives and experiences of SGM youth should include multiple strategies, including national and local anti-bullying policies, teaching about LGBTI+ issues in classrooms, training for school staff, demonstrating support via visual displays and having appointed staff member(s) who give dedicated support to SGM youth. Successful interventions need to be built on preliminary analysis of the needs of SGM young people and other stakeholders (such as their families and teachers), should consider characteristics of the given settings (e.g. the size of the school and ethnic diversity in the neighbourhood), and be complemented with a continued assessment of its efficacy.

Knowledge gaps include:

- The lack of comparisons between sexual minority and heterosexual / gender minority and cisgender youth
- Studies that go beyond descriptive analyses and attempt to understand causal mechanisms of SGM inequalities
- Considering intersectionality and multiple marginalisation
- Investigations of positive aspects and protective factors
- A lack of systematic documentation of interventions and evaluations of their efficacy.

Many studies recruited young people who identify as lesbian, gay, or bisexual (less frequently those who identify as trans or non-binary). While acknowledging the ethical and methodological difficulties (e.g. the need to obtain parental consent), it should be noted that this approach excludes young people who are not out to their parent(s) and therefore cannot obtain parental consent.

Sixteen of the 126 studies (13%) were conducted in the Republic of Ireland. In general, methods and results of these studies largely mirror those found in studies conducted in other countries. While bullying and mental health issues of SGM young people as well as their (adverse) school and family experiences have been extensively studied, there is a lack of attention to protective factors and positive developmental assets, and gender minority young people are underrepresented. Another gap in research on SGM youth in Ireland is the lack of comprehensive, school-based interventions, and studies measuring their impact.

Policy and practice implications

We have identified many studies which demonstrated that both national and local anti-bullying and anti-discrimination policies that explicitly mention sexuality and gender can enhance the sense of safety in SGM youth and reduce their adverse school experiences. It is important that national policy provides general guidelines; however, SGM young people and other stakeholders should be involved in setting local regulations. Such 'bottom-up' processes should be encouraged in addition to developing all elements of the safe school initiatives and health promotion programmes in schools and other settings.

Our landscape and knowledge gap analysis has policy implications. These can be summarised as follows:

1. Training on LGBTI+ issues for teaching and support staff as well as healthcare and social care personnel should be developed and implemented. This could be aligned or integrated with a rights-based approach to health and social care.
2. Schools and other educational, social and healthcare services, as well as businesses and employers in the private sector, should create or review anti-bullying policies and practices based on national guidelines for LGBTI+-inclusive environments.
3. Parents and other family members of LGBTI+ children, such as grandparents and siblings, need support. They should be provided with evidence-based information on LGBTI+, and have the opportunity to engage with services to help them developing and maintain supportive and caring relationships. These supports should include acceptance of sexual or gender minority identity and actions to address bullying or harassment.
4. Families of trans children need evidence-based information and specific support on issues related to gender identity and interventions which help gender transitioning.
5. Families of children living with intersex variations need evidence-based information and specific support around sex and gender development.
6. LGBTI+ inclusivity needs to be improved in school curricula as well as in sports and culture. This would ensure better representation and 'normalisation' of LGBTI+ issues and identities. Establishing LGBTI+-friendly initiatives as Gender-Sexuality Alliances in schools have documented positive impact on the health of SGM children as well as their non-minority peers.
7. There are some LGBTI+-specific resources that foster resilience. LGBTI+ children and their families need support in how to avail of such resources. For instance, belonging to LGBTI+ youth associations and volunteering for the community may enhance resilience in young people. Their families may benefit from attending support groups or joining LGBTI+ organisations as allies.

8. Building positive and pro-LGBTI+ structural environments need to continue. This involves improving legal frameworks and supportive policies, increasing the visibility of LGBTI+ (and LGBTI+ ally) people, and providing gender neutral facilities.
9. Gender identity and gender diversity should be included in all initiatives, with a special focus on transgender, gender non-binary and intersex identities.
10. Further research is needed on SGM youth. Instead of descriptive studies on bullying and mental health issues, more emphasis should be given to needs analyses and intervention studies, particularly in relation to family/parental support.
11. Existing population health surveys with children and adolescents need political and infrastructural support in developing and administering evidence-based measures of sex assigned at birth, gender identity, and different dimensions of sexual orientation.

1. Introduction

1. Introduction

In this report, we present a landscape of research conducted and data collected in Ireland and other European countries on young people who belong to sexual and gender minorities, to complement the Irish *LGBTI+ National Youth Strategy 2018-2020* (DCYA, 2018), the world's first governmental strategy document that aims to improve the lives of LGBTI+ young people.

1.1. What is LGBTI+?

Across various cultures and countries, a number of people belong to sexual and gender minorities, identifying as **lesbian**, **gay**, **bisexual**, **trans**, **queer**, **intersex**[1] or other minorities – these groups are sometimes abbreviated as LGBT, LGBTQ, LGBTI+, LGBTIQ+. Occasionally the acronym is expanded, for instance to LGBTQQIP2SAA, comprising of lesbian, gay, bisexual, trans(gender), queer, questioning, intersex, pansexual, two-spirit, asexual and ally identities.

The term **sexual minority** is an umbrella term for those individuals whose sexual orientation is not heterosexual. **Gender minority** is an umbrella term that encompasses transgender and gender-nonconforming people – individuals whose current gender identity or gender expression do not conform to social expectations based on their sex assigned at birth (IOM, 2011, Richards et al., 2016, The GenIUSS Group, 2014). **Cisgender**, in contrast, is a term used to describe when someone's social gender and biological sex correspond. Gender, sex, sexuality and sexual orientation are complex phenomena deeply interwoven with one another, and are influenced by a network of biological, social and psychological factors (Diamond, 2003, Fausto-Sterling, 2019, Ganna et al., 2019). The way in which gender identity is communicated through somebody's appearance and behaviour is termed **gender expression**.

One's gender identity and gender expression reveals nothing about the person's **sexual orientation**, which includes sexual identity (the term used by the individual to describe themselves), attraction (which gender or genders toward whom the individual is romantically or sexually attracted), and behaviour (which gender(s) are the sexual partner(s) of the individual) (Chamberlain and Cook, 2019). Some individuals who do not identify with the traditional 'man'/'woman' gender labels may use the terms **non-**

1 The terms highlighted in the text are defined in the Glossary in Appendix A.

binary or **gender non-conforming** to define their gender identity. Intersex, or people with **intersex variations** typically refers to individuals whose genitals, reproductive organs and /or chromosomal make-up do not conform to the standard definition of 'male' or 'female' bodies (OII-USA, 2013). In this report, we will use either LGBTI+ or Sexual and Gender Minority (SGM) terms, unless we refer to a specific identity (identities) or subgroup(s).

One of the biggest challenges in synthesising and analysing the vast number of scientific studies conducted with SGM individuals is the large diversity and confusion in terminology. This confusion is demonstrated by the various acronyms we have cited above. In a 'review of reviews' article, Lee et al. (2016) identified 82 different terms to describe sexual and gender minorities. This diversity, and the (in)consequent use of different terms raises the question of whether people can be classified based on their gender and sexuality, and whether individuals can be reduced to certain letters in acronyms (Hales et al., 2017). A national survey conducted in the US revealed that young people aged 13 to 17-years-old used 26 different terms to describe their sexual orientation and gender identities (Watson et al., 2020b), which again shows that certain letters, or their combinations, may not reflect the diversity in identity terms and expressions that young people employ. Acronyms, no matter how long they are, will never be comprehensive enough to embrace all identities, and may exclude those whose labels are not within the letters of the acronym. Moreover, people may be even further marginalised due to their identity or gender expression if they do not identify with any of these terms.

1.2. Why it is important to study the lives of LGBTI+ young people?

There have been rapid and dramatic positive changes in attitudes and perspectives towards LGBTI+ people in many countries in recent years (Baunach, 2011, Flores, 2014, Keleher and Smith, 2012, Morris et al., 2014, van der Star and Bränström, 2015). Still, disparities across various indicators of health and well-being remain. Many of these can be traced back to adolescence but have effects which last long into adulthood (Cochran and Mays, 2007, Cochran et al., 2003). Such disparities are embedded in a complex system of health determinants that include characteristics of the family, friends and peer networks, schools, the healthcare and social care system, and wider society.

Two central concepts which help in understanding and addressing these disparities are **stigma** (Hatzenbuehler and Pachankis, 2016) and **minority stress** (Meyer, 1995, 2003, 2007). Stigma can be defined as a complex social phenomenon in which an individual or group of individuals are de-valued as a result of their traits, characteristics or identity. This process occurs at the micro-, meso- and macro- levels of social interaction, has various forms and can negatively affect a person's life chances, including their health and well-being (Stangl et al., 2019). Macro-level stigma, also known as structural stigma, can be defined as a set of socio-cultural norms and practices, and institutional policies that implicitly disadvantage stigmatised groups (Hatzenbuehler and Link, 2014). In the context of LGBTI+ individuals, stigmatisation is driven by **homophobia**, **biphobia** and **transphobia** – negative attitudes to and overt discrimination against individuals or groups who define themselves or are perceived as homosexual, bisexual and/or transgender. Other sexual and gender minorities are also affected by similar discriminatory attitudes and behaviours. Minority stress refers to the "excess stress to which individuals from stigmatised social categories are exposed as a result of their social, often a minority, position" (Meyer, 2003, p. 675).

In spite of positive societal changes, these health disparities have remained relatively stable over time and may be associated with minority stress. For instance, youth risk behaviours such as tobacco smoking or alcohol consumption show a general decrease, but the gap between **heterosexual**/cisgender and SGM young people has remained stable (Goodenow et al., 2016, Homma et al., 2016, Watson et al., 2018). Sexual and Gender Minority young people also tend to be disproportionately affected by exclusion and bullying-victimisation, which are substantial elements of minority stress. Young people who have multiple or intersecting minority status (for instance, being LGBTI+ and also belonging to the female sex or an ethnic, racial or religious minority) may experience an additional burden (Button et al., 2012, Corliss et al., 2014, Dürrbaum and Sattler, 2020, Feinstein et al., 2019, Lytle et al., 2014, Pollitt et al., 2018, Poteat et al., 2009).

Other key health and social domains where LGBTI+ youth experience inequalities are education and employment (Aragon et al., 2014, Kosciw et al., 2013); access to healthcare (Hafeez et al., 2017); mental health outcomes (Marshal et al., 2011, Veale et al., 2017); and exposure to violence (Rimes et al., 2017, Schneeberger et al., 2014). Even within sexual and gender minorities, remarkable disparities are documented. Bisexual, intersex, trans and non-binary youth, compared to their gay or lesbian cisgender peers, are faring worse across a range of indicators (Aparicio-Garcia et al., 2018, Reisner et al., 2016).

Nevertheless, these issues as well as positive aspects of belonging to a sexual and gender minority remain under-researched. Protective factors that may be associated with better health outcomes have also been overlooked, and, at least in the European context, robust intervention research is scarce. Thus, there is a need for a greater focus on mapping and evaluating interventions that could improve the lives of SGM youth. In the subsequent chapters, based on the available evidence, recommendations are provided for researchers and research commissioners to help documenting such initiatives and assessing their efficacy.

1.3. A lack of systematic evidence in Ireland and Europe

While a considerable body of research on sexual and gender minorities has been aggregated, the vast majority of these studies were conducted in North America. It is unclear whether their findings and policy recommendations can be generalised to other countries and cultures. Nevertheless, there are studies conducted in Europe, and we have identified a few pieces that include international comparisons. To the best of our knowledge no researchers have attempted to map the geographical distribution of such studies within Europe, despite the fact that there have been calls for more systematic research in Europe and globally (Bränström and van der Star, 2016, Saewyc, 2011). The fifteenth objective of the *LGBTI+ National Youth Strategy 2018-2020* (DCYA, 2018) outlines that the quality of LGBTI+ data needs to be improved, and more targeted research is needed to ensure evidence-informed policy and service delivery.

1.4. Aims

This landscape and knowledge gap analysis systematically maps research evidence on SGM youth in Ireland and more broadly in Europe. We use the term landscape analysis to describe the first phase of the project, the identification of relevant material and the the mapping process. The second phase is a research and data gap analysis to identify knowledge gaps – those areas in which further research in Ireland or Europe is needed. A scoping review and mixed-methods review approach was used to identify the nature and extent of available evidence, and to identify under-researched areas (Grant and Booth, 2009).

The overall goal of the report is to inform decision-makers on the disparities in gender and sexual minority young people. Additional aims are (1) to examine protective factors and positive aspects, in order to balance the predominant 'victimising' narrative on SGM young, and (2) based on the synthesised evidence, to provide recommendations to stakeholders.

1.5. Research questions

1. What quantity and quality of evidence, in the form of reports, journal articles and datasets, on SGM young people (between the age of 10 and 26) has been published in European countries, and in particular in Ireland, since 2000, and what are their main conclusions?
2. How many reviews and meta-analyses have been carried out internationally with the same population(s) since 2000, and what are their main conclusions?
3. What are the knowledge gaps that need to be addressed to fulfil Objective 15[2] of the *LGBTI+ National Youth Strategy 2018-2020*?

Although we had not set formal hypotheses, it was anticipated that a) the overwhelming majority of empirical studies are conducted in North America, b) that the fifteen objectives of the *LGBTI+ National Youth Strategy 2018-2020* are not covered evenly by the identified studies, and c) that the available materials will vary widely in scope, depth, sample construction, methodological and analytic approaches.

1.6. The structure of this report

In the next section, we briefly describe the methods of the landscape and knowledge gap analysis. Then we provide an overview of the results in the form of a density map which shows how identified studies cover the goals and objectives of the *LGBTI+ National Youth Strategy (NYS) 2018-2020*. The main body of the report summarises the international and Irish findings for the fifteen NYS objectives.

2 **Enhance the quality of LGBTI+ data and commission research to ensure evidence-informed policy and service delivery.**

In each of these sub-sections, we provide a brief introduction, discuss positive aspects, protective factors and good practices. We also consider the **additionality** and **intersectionality** of the findings identified. Intersectionality refers to the complex ways in which individuals or groups of individuals may experience compound or intersecting forms of oppression, stigma and discrimination as a result of membership in one or more groups of marginalised identities (Crenshaw, 1991). We introduce the term 'additionality' in order to distinguish between the normative burden and problems of child and adolescent development and the excess burden stemming from SGM minority status. All sub-sections end with a summary of the knowledge gaps found related to specific objective, and recommendations for further research.

Finally, we discuss the findings of our analyses and reflect on the quality and diversity of the research landscape on SGM young people in Ireland and other countries of Europe, and summarise policy implications.

It is important to note that throughout Section 3 (Results) we make reference to the studies identified within the landscape analysis. However, at certain points other references were needed in order to provide context for the results, or highlight that evidence was not available in European countries but often found in North America. For the sake of better readability, we have not made a distinction between references featured in the landscape analysis and additional references. However these additional references are only included in the introductory text to each subsection and in the knowledge gaps / recommendations for research throughout Section 3 (Results) and Section 4 (Discussion). The reference list contains all sources included in the present Report. Appendix C contains a list of the evidence identified through the landscape analysis.

2. Method

2. Method

Our Study Protocol (Költő et al., 2019c) has been pre-registered at the Open Science Foundation website (https://osf.io/46q8f) where you can find a more detailed description of the methodological aspects of this study.

2.1. Phase 1: Landscape analysis – review of existing Irish and international research

We have organised the landscape analysis around five sources of potential information (national/international, published findings/grey literature and publicly available datasets) and seven strategies to collect all available knowledge. These are summarised in **Table 2**. The evidence identified was systematically entered into a database with two blocks (the Landscape and the Knowledge Gap phase). An Excel spreadsheet was constructed, which is summarised in **Table 3**. The framework for this spreadsheet can be downloaded from: https://osf.io/d65tb/.

Using the five-point search strategy outlined above, we populated the worksheet with evidence classified into the five groups: national/international, published/unpublished or grey literature, and available data. The first block consisted of the main attributes of each piece of evidence (data or publication) including how it was identified, the source and type of evidence (URL; data, book, peer-reviewed article, research/technical report, fact sheet, policy briefing, etc.), title, details of authors, venue of publication (e.g. name of the scientific journal or series); whether the information is in data format, whether it is stored in a metadata repository; DOI and/or other identifiers.

In the second block of the worksheet, characteristics of the piece of evidence were analysed and listed, including the aim of the study, research questions/hypotheses, characteristics of the sample, how the Sexual and Gender Minority participants were categorised, the predictor and outcome variables employed (where relevant), what analytic techniques were used (including theoretical approach to analysis where relevant); main findings; practical/policy implications; and conclusions drawn, with special regards to gaps or identified need for future research.

Table 2. Strategies for research and data identification

Source Strategy	National published data and literature	National grey or unpublished data and literature	International published data and literature	International grey or unpublished data and literature	National or International datasets
1. Database search	Search for published peer-reviewed research outputs carried out with LGBTI+ / SGM youth in Ireland		Search for published peer-reviewed research outputs carried out with LGBTI+ / SGM youth internationally		Search for relevant available datasets via databases
2. Online search		Search for unpublished grey literature (reports, strategy documents) and on-going research in Ireland		Search for unpublished grey literature (reports, strategy documents) and on-going research internationally	Search for relevant available datasets online via standard search engines
3. Approach identified researchers	Contact authors of the identified research outputs if they conducted further research in the area since publication		Contact authors of the identified research outputs if they conducted further research in the area since publication		Contact authors of the identified research outputs to clarify if their datasets are publicly available with accompanying documentation
4. Approach national governmental bodies and national and international stakeholder associations	Contact governmental bodies and stakeholder associations if they conducted research on LGBTI+ youth (both current and past) or plan to in the near future		Contact international stakeholder associations (e.g. ILGA-Europe, European Union Agency for Fundamental Rights and ask their help in identifying additional datasets, research outputs or projects in progress		Contact owners and commissioners of the identified datasets to ascertain if they are publicly available with accompanying documentation
5. Utilise international HBSC research network			Contact HBSC Principal Investigators in 49 countries and ask their help in identifying additional datasets and research outputs, completed or in progress.		
Collate Findings	Create the Landscape Database and Assessment of Quality and Applicability				
International Expert (Prof. Saewyc)	The International Expert reviews Landscape Analysis findings for completeness and professional content				

Table 3. Grid output of the Landscape and Knowledge Gap Analysis, with the main attributes of the listed evidence

<table>
<tr><th></th><th>1a: Landscape Analysis, first phase: Review of existing Irish and international research, evidence and data</th><th>1b: Landscape Analysis, second phase: Identifying data sources and indicators; recording high quality data and indicators</th><th>2: Knowledge Gap Analysis</th></tr>
<tr><td>1. National published literature</td><td rowspan="4">Strategy of identification
Source
Data or publication
Type of study
Design
Type of publication
Title
Author(s)
Affiliation of authors
Corresponding author's availability
Venue published
Metadata repository
DOI
Other identifier(s)</td><td rowspan="4">Aim
Research question(s)
Research hypothesis(es)
Sample
Gender / Sexual Minority characteristics
Independent variables
Dependent variables
Methods of statistical / qualitative analysis
Main findings
Practical implications
Policy implications
Conclusions
Relevance to the LGBTI+ NYS
Evidence level: according to CEBM and MMAT/AACODS classifications</td><td rowspan="4">Research gap(s)
Strength
Quality
Applicability to Irish context, specifically the LGBTI+ National Youth Strategy 2018-2020
Overall evaluation
Recommendations</td></tr>
<tr><td>2. National grey or unpublished literature</td></tr>
<tr><td>3. International published literature</td></tr>
<tr><td>4. International grey or unpublished literature</td></tr>
<tr><td>5. National or International datasets</td><td colspan="3">Relevant points from 1 and 2 above plus metadata, hyperlinks, availability, data documentation, applicability assessment and quality indicators as agreed.</td></tr>
</table>

For further information and a more detailed breakdown of the main attributes, please consult the frame spreadsheet (https://osf.io/d65tb/).

2.2. Phase 2: Research and Data Gap Analysis

Once the available evidence and identified data sets were mapped and added to the spreadsheet, they were analysed for strength, quality and applicability. If the document was international (European) research or was conducted in a regional or local setting within Ireland, its applicability for the Irish (national) context was also assessed as described below.

2.2.1. Strength

Strength of the evidence was assessed against the following criteria:

- **Coverage of the data** – local, regional, national, or cross-national
- **Representativeness** of the data
- **Scope of the analysis** – descriptive, correlational, or looking into probable causalities (mediation, structural equation modelling), or profiling of the groups (cluster analysis, latent class analysis)
- **Temporal dimension** – are the data cross-sectional or longitudinal? If trends are analysed, are the time and cohort effects separated?
- **Gender comparisons** – are the data analysed by gender breakdown, has the study gone beyond gender categories, are trans, intersex, genderqueer or other non-binary gender identities studied?
- **Sexual orientation/identity comparisons:** are lesbian, gay, bisexual (or same-sex attracted, both-sex attracted) groups separately analysed?
- **Dimensions of sexual orientation** – What measures were used to categorise sexual minority youths (romantic attraction, love, dating, sex of the romantic partners, sex of sexual partners, self-identified labels); are response(s) expressing uncertainty allowed; is categorisation based on a single measure, or correspondence of different categories (e.g. sex of sexual partner and self-identified labels)?
- **Intersectionality** – are grounds of marginalisation / discrimination other than SGM studied? Are LGBTI+ youths with other minority status (e.g. ethnic or migrant status, having a chronic condition or disability) studied?

2.2.2. Quality appraisal

Most scoping reviews aim to summarise and chart previous work on a given topic but critical appraisal of the quality of the material is usually not involved (Tricco et al., 2018). The present landscape and knowledge gap analysis, however, attempted to assess the quality of the identified literature and data. The purpose was to inform recommendations on what areas of LGBTI+ youth research should be adapted and/or improved. There is no comprehensive system which could have been adopted to evaluate all pieces of empirical evidence, including datasets, grey literature, peer-reviewed quantitative, qualitative and mixed methods studies and aggregated evidence (such as meta-analyses and literature reviews). Therefore we employed a range of methods to appraise the quality of included material. These are described in detail in the protocol (Költő et al., 2019c). We did not exclude any pieces of the identified material on the basis of their quality.

2.2.3. Applicability

Applicability of the international findings/indicators in Irish context was assessed on the basis whether their sampling, method(s), and indicators would be in line with the goals and objectives of the *LGBTI+ National Youth Strategy*. Strengths and weaknesses of the materials were analysed with special regard to this aspect.

2.2.4. Overall evaluation

Based on the results of the Research and Knowledge Gap Analysis, an overall evaluation of all reviewed evidence was provided, by objective of the LGBTI+ youth strategy. The main dimension of the evaluation was whether there is a gap on the given topic in the context of LGBTI+ youth in Ireland, and if so, can we use findings from other countries to address that gap. All studies were classified into the following categories:

1. **No further action needed: high quality national data exist.** The national Irish data/output answers the needs of LGBTI+ youth, is strong and high quality, the given need is well addressed in terms of research and can be aligned with the objectives of the *LGBTI+ National Youth Strategy 2018-2020*.
2. **No further action needed: research needs in Ireland are covered.** The international data/output answers the needs of LGBTI+ youth, is strong and high quality, but either data from Ireland is part of the international comparison, or the given need is already addressed by existing and well-documented research in Ireland.

3. **National research needs to be improved.** The national Irish data/output answers the needs of LGBTI+ youth but is weak or low quality. The research team will give recommendations for further studies that can improve the strength and quality of the findings for the given health need, sample or methods.
4. **International research should be adapted.** The given international data/output answers to needs of LGBTI+ youth, is strong and high quality, the area, method or indicators are not yet covered in existing and well-documented research in Ireland, the given indicators could have been aligned with the *LGBTI+ National Youth Strategy 2018-2020*'s objectives. The research team will formulate recommendations on how the given research could have been adapted to the Irish nationwide setting.
5. **International research could be adapted with modifications.** The given international data/output answers to needs of LGBTI+ youth, is weak or low quality, but elements of the work (e.g. comparisons of specific sub-groups, or additional indicators) could be implemented in Irish settings with appropriate modifications to the *LGBTI+ National Youth Strategy 2018-2020*'s objectives.
6. **No further action needed: International research is not relevant.** The given international evidence, regardless of its strength or quality, is not relevant or applicable in an Irish context.

2.3. Data collection procedures

2.3.1. Methods

Five methods were used to identify and collate existing evidence:

1. **A focused online database search** for peer-reviewed research findings in eight databases (PubMed, Web of Science, CINAHL, Embase, ProQuest, PsychInfo/OVID, Scopus and ERIC), with a combination of keywords:
   - > Descriptors of LGBTI+ / Gender or Sexual Minority, AND
   - > Descriptors for adolescent, youth, children, young people AND
   - > Descriptors for the five 'Better Outcomes, Brighter Futures' framework (DCYA, 2014) outcomes. (For the keywords, see Appendix B).

2. An **overall online search** via a standard search engine and specific databases of grey literature (e.g. Google Scholar, OpenGrey, RIAN, EThOS, ProQuest, WorldCat, Networked Digital Library of Theses and Dissertations, Open Access Theses and Dissertations) was conducted, to identify a) Irish and international unpublished sources of knowledge (strategy and policy documents, fact sheets, technical reports, short reports) and b) publicly available or open access datasets (WHO Global Observatory, OECDdata.org, EU Open Data Portal, ESRC UK Data Service, Register of Research Data Repositories, Research Pipeline), using a combination of relevant research terms given in Appendix B.

3. To help ensure as complete coverage as possible, a number of corresponding authors of the identified research outputs **were contacted via email (pearl-growing) to inquire about further research** they may have conducted in the area and if they have made the resultant datasets publicly available. Access to these was requested from authors, commissioners or data owners, as relevant.

4. We created **a comprehensive list of all European stakeholders** – including national governmental bodies, LGBTI+ associations and local resource centres, and contacted them via e-mail to enquire about any work they had conducted that was not available online. International stakeholder organisations outside Europe were identified in the same manner and were contacted regarding their unpublished work. Our list was based on the international or national members of the European region of the International Lesbian, Gay, Bisexual, Trans and Intersex Association (ILGA-Europe). We contacted all member associations that had a valid e-mail address.

5. Principal Investigators of the international HBSC Network from the 49 countries that are currently participating in the network were contacted. These countries cover the geographical areas of Europe, North America and the former Soviet member republics. Of these, special emphasis was given to the 28 HBSC member countries of the European Union.

The findings have been reviewed by our International Expert, Professor Elizabeth M. Saewyc (School of Nursing, University of British Columbia, Vancouver, Canada) for completeness and professional content.

2.3.2. Inclusion criteria

We limited the collection to material published in English. We aimed to include all studies published in peer-reviewed outlets and grey literature within the geographical boundaries of the European Union. No geographical constraints were applied for review papers (including systematic and other type reviews and meta-analyses). We only included primary and review studies published between January 2000 and September 2019, and datasets between January 2010 and September 2019. A methodological dilemma arose as to what age limits to apply. Given the age distributions in the reviewed evidence, we decided to include all studies where participants were 26 years or younger. If the given study involved older participants, the inclusion criteria was that at least 50% of the participants should be 26 years old or younger. We did not apply any disciplinary boundaries to the search. In case of conflicting evaluation and ambiguity, the given records were discussed with a third researcher until consensus was reached.

3. Results

3. Results

Applying the methods and the inclusion criteria outlined above, we identified 4563 records in scientific databases, and 40 records from other sources. Following the cleaning process outlined in the Study Protocol (Költő et al., 2019c), 126 publications remained. These were subsequently entered into the landscape and knowledge gap spreadsheet.

The next step was to assign each record to the fifteen objectives in the *LGBTI+ National Youth Strategy 2018-2020*. The results are displayed in a density map (**Figure 1**) which demonstrates the extent of research coverage for each. Most of the identified records are relevant to more than one objective (on average, each record was associated with 3.31 objectives); the percentages indicated in the density map are inclusive of these overlaps. The map shows that the distribution of the evidence is uneven across objectives:

- **High coverage:** Creating a more supportive and inclusive environment for LGBTI+ young people in formal education; creating safe environments.
- **Moderate coverage:** Responding effectively to the mental health needs of LGBTI+ young people; improving the physical and mental health of transgender youth
- **Poor coverage:** Ensuring equal employment opportunities and an inclusive work environment for LGBTI+ young people; addressing fragmentation in funding and support networking on organisations to work collaboratively.

In the following sub-sections, we provide a brief introduction and then summarise the identified evidence relevant to each objective. First, we give an overview of how the given objective is represented in international and Irish studies. We analyse whether the findings demonstrate additional importance for LGBTI+ young people (i.e., whether they are specific to LGBTI+ compared to other groups of young people), and whether intersectionality is examined. Positive aspects and protective factors emerging from the studies are summarised, and good practices and interventions are highlighted. Next, knowledge gaps are identified which highlight whether more research on the topic is needed in Ireland. In some cases the research gaps are broader than the specific objective of the *LGBTI+ National Youth Strategy 2018-2020*. Finally, we offer recommendations for researchers on future studies that could help address the identified knowledge gaps.

Figure 1. Density map of research on LGBTI+ youth across the LGBTI+ National Youth Strategy Goals and Objectives

Index – level of representation

Very poor	Poor	Quite poor	Some	Fair	Quite high	High	Very high
(1.0–2.78%)	(2.79–4.55%)	(4.56–6.33%)	(6.34–8.10%)	(8.11–9.88%)	(9.89–11.65%)	(11.66–13.43%)	(13.44–15.20%)

GOAL 1: Create a safe, supportive and inclusive environment for LGBTI+ young people

Objective 1: Create a more supportive and inclusive environment for LGBTI+ young people in formal education settings (15.2%)	**Objective 2:** Create safe environments for LGBTI+ young people (14.2%)	**Objective 3:** Make all youth services more inclusive of LGBTI+ young people and provide accessible LGBTI+ youth services nationally (5.9%)
Objective 4: Ensure equal employment opportunity and an inclusive work environment for LGBTI+ young people (2.4%)	**Objective 5:** Provide a more supportive and inclusive environment that encourages positive LGBTI+ representation and participation in culture, society, and sport, and reduces LGBTI+ stigma (9.6%)	**Objective 6:** Expand and develop supports to parents and families of LGBTI+ young people (4.7%)
Objective 7: Provide capacity building measures among service providers to improve their understanding of, and ability to engage with, LGBTI+ young people (9.4%)	**Objective 8:** Address gaps in current legislation and policies, and ensure inclusion of LGBTI+ young people in future legislation and policy development (3.3%)	**Objective 9:** Address fragmentation in funding and support networking of organisations to work collaboratively (1.2%)
	Objective 10: Provide an inclusive physical environment for transgender and intersex young people (4.7%)	

GOAL 2: Improve the physical, mental and sexual health of LGBTI+ young people

Objective 11: Respond effectively to the mental health needs of LGBTI+ young people (11.4%)	**Objective 12:** Strengthen sexual health services and education to respond to the needs of LGBTI+ young people, including in the area of sexual consent (4.3%)	**Objective 13:** Improve the physical and mental health of transgender young people (8.3%)	**Objective 14:** Improve the understanding of, and the response to, the physical and mental health needs of intersex young people (2.2%)

GOAL 3: Develop the research and data environment to better understand the lives of LGBTI+ young people

Objective 15: Enhance the quality of LGBTI+ data and commission research to ensure evidence-informed policy and service delivery **(3.3%)**

3.1. Objective 1: Supportive and inclusive environments in formal education

The first objective of the LGBTI+ National Youth Strategy is to create a more supportive and inclusive environment for LGBTI+ youth in formal education settings. It includes eight actions, from encouraging schools to develop a whole-school inclusion policy, reviewing and updating professional development supports for teachers, developing and piloting a student-centred and evidence-based model of peer support for LGBTI+ youth and their allies in post-primary schools, and to support student-led initiatives in higher education that aim to increase LGBTI+ awareness.

Inclusive education, in the broad sense, is based on the premises that all children have a fundamental right to education and learning; every child has unique characteristics and interests; and educational systems should be designed, and educational programmes implemented, to meet the wide diversity of characteristics and needs of young people (UNESCO, 1994). A first step of creating inclusive environments is to make schools aware that there are non-heterosexual students in their schools and to ensure that non-heterosexual students are provided with the relevant protection and education (McNamee, 2006). Sexual and gender diversity inclusive practices in education are complex and multidimensional (Ávila, 2018). These include:

- Legislation: Anti-discrimination and anti-bullying legislation or action plans, at both national and local level, including in school policies.
- Curricula: LGBTI+ topics covered in various subjects, most importantly in sexuality and relationships education.
- Training: Mandatory training programmes for teachers and/or other educational professionals to increase awareness and sensitivity to the specific needs of LGBTI+ pupils.
- Data collection on bullying and harassment.

At the level of the school and classrooms, various interventions and practices can be implemented to increase and ensure inclusion of sexual and gender minority students.

As illustrated in **Figure 1** (the density map of the identified research outputs), the largest number of research outputs, 75 records in total were relevant to this objective. In order to summarise these outputs, first we grouped them thematically (**Table 4**).

Table 4. A thematic grouping of studies relevant to Objective 1 of the *LGBTI+ National Youth Strategy* (Supportive and inclusive environments in formal education)

Topic	International literature	Irish literature
Educational experiences, bullying, school violence	103, 132, 201, 206, 208, 209, 210, 211, 212, 213, 214, 215, 222, 228, 229, 231, 233, 238, 239, 306, 308, 317, 318, 320, 321, 322, 323, 502, 508	155, 205, 217, 317*, 325, 405
Mental health, suicide, risk behaviour	101, 102, 108, 110, 113, 116, 123, 132, 150, 153, 216, 219, 221, 304, 306	120, 128, 145, 152, 155, 217, 312, 507
Inclusive education, safe schools, gender-sexuality alliances (GSAs), human rights	147, 202, 203, 206, 209, 220, 226, 232, 502, 514	128, 155, 226*, 232*, 312, 325, 405, 507
Social exclusion, discrimination and marginalisation	102, 134, 215, 315, 316, 239	217, 404*, 503
Positive aspects, protective factors, resilience, well-being	105, 126, 127, 309, 502	145, 312, 503
Needs and voices of LGBTI+ young people	134, 224, 225, 324	405, 507

The numbers refer to the ID of the given outputs (consult Appendix C for the full list of references). Some studies include more than one topic; hence some numbers overlap between cells. Studies indicated by * are international comparisons which contain Irish data.

As **Table 4** shows, most international research outputs that are related to inclusivity analyse educational experiences, bullying, and school violence. Since the issues of bullying and school violence are closely associated with safety, they will be discussed in Section 3.2 on safe environments. It is important to note that effective inclusion policies involve explicitly sanctioning bullying and other forms of discrimination and exclusion, however many school-level policies do not mention homophobic bullying (Smith et al., 2008).

3.1.1. Findings from international studies

There are various ways in which LGBTI+ inclusivity in educational settings can be improved. According to a study carried out with SGM young people in Northern Ireland, the most frequent suggestions for what would help them in school were: including sexual orientation in the curriculum (90%); promoting equality of opportunity

for LGBTI+ students (89%); staff training in sexual orientation and homophobia (87%); dissemination of information about LGBTI+ issues (79%); and school GSAs (70%) (Boyd, 2011). Similar findings were reported by Black et al. (2012). A Dutch study (Sandfort et al., 2010) found that in those schools where expectations and rules were experienced as clear and consistent, there were no difference in the frequency of mental health problems among sexual minority and non-minority students. In schools where expectations and rules were experienced as less consistent, students belonging to sexual minorities reported significantly more mental health problems than their non-minority peers. Perceived cultural pluralism of the school had no such differential effect. This finding implies that structural features of the schools, broader than attitudes and approaches to LGBTI+, may influence the mental health of sexual (and probably gender) minority students.

Potential benefits of LGBTI+-inclusive education include an improved understanding of people and the world around them, a reduction in (homophobic) bullying, and the provision of an essential safeguarding mechanism that protects SGM youth. However, in a study with young people from the United Kingdom, only 5% of young people were taught about LGBT sexuality and relationships, while ninety-seven percent of respondents thought that all sexuality and relationships education classes should be LGBT-inclusive and 91% thought that trans awareness should be taught in schools. Young people were eight times more likely to rate their sexuality and relationships education classes as 'excellent' if it was LGBT-inclusive (THT, 2016).

According to the International Lesbian, Gay, Bisexual, Transgender, Queer and Intersex Youth & Student Organisation's *LGBTQI Inclusive Education Report* (Ávila, 2018), of the 47 Council of Europe member states (including Belarus and Kosovo), some governments have already taken significant steps to ensure education is inclusive of all learners. In particular, 69.4% of the countries have implemented anti-discrimination laws or action plans applicable to education that explicitly mention sexual orientation, gender identity and expression, or variations in sex characteristics as grounds for protection. Other practices, however, still need to be improved in most countries. Overall, the main areas for improvement are compulsory education curricula, mandatory teacher training and data collection on bullying and harassment on grounds of actual or perceived sexual orientation, gender identity and expression or variation in sex characteristics. There were only four countries (Malta, Netherlands, Norway

and Sweden) that provide most of these measures. Some regions in Spain have also developed inclusive laws and policies, but they have not been implemented nationally. In contrast, eleven countries had failed to implement any measure at the time of writing the report (Armenia, Azerbaijan, Belarus, Latvia, Macedonia, Monaco, Poland, Russia, San Marino, Turkey and Ukraine).

LGBTI+ in school curricula

A large number of SGM students report that they have never learnt about LGBTI+-related topics in the school (Bradlow et al., 2017), although the vast majority of them would like to see such perspectives, and LGBTI+ authors, more systematically included in the curriculum (Acciari, 2014). It is important to critically revisit how LGBTI+ issues should be covered in different subjects in a way that is not just limited to sexuality and the 'tokenistic gay and lesbian lesson' but taught cross-curricularly to help children understand and challenge heteronormativity (Formby, 2015). A Northern Irish study found that 24% of the participants had been taught something about being LGBTI+ that they knew at the time of the survey to be untrue. Only 6% reported that they have learnt something in sex education class that they felt was relevant to them, and 79% reported that they did not learn anything about LGBTI+ rights in school (Boyd, 2011). Another important area many sexual health and relationships education curricula fail to include is specific information about transgender and other gender nonconforming identities (Boskey, 2014). However, inclusion of LGBTI+ in the school curricula, on its own, is not sufficient support to SGM youth. A comparison between 1984 and 2001 data revealed that mentioning homosexuality in school classes – and the number of those who regarded this helpful – had significantly increased, but somewhat paradoxically it was accompanied by worrying increases in verbal abuse, physical assault and feelings of isolation (Ellis and High, 2004).

Teacher training

Training for educators is required to appropriately respond to queer student issues. In a review on queer youth in educational research, a general observation was that many teachers themselves expressed a strong desire for more training on relevant issues (Jones et al., 2018). The presence of supportive teachers and other school staff is directly linked with student well-being at school (Sandor et al., 2017). Having even one dedicated school staff member with responsibility for supporting LGBTI+ students can make a difference to the well-being and sense of safety of SGM youth

(McNamee, 2006). This finding, however, is contradicted by another study showing that the presence of supportive staff alone was not sufficient to encourage students to approach school staff with problems; nor was it enough to make changes in a hostile climate, where bullying and harassment were often unaddressed (Pizmony-Levy and BeLonG To, 2019). Nevertheless, the benefits of having supportive staff are apparent. A Hungarian study, for example, found that pupils who reported having a higher number of teachers and school staff that support LGBTI+ students were more likely to report greater acceptance of LGBTI+ people, to feel part of their school community, and less likely to miss days of school because of feeling unsafe because of their sexual orientation, gender identity or gender expression (Sandor et al., 2017).

School-level policies and interventions

A review of 17 studies showed that students who attended schools with visible safe school policies and programmes reported more positive psychological outcomes. 'Gay-Straight Alliances (GSAs)' were strongly associated with positive sexual diversity climates and lower incidence of homophobic bullying and remarks (Marx and Kettrey, 2016). Students in schools with even one of the safe school interventions perceived their school to be a safer, less sexually prejudiced environment. Policies and programmes in combination with supports had the most positive outcomes (Black et al., 2012). Sandor et al. (2017) reported that LGBTI+ students in schools with *any* type of policy about bullying or harassment were: more likely to report that teachers intervened when homophobic or transphobic remarks were made; more likely to report incidents of harassment and assault to school staff; and more likely to report that staff intervention regarding harassment and assault was effective.

Anti-bullying laws and policies exist in many countries, but research shows that these are not appropriately addressing the needs of LGBTI+ students. Policies may have positive as well as negative impacts on LGBTI+ inclusivity. For instance, in some US states, federal policies follow a "No Promo Homo" principle (Abreu et al., 2016). This term, short for "No promotion of homosexuality", refers to local or state-level laws and policies explicitly forbidding school staff to discuss LGBTI+ people, or LGBTI+-related topics, in a positive way or at all (Eskridge Jr, 2000). School-level policies and regulations have greater role than federal or state-level regulations (Abreu et al., 2016). This finding indirectly implies that any action to increase inclusivity must be initiated within the given setting. While the principles of inclusivity are universal (UNESCO, 1994), there is no single 'one size fits all' approach that can be used in every school.

Datasets

Ávila (2018) recommends that data on bullying and harassment of LGBTI+ young people be collected in a systematic way in order to improve inclusive education. While this objective is well covered within the published findings, available data sources seem to be very scarce. Only two datasets were found that contain any data on LGBTI+ inclusive approaches in education. One of these is a comprehensive survey on young people's lifestyles in Northern Ireland (Schubotz, 2017), in which sexual minority students can be categorised based on their sexual attraction. Additional to evidence that is well covered in published studies, this resource contains data on various aspects of volunteering work and community connectedness, which would be important to investigate in detail. The other resource contains transcripts of focus groups and individual interviews with LGBT young people from the United Kingdom on the topic of suicide (Roen et al., 2006). An important outcome of this qualitative work is that seeking safe spaces and supportive communities is a potential strategy of LGBTI+ young people to combat suicidality, which therefore contributes to their resilience.

3.1.2. Findings from Irish studies

The good news is that according to an international comparison of how well the educational system is doing to cater for SGM students (Dankmeijer, 2017), Ireland was ranked at the top. The study used a 15-element scoring system, completed by local expert activists. The system measured whether:

- schools are accessible to SGM students (e.g. allowing freedom of expression, protecting students from bullying, preventing drop-out)
- sexual diversity is represented in the curriculum
- staff and school environment are supportive to SGM students (e.g. staff are competent in teaching about sexual diversity, and SGM staff themselves are protected).

It should be noted, however, that this excellent score does not correspond with other findings. For example, the ILGA Rainbow Score (47%) (ILGA-Europe, 2019) indicates that the legislative and legal environment in Ireland is not fully LGBTI+ inclusive. Cross-national comparisons also do not provide a local picture (i.e., differences across schools within the country). According to the *LGBTIreland Report* (Higgins et al., 2016), most participants rated their school as 'somewhat' LGBTI+-friendly; 72% reported

that they felt they belonged or somewhat belonged in their school as LGBTI+; however, less than half (43.7%) reported that they received positive affirmation of their LGBTI+ identity within school. Lived experiences of many LGBTI+ young people, especially in rural areas of Ireland, is often characterised by social exclusion, bullying, harassment, and a lack of acceptance (Bowen, 2019, Mannix-McNamara et al., 2013). In an international comparison of experiences of social exclusion, an Irish respondent emphasised that the lack of openly LGBTI+ teachers, who could be potential positive role models for LGBTI+ students, seemed to be a part of the general problem of acceptance: "very few if any teachers are openly gay because it's not a conducive environment for employees to be out in either" (Takács, 2006).

LGBTI+ in school curricula

According to the 2019 School Climate Survey (Pizmony-Levy and BeLonG To, 2019), more than two thirds (68%) of LGBTI+ students report they were not taught anything positive about LGBTI+ identities in school. They identified positive representations of LGBTI+ topics in SPHE (23%), English (7%) and History (6%). Including LGBTI+ related issues in the curriculum means students are 26% more likely to feel accepted by the student body, 20% more likely they belong at school, and 9% more likely to not to miss days of school due to feeling unsafe (Pizmony-Levy and BeLonG To, 2019). In another study, negative portrayal of LGBTI+ in school curricula was experienced by half of the respondents (Reygan, 2009).

Teacher training

We did not identify any research on teaching materials or training programmes for teachers and other school staff to improve LGBTI+ sensitivity and address specific problems of SGM students. Lesbian, gay and bisexual young people from Ireland, however, highlighted the need for teachers to receive training in these issues (Reygan, 2009). In a qualitative study carried out in the UK practitioners, including schoolteachers, expressed a desire for holistic and specific training on LGBTI+ issues that addresses the complex and challenging issues that arise, and which includes the voice of SGM young people directly (Sherriff et al., 2011). Such qualitative studies in Ireland should also map how and why formal and informal curricula do, or do not, include issues about sexuality and gender identity (Formby, 2015). It is important that teachers themselves are asked what resources they need in order to include LGBTI+ issues in the curricula of their subjects and to respond effectively to the problems of their sexual or gender minority students (Jones et al., 2018).

School-level policies and interventions

Although 88% of LGBTI+ students report that they have an anti-bullying and harassment policy in their school, only 29% of students reported that the policy explicitly mentioned sexual orientation or gender identity and expression (Pizmony-Levy and BeLonG To, 2019). This highlights the need for whole-school policies to ensure the inclusion of LGBTI+ young people, with particular regard to exploring opportunities for the appropriate inclusion of LGBTI+ lives in the teaching curriculum (DCYA, 2018).

Data collection

Publicly available data sources from the Republic of Ireland are extremely scarce. We identified only one repository dataset. The Growing up in Ireland Child Cohort study's Wave 3 data (ESRI, 2014) offers cross-sectional data on 17-and 18-year olds who were born in 1998. The dataset includes measures of gender and sexual minority status and having a girl- or boyfriend. The large number of potential predictor and outcome variables includes experiences in school, family and neighbourhood; therefore, there is high potential for a cross-sectional picture of perceived inclusion within this birth cohort. The 2018 Irish Health Behaviour in School-aged Children study (Költő et al., 2020b) also enables categorisation of a nationally representative sample of 15-17-year olds based on same-, both-, and opposite-gender romantic attraction. The *LGBTIreland Report* (Higgins et al., 2016), the 2019 *School Climate Survey* (Pizmony-Levy and BeLonG To, 2019), and the most recently published My Word Survey 2 (Dooley et al., 2019) are also important sources of potential analyses on SGM youth's sense of inclusion in Ireland.

Communities outside the school

Young people may have positive experiences and find a sense of belonging outside formal education settings that can empower them to face exclusion within the educational system. A qualitative study carried out with LGBTI+ individuals in Ireland illustrated that creative and sports communities may give young people interpersonal recognition which may act as a buffer against minority stress (Ceatha et al., 2019).

3.1.3. Additionality and intersectionality

It is important to recognise that many children from marginalised groups other than SGM may face similar psychosocial stressors and negative consequences to those experienced by LGBTI+ young people, as there are common mechanisms of social

exclusion, discrimination and marginalisation (Molcho et al., 2008). Conversely, social mechanisms in adolescents that contribute to the social exclusion, bullying and harassment of LGBTI+ young people (Russell and Fish, 2016) may be generalised to members of other (or multiple) minority groups. Increasing LGBTI+ inclusivity in schools has the additional benefit for LGBTI+ students to feel more valued, accepted and respected if the above outlined actions are implemented.

3.1.4. Positive aspects and protective factors

Evidence on the factors that promote inclusion and thus contribute to resilience and well-being among SGM youth are largely missing. A review of adaptive coping and mental health in lesbian adolescents and young adults emphasised the importance of a 'strengths' approach (Kulkin, 2006). It identified individual factors such as proactive problem solving, internal locus of control, and using functional coping strategies such as utilising someone's social network, practicing relaxation, or going to therapy. Stable and caring family and affirming relationships contribute to the feelings of self-esteem and self-efficacy. Finally, those who felt they are able to successfully cope with stressful life events such as coming out, perceived these events as beneficial to them. The latter is closely related to the concept of **coming out growth**[3], the progress and sense of personal development due to understanding and disclosing someone's sexual identity.

In a systematic review on protective factors in transgender and gender variant youth, Johns et al. (2018a) identified 27 unique protective factors, which they grouped into individual, relationship and community levels. The community-level protective factors included school policies, organisational resources and visibility of the communities, which can be clearly linked to LGBTI+ inclusion.

It is also important to acknowledge and document that educational contexts can embrace and adapt to societal changes and thus may become more inclusive. In a qualitative study with bisexual boys, most respondents reported that they felt coming out was a positive experience for them, and that their schools and teachers were supportive, especially if there were anti-bullying campaigns or gay-straight alliances in the school (Morris et al., 2014).

3 Conceptualised by US authors Vaughan and Waehler (2010).

Including LGBTI+-related issues in the curriculum in a positive way may make LGBTI+ students feel like more valued members of the school community, and it may also promote more positive feelings about LGBTI+ issues and persons among their peers, which seems to result in a more positive school climate (Pizmony-Levy, 2017). The good news is that it seems there has been some advance in the coverage of LGBTI+ issues in the school curricula (Formby, 2015), and in general, a large number of European countries implement at least some actions to improve LGBTI+ inclusion in educational settings (Ávila, 2018).

Many LGBTI+ people feel that their sexual or gender minority status helped them improve their skills of empathy and compassion, and some credit their experiences with prejudice as important to care for others who are also oppressed and stigmatised, on other or multiple grounds (Riggle and Rostosky, 2012). This may act as a driving factor to work for social justice and participate in various types of activism. The evidence supports that many SGM young people volunteer for the local LGBTI+ communities and are involved in activism (Acciari, 2014, Blackburn and McCready, 2009) or express a desire to belong to such a group (Carolan and Redmond, 2003). In a US study with students in 33 GSAs, greater GSA involvement was associated with higher levels of civic engagement, advocacy, and awareness-raising, not just specific to LGBTI+ issues but also in general. The effect was independent of sexual orientation or gender identity, and was partially mediated through youths' greater sense of agency (Poteat et al., 2018).

3.1.5. Good practices and interventions

First, it is important to note the positive changes recently taking place in Ireland. There are remarkable teachers and school staff across Ireland improving lives by creating safe, supportive spaces for LGBTI+ students (Pizmony-Levy and BeLonG To, 2019). There is, however, room for further improvement. Below we make some suggestions based on the available evidence.

- The characteristics of the setting and the needs of local stakeholders need to be considered in implementing changes (e.g., Bowen, 2019). School characteristics (e.g. school size, location and demographic composition of the students) make a difference in the efficacy of GSAs (Goodenow et al., 2006). In larger schools, setting up a GSA may be beneficial, while in

smaller schools, other types of interventions may have a better effect. For instance, many schools in Ireland organise a "Stand Up Awareness Week", which includes teaching about notable historical LGBTI+ personalities, placing LGBTI+ terminology posters in social venues, or organising a table quiz.[4] Repeated events may have an additional cumulative positive impact on the school. Such actions should be flexibly used and adapted to the local setting. Any planned interventions should be preceded by consultations with students, teachers, parents and other stakeholders.

- Another important finding is that different forms and types of interventions are interrelated with each other and school characteristics. For instance, schools that have safe school and anti-bullying policies are more likely to also have SGM student support groups (Goodenow et al., 2006). Ideally, different interventions should be sequential: first there should be explicit school-level policies and adequate teacher and school personnel training before LGBTI+ issues are added in the curriculum, or a GSA is established. These findings highlight the importance of a holistic, whole-school approach. Ad-hoc, tokenistic actions will not have the same effect as interventions that are rooted in evidence and implemented on the basis of consensus of all stakeholders, with all of them actively being involved.
- Ideally, development of school curricula and implementing other inclusive school activities do not simply seek to raise LGBTI+ inclusivity but recognise that the oppression of sexual and gender minority individuals (just like other marginalised groups) is part of a more general cultural and societal pattern which needs to be challenged (Formby, 2015).
- Issues of gender expectation, non-conformity and gender roles are relevant to all youth. Beside teaching about sexual orientations and sexualities, including gender identity development in curricula can help students better understand gender diversity (Boskey, 2014).
- Teaching LGBTI+ issues alongside concepts like compassion, empathy and social justice (Riggle and Rostosky, 2012) may have an added pedagogical value.

4 **A comprehensive toolkit for organising a "Stand Up Awareness Week" can be downloaded at: http://www.belongto.org/professionals/standup/.**

3.1.6. Knowledge gaps and recommendations for further research

Further investigation is needed on what makes schools inclusive. What are the needs of (LGBTI+ and non-LGBTI+) pupils? What resources and training teachers need to make schools a more inclusive environment? What are the perspectives and needs of parents and other family members? To some extent these are captured in international (Neill and Meehan, 2017) and in Irish regional (Bowen, 2019) studies, but at the national level so far we only have a list of 'burning issues' (Noone, 2018).

Irish studies with LGBTI+ young people should map experiences of discrimination, and dedicated qualitative work is needed on experiences of trans, intersex and other gender diverse young people to better understand their specific vulnerability. A methodological exploration is needed on best practices for collecting data on gender identity as well as sex assigned, or registered, at birth in research studies (Jones, 2019).

Studying the efficacy of interventions to improve SGM individuals' lives is a salient area of LGBTI+ research (Stall et al., 2020). According to our analysis, there is a dearth of such studies in Ireland and other European countries. There is a need for implementation studies, for example, evaluating the impact of the planned reform of Social, Personal and Health Education (SPHE) on sense of inclusion. Evaluations of the impact of LGBTI+ diversity training on practitioners and on practice with young people are required, as are evaluations of participatory training models (Sherriff et al., 2011).

While there has been numerous cross-sectional studies, there have been no trend analyses or longitudinal studies to test whether the implementation of inclusive policies have had any positive impacts on LGBTI+ and non-LGBTI+ young people. The Growing Up in Ireland study (ESRI, 2014) does have this capacity. Other population studies in Ireland and other European countries, such as PISA (McKeown et al., 2019), could cover different dimensions of sexual orientation and gender diversity and conduct international comparisons on the impacts on SGM young people.

3.2. Objective 2: Safe environments

This objective includes six actions, ranging from having at least two trained LGBTI+ liaison officers in each Garda division, Joint Policing Committees to consult and engage with LGBTI+ organisations, and collecting data on LGBTI+ related crimes, to ensuring that in reception centres and accommodation centres for people seeking or granted international protection, and that compliance criteria and safety standards are developed and implemented. The last action point under this objective is mapping existing LGBTI+ youth services and groups and considering how more alcohol-free safe spaces can be provided that are inclusive of LGBTI+ young people. In total, 70 research outputs were relevant to this goal, however most of these focus on bullying-victimisation and explore bullying in educational settings. Only six international studies and two studies conducted in the Republic of Ireland explore safety issues outside school settings.

3.2.1. Findings from international studies

Bullying and peer victimisation

SGM youth's perceived safety is largely determined by the presence or absence of bullying, harassment and violence related to their sexuality or gender expression. We have identified studies from Spain (Aparicio-Garcia et al., 2018, Galan et al., 2008), Portugal (Freitas et al., 2016), the Netherlands (Pizmony-Levy, 2018, Sandfort et al., 2010, van Bergen and Spiegel, 2014), Northern Ireland (Boyd, 2011, Carolan and Redmond, 2003, McNamee, 2006, Neill and Meehan, 2017, PACEC, 2017, Schubotz and O'Hara, 2010), England (Formby, 2015, Henderson, 2016, Sherriff et al., 2011), Scotland (Lough Dennell et al., 2018), United Kingdom (Acciari, 2014, Formby, 2014, Witcomb et al., 2019), Hungary (Karsay, 2015, Sandor et al., 2017), Lithuania (Gasinska, 2015, LGL, n.d.), Sweden (Donahue et al., 2017) and Malta (Pizmony-Levy, 2017) as well as international comparisons (Magić and Selun, 2016, Takács, 2006, UNESCO, 2016) unequivocally demonstrating that SGM youth experience various forms of bullying, discrimination and social exclusion in educational settings. These include teasing, name-calling, verbal insults, physical violence, exclusion from groups, damaging or stealing their property, sharing of unflattering or embarrassing photos or videos, intentional exclusion by peers, being the target of mean lies and rumours, and other forms of harassment. It seems that various forms of bullying and violence are substantially determined by an aggressive peer group social climate (Poteat, 2008). In most cases, the perpetrators were classmates or fellow students, however

a remarkable number of young people experienced discriminatory remarks or active discrimination from their teachers or other school staff (Formby, 2014).

Do teachers listen and intervene?

Students often do not report school-based incidents of abuse and assault. Many SGM youth do not report these incidents or ask for help because they anticipate, or have previously experienced, that teachers do not listen to or minimise their problems (Acciari, 2014, Bachmann and Gooch, 2018, Karsay, 2015). Many students additionally feel that their teachers are indifferent to homophobic language (Boyd, 2011) and many report that there is no one with whom they could discuss these problems (Gasinska, 2015).

In a study of reporting on bullying and violence in Hungary, two thirds of LGBTI+ students had never reported what happened (Sandor et al., 2017). Around half feared being **outed** to staff or family members (i.e., their sexual or gender identity being disclosed to others without their consent) if they did report such incidents. Half of them thought school staff would have done nothing about it. Indeed, the most frequently reported reaction from school staff was that teachers told victims of harassment or assault to ignore the incident; 52% of the students reported this. Forty-four percent of students indicated that school staff had talked to the perpetrator and told them to stop. However, around one third of the students reported that the teacher or other school staff had not taken any action.

Teachers often fail to intervene not because of their negative attitudes, but because they feel emotionally and cognitively unprepared to support queer students. Most educators report a strong desire to receive more training on working with and handling issues related to their students' sexual identity (Jones et al., 2018).

Are policies effective?

Evidence on whether state- and school-level policies effectively reduce the frequency of gender- or sexuality-based bullying and violence is conflicting. In some countries, having *any* type of school policy about bullying or harassment encourages students to report such incidents, and they are more likely to feel that staff intervention was effective (Sandor et al., 2017). In other countries, if the school has anti-bullying and/or inclusion policies which explicitly mention LGBTI+, then SGM students feel safer and are more likely to report incidents (Beattie, 2008). Other studies, however, have shown

that even policies that explicitly outline LGBTI+ as grounds for bullying and violence seem to be insufficient (Abreu et al., 2016). Policies and practices within schools can also be experienced negatively by LGBTI+ pupils. Examples include several schools that outed lesbian/gay pupils by making them change for physical education classes separately from other students, leading some to feel marginalised and excluded, and contributing to them not attending PE and/or school (Formby, 2014).

Many educational systems are poorly equipped to handle diversity. Inclusionary measures at school should be designed and implemented in a continuous manner, and instead of introducing a fixed, one-off action, better solutions need to be sought (Dominski, 2016). The participatory approach (i.e., including students in creating and revising policies) seems to be a more effective way of addressing the concerns of minority groups and assuring that adequate responses are included in the policies.

Schools tend to mirror wider social inequalities, and educational environments may reproduce different forms of violence. Such violence is not derived from the students and staff themselves but from relational mechanisms like power imbalances. Therefore instead of interventions that focus on individualising bullying, we rather need to recognise the structural issues which are related to hetero- and cis-normativity (Perger, 2018). This also implies that addressing hostility and violence in schools may have a reciprocal long-term benefit for the whole society.

The frequency of bullying and peer victimisation

Due to the large variations in methodology, the investigated populations, the ways in which bullying is defined, the lack of control comparisons with heterosexual and cisgender peers, and cultural differences, it is difficult to be exact on the percentage of LGBTI+ youth who regularly experience bullying. According to a quantitative meta-analysis of 18 studies, of which 16 were conducted in the U.S, one in Canada and one in the United Kingdom, the aggregated odds ratio of gay, lesbian and bisexual students to be bullied or teased by their peers was 2.24 compared to their heterosexual counterparts. Their odds for victimisation (in terms of physical and sexual victimisation) was 1.82. This means that lesbian, gay and bisexual students were roughly twice as likely to experience bullying and victimisation than heterosexual students (Fedewa and Ahn, 2011). Given that within a country, or even a region, schools may largely vary in contextual characteristics (e.g. socio-demographic

composition of the student body, cultural heritage, incidence of violence and crime in the neighbourhood, school policies, attitudes of school staff), this estimate may not be useful for individual schools.

Consequences

Bullying and peer-victimisation has been consistently associated with various negative outcomes, including psychological (suicidal ideation and suicide attempts, mental health problems), behavioural (substance use, externalising problems) and social outcomes (hostile school climate, lack of belonging to school, lack of social support) (Fedewa and Ahn, 2011). Other consequences include avoiding school and absenteeism due to fear of further bullying, victimisation and academic underachievement (Friedman et al., 2011, Jones et al., 2018). Nevertheless it is also important to recognise that there are some LGBTI+ pupils who excel academically, get involved in extracurricular activities and develop heightened resilience in face of adversities (Jones et al., 2018, Saewyc, 2011).

Different subgroups within LGBTI+ have different risks

The disparities faced by SGM youth may be interwoven with those of females. In some studies, no evidence was found that lesbian, bisexual, trans and other SGM females are at higher risk than gay, bisexual, trans and other SGM males (e.g., Fedewa and Ahn, 2011, Mueller et al., 2015). However other studies have documented females facing higher or additional adversity compared to males. While sexual minority girls felt safer in school (Gasinska, 2015) and faced less hostility than boys (Galan et al., 2008), they were more vulnerable to the negative mental health consequences of bullying and peer victimisation (Dürrbaum and Sattler, 2020, Sandfort et al., 2010, Vanden Berghe et al., 2010).

Bisexual youth seem to have higher risk for bullying and peer victimisation compared to that of their lesbian and gay peers, which may be linked to both **heterosexism** and **monosexism** (i.e. the belief that heterosexuality and/or homosexuality are superior to, or more legitimate than, bisexuality) (Feinstein et al., 2019). Bisexual or both-gender attracted individuals are often invisible within their micro-environment and the wider society. The social environment may deny their experiences and identity. Bisexual individuals may be miscategorised as exclusively attracted to same or opposite-gender partners. They may be rejected and marginalised not just by heterosexual peers, but

also by those who identify as gay or lesbian (Flanders et al., 2015, Russell, 2011). Bisexuality is often seen as 'a phase', a transitional period between heterosexuality and homosexuality (Morris et al., 2014). This may also be the case for young people belonging to other sexual minorities.

Compared to sexual minority young people, trans and gender diverse youth seem to have even higher risk for bullying and peer victimisation (Witcomb et al., 2019). In our landscape analysis, all studies that disaggregated their sample to transgender versus cisgender groups, consistently found that trans youth are more likely to experience bullying, harassment and violence related to gender identity, than their cisgender peers (Acciari, 2014, Bachmann and Gooch, 2018, Boyd, 2011, Karsay, 2015, Neill and Meehan, 2017). Young people identifying as non-binary seem to be especially vulnerable to school violence (Aparicio-Garcia et al., 2018). Here an interaction was found between sex assigned at birth and gender identity: Non-binary and trans youth whose sex assigned at birth is male reported more physical assault than their female assigned at birth counterparts, while female assigned at birth non-binary and trans youth were more likely to report sexual assault (Rimes et al., 2017). These disparities are reflected in the high prevalence of many mental health issues in transgender and other gender minority youth (Aparicio-Garcia et al., 2018, Rimes et al., 2017, Wilson and Cariola, 2020).

Other forms and types of violence and abuse outside the school

The safety of many SGM youth is considered to be under threat not only in school settings but in other environments as well, but evidence on this is rather scarce. Many LGBTI+ young people reported feeling unsafe on public transport (Lough Dennell et al., 2018). Both sexual and gender minority youth have elevated risk of sexual abuse (Priebe and Svedin, 2012, Rimes et al., 2017) and dating violence compared to their non-LGBTI+ peers (Reuter and Whitton, 2018). Disparities were larger for: males than females for sexual abuse; females than males for assault at school; and bisexual than lesbian/gay young people for both parental physical abuse and missing school through fear (Friedman et al., 2011). In a systematic review, 73 studies on various stressful childhood experiences were analysed, including sexual abuse, physical abuse, emotional abuse, physical neglect, and emotional neglect. Lesbian, gay, bisexual and transgender respondents reported relatively high prevalence of such experiences. Outcomes related to stressful childhood experiences in LGBT individuals included psychiatric symptoms, substance abuse, re-victimisation and

dysfunctional behavioural adjustments (Schneeberger et al., 2014). However, the majority of these studies were conducted in the US, highlighting the pressing need for more investigations to be carried out in other countries and cultures.

3.2.2. Findings from Irish studies

Studies conducted in the Republic of Ireland (Bowen, 2019, Kelleher, 2009, Mannix-McNamara et al., 2013, Mayock et al., 2009, Noone, 2018, Reygan, 2009) largely mirror the main findings of international studies. According to the *LGBTIreland Report* (Higgins et al., 2016), around half (48%) of the respondents had experienced LGBTI+ related bullying in school, while 67% had witnessed it and 4% had left school early because of bullying. Those who had experienced LGBTI+ related bullying at school had significantly higher scores on depression, anxiety, stress and alcohol use scales and lower self-esteem, and were also more likely to report self-harm, suicidal thoughts and suicide attempts. In the *School Climate Survey* (Pizmony-Levy and BeLonG To, 2019), 60% of LGBTI+ students had been verbally harassed because of their sexual orientation, and 44% because of their gender expression. Around 40% of the students reported physical harassment (e.g. being shoved or pushed) and 20% physical assault (e.g. being punched, kicked or injured with a weapon). A large majority (over 70%) reported that they do not feel safe at school. Many respondents felt that their teachers and families would not give them effective help when they experience bullying. That was their main reason for not reporting such incidents. Around 40% reported that they had missed school to avoid victimisation based on their sexual orientation or gender expression.

Safety issues and concerns outside school settings were mentioned tangentially, mostly in relation to negative experiences in the workplace and local community (Mannix-McNamara et al., 2013). However, in the *Supporting LGBT Lives in Ireland* study (Mayock et al., 2009), 80% of the SGM respondents reported having ever been verbally insulted; 43% having been threatened with physical violence; 24% having been punched, kicked or beaten; 8% attacked with a weapon or implement (e.g. a knife, gun, bottle or stick); 9% having been sexually attacked; and 34% of the respondents reported that someone had threatened to out them. While the setting for these episodes was not recorded, the qualitative element of the study revealed that many of these incidents happened in everyday settings, such as walking down on the street. These results are indicative of hostility and homo- bi-, and transphobic climate in Ireland.

There is, however, some good news. Higgins et al. (2016) report that as part of BeLongTo's 'StandUp' campaign, 25% of young people reported that their school had displayed a poster and 13% that a member of staff had spoken about the campaign to students. Five themes on improving school for LGBTI+ students were raised: the creation of safe spaces/support groups/addressing bullying (34%); affirming LGBTI+ identity (25%); formal education on LGBTI+ issues in class (25%); promoting inclusion, diversity and equality (12%); and training for the teachers (4%). Those young people who reported learning positive information about LGBTI+ in classes were more likely to feel accepted, belong to their school and were less likely to miss school days because of feeling unsafe (Pizmony-Levy and BeLonG To, 2019).

3.2.3. Additionality and intersectionality

Exposure to violence may be driven or compounded by factors other than LGBTI+ status, such as race, ethnicity or nationality (Toomey et al., 2017) disability status or chronic condition (Harley et al., 2002), or physical appearance. Bisexual youth from ethnic minorities may be affected by hetero- and monosexism as well as racist prejudices (Feinstein et al., 2019).

In this review of research across Europe, no studies which compared the relative risk of bullying victimisation of young people belonging to sexual and gender minorities were identified. It is therefore difficult to estimate the additional risk of bullying, harassment and other violence for SGM compared to other minorities. Comparisons of LGBTI+ and heterosexual/cisgender youth are similarly limited.

3.2.4. Positive aspects and protective factors

Protective factors for SGM youth may be found across the individual, relationship, community and societal level of Bronfenbrenner's (1979) socioecological model. Self-esteem at the individual level, healthy relationships with parents and peers at the relationship-level, and GSAs at the community level have emerged as protective factors across multiple studies (Johns et al., 2018a).

Among individual factors, resilience should be emphasised as a protective factor against the adverse effects of bullying and violence. Some authors understand resilience as a personality characteristic, focused on adaptation to risk factors and capacity to bounce back from adversity (Zimmerman, 2013). Others consider resilience to be a

social process (Afifi et al., 2016), or emphasise the socio-ecological context in which resilience can develop (Ungar, 2011). Amodeo et al. (2018) presented a training program developed with eight transgender Italian young people who experienced transphobic incidents. The intervention followed an empowerment, peer-group-based methodology. Three themes were identified: identity affirmation, self-acceptance, and group as support. Using standardised methods to monitor any changes, they found that the training increased the resilience skills of the participants. This intervention highlights that individual resilience is closely related to belonging to supportive groups and social networks, which may give affirmative and validating feedback to LGBTI+ young people.

An important resource of protection and sense of safety is provided by having caring and supportive family and friends. It seems that having a cross-orientation (i.e., heterosexual) best friend is associated with reduced stigma and internalised homonegativity in lesbian, gay and bisexual youth (Baiocco et al., 2012). This finding underscores the need not only to create support structures available for sexual minority students but also to promote inclusive and safe environments that foster respect and affirmation among all students, while encouraging and facilitating friendships across sexual orientations and across gender identities.

3.2.5. Good practices and interventions

Much of what was outlined in Section 3.2 in relation to inclusive state- and school-level policies and good practices is closely linked to that of safety and bullying. Any actions that aim to increase inclusivity in the school will necessarily tackle bullying and harassment. Research on other aspects of good practice in this area is very rare. In general, young people's sense of safety and belonging is better when they feel there is a trustworthy, caring and empathetic adult they can turn to. Young people consistently view the trusted adult's role as positive, and indicate that having such a person can help achieve outcomes such as higher educational attainment, optimism, self-efficacy and reduced internalising symptoms (Whitehead et al., 2019).

3.2.6. Knowledge gaps and recommendations for further research

Intervention and prevention efforts should focus on improving the supportiveness and inclusivity of the climates within which LGBTI+ young people live (Gower et al., 2018). As mentioned above, most of the identified studies in the area of safe environments deal with school-based bullying victimisation of SGM youth. Other areas (e.g.

violence experienced in other settings, the prevalence of LGBTI+-related crimes, or inclusive practices in state agencies for young people seeking or granted international protection) are very rarely investigated. Further studies are needed to better understand in which settings SGM youth experience violence and what interventions are needed to make those spaces safer and more inclusive.

A general shortcoming of many studies we reviewed is that they usually involved only SGM samples. Therefore, we do not know how the apparently high prevalence of bullying, violence and abuse compares to that of the general population, groups of heterosexual/cisgender young people of the same age, or to other marginalised groups. Only one meta-analysis dealt with the relative risk of bullying victimisation of sexual minority youth compared to their heterosexual counterparts. It found that lesbian, gay and bisexual youth were disproportionately affected by bullying and violence victimisation than their heterosexual peers (Fedewa and Ahn, 2011). The generalisability of this meta-analysis is somewhat limited by the fact that the majority of the included studies were conducted in the United States.

There is some evidence, also from the US, that sexual behaviour and sexual identity may interact. Adolescents who self-identified as heterosexual but reported to have same-gender sexual partners were three times more likely to be bullied than their peers identifying as lesbian, gay or bisexual (Turpin et al., 2019). It therefore may be important to distinguish between identity and behaviour when conducting research on the bullying experiences of SGM youth.

To the best of our knowledge, there are no European studies that have investigated whether there are any temporal changes in LGBTI+ young people's bullying-victimisation. Despite the high rates of in-school victimisation of LGBTI+ young people, research in North America shows that public opinion of SGM issues has become more positive over time, with increasing support for the SGM civil rights and a decrease in negative attitudes toward homosexuality in general. Nevertheless, a trend analysis conducted in North America showed that in terms of safety, bullying victimisation and violence-related experiences, not all SGM groups had seen positive changes over time. Improvement in school safety was more consistent for heterosexual youth and gay males than for bisexual young people or lesbian females (Goodenow et al., 2016). There is a need to replicate these longer-term studies in the Irish or broader European context.

Healthcare providers should be prepared to rapidly screen for bullying, assess for injuries and acute psychiatric issues that require immediate attention, and provide appropriate referrals such as psychiatry and social services (Waseem et al., 2013). Further studies are required in Ireland and other European countries on the healthcare needs of LGBTI+ young people, whether the healthcare systems meet those needs and whether young people feel safe and accepted in healthcare settings.

Population-based studies are also suitable for mapping intersectionality in LGBTI+ related bullying, including not only measures of sexual orientation, but gender identity, sex assigned at birth, ethnicity, nationality, disability status or chronic conditions, religion and other potential intersecting minority identifiers. Collecting such data would also enable researchers to compare the relative risk of different minorities for and exposure to violence. It is important to note that large sample sizes would be required for these analyses.

Implementation studies are largely missing. It would be important that interventions to improve inclusion and school safety for LGBTI+ young people are planned on the basis of local needs analysis and consultations with youth and other stakeholders; appropriate evaluation designs are adopted; and that the sustainability and flexibility of such interventions are assessed.

While there is extensive international and Irish data on bullying, there has been less emphasis on the identification of protective factors or on intervention studies designed to reduce bullying behaviour and the associated negative outcomes. Future research should endeavour to include both of these elements.

3.3. Objective 3: Inclusive youth services

This objective concerns assuring all youth services are inclusive of LGBTI+ young people and the provision of accessible youth services nationally. It contains two actions: (a) ensure all youth services in receipt of funding have a policy on inclusion of LGBTI+ young people; (b) address gaps in provision, with particular reference to access to services and groups in rural areas. This objective is moderately represented in the identified resources, with 29 of the studies speaking to it.

3.3.1. Findings from international studies

A general conclusion of the reviewed studies is that all professionals who provide services to youth should be aware that LGBTI+ young people may have specific vulnerabilities and needs. Currently, they are invisible and marginalised in many environments, including youth educational, social and healthcare services. Many pieces of research highlight that staff of institutions and organisations providing care should receive appropriate training on the needs and concerns of SGM youth, including how to recognise and address bullying and maltreatment (Tellier, 2017, Wilson and Cariola, 2020). Adequate training may help overcome practitioners' fears of potential damage or accusations around helping young people coming out (Sherriff et al., 2011). Such training should be embedded within continuing professional development and in-service training for healthcare and social care providers as well as educators (Neill and Meehan, 2017).

In some countries LGBTI+ youth's need for targeted support and services are documented. However, only a minority of locations (mainly urban settings) have services that address these specific needs, and many young people feel discriminated against and not listened to properly when they seek help (Karsay, 2015, Metro Charity, 2016). It has been emphasised that in order to effectively help these young people, multiple contexts (social policies, communities and schools, families and individuals) should be targeted, and linkages between them need to be facilitated (Blais et al., 2015).

3.3.2. Findings from Irish studies

The identified Irish resources largely echo international findings. Young people have emphasised the lack of acceptance and understanding of LGBTI+ individuals as well as lack of LGBTI+ spaces and resources (Bowen, 2019, Noone, 2018). It should be acknowledged that many LGBTI+ individuals are vulnerable to psychological distress

and its negative impacts on mental and physical health. It has been highlighted, however, that services (including policies and programmes) should avoid representing LGBTI+ people as a whole as being at risk for poor mental health or suicidality. Similarly, educational interventions should not be based on the premise that all LGBTI+ young people are 'victims' (Mayock et al., 2009). The need for services supporting parents and families has also been highlighted (Mayock et al., 2009, McCann et al., 2017). However, there is also evidence that existing services may not be accessed by LGBTI+ young people because of barriers related to distance, fear, shame, anticipation of pressure to come out, or feeling discomfort with one's sexual orientation or gender identity (Mannix-McNamara et al., 2013).

3.3.3. Additionality and intersectionality

Among LGBTI+ individuals, young people may be especially vulnerable to social exclusion for additional, age-specific reasons – for instance their economic and emotional dependence on parents and adults in general; lack of positive role models; lack of support in coming out; and being socialised in heteronormative environments (Russell and Fish, 2016). However, in line with an emerging shift from families to peer networks during adolescence, SGM youth may face additional minority stress due to ostracism and rejection in peer groups (Russell and Fish, 2016). One study highlighted that services and training should be mindful of the needs of LGBTI+ young people, especially young women (Formby, 2011), as they face the multiple marginalisation related not just to their sexuality but their gender as well. SGM youth are more likely than their heterosexual and cisgender peers to report discrimination in different settings, including in services, based on other grounds, such as their ethnicity, country of origin, disability and other factors (Karsay, 2015). SGM youth are also at disproportionate risk of experiencing homelessness, most often due to expulsion from family home and/or conflicts with the parents. This is an additional burden and grounds for exclusion and discrimination (Abramovich, 2012, Keuroghlian et al., 2014).

3.3.4. Positive aspects and protective factors

In Scotland, an increasing number of LGBTI+ young people think that their country is a good place to live, despite acknowledging that homophobia and transphobia are still problems; and 42% reported that they are involved in social actions or volunteer work, such as supporting charities, mentoring, supporting others, or campaigning (Lough Dennell et al., 2018). Young people who felt comfortable with their gender and/or

sexual identity, were more likely to seek out and avail of services (Mannix-McNamara et al., 2013). Some trans young people expressed the importance of being resilient in face of adversity, and they noted meditation, sport, artwork, social support in trans youth clubs, mutual trust and group identification as protective factors (Zeeman et al., 2017).

3.3.5. Good practices and interventions

- Using appropriate language (e.g. addressing trans young people using their preferred pronouns (Zeeman et al., 2017).
- Having even *one* identifiable staff member in the given service who is trained in LGBTI+ issues and recognises their specific needs can be helpful for young people (Lough Dennell et al., 2018).
- Addressing and challenging heterosexism, homophobia and transphobia in the context of working with young people (Mayock et al., 2009).
- Acknowledging the importance of working with parents and families of young people, and providing guidance on how they can support their children (Mayock et al., 2009).
- The 'ideal' LGBTI+ youth service should include various types and forms of support, including one-to-one consultation sessions, drop-in sessions, group activities, opportunities to meet other LGBTI+ young people and a safe space for hanging out (Pope and Sherriff, 2008), and should be tailored to the needs of local stakeholders.

3.3.6. Knowledge gaps and recommendations for further research

More studies are needed to explore young people's experiences with LGBTI+ services. The Department of Children, Disability, Equality, Integration and Youth (then Department of Children and Youth Affairs) provided funding to Education and Training Boards (ETBs) in 2018 to complete mapping of LGBTI+ services in their ETB area (DCYA, 2019). The result of this audit was in line with earlier evidence that rural youth are are underserved by services and support (Mannix-McNamara et al., 2013).

3.4. Objective 4: Equal employment and inclusive work environment

Objective four of the *LGBTI+ National Youth Strategy 2018-2020* highlights the need to ensure equal employment and an inclusive work environment for LGBTI+ young people. There are three actions under this objective: (a) provide relevant information and guidelines to employers; (b) develop guidance for transgender youth to support their continuous participation at the workplace, especially during their transition process; and (c) develop and distribute Further Education and Training to those LGBTI+ young people who have left school early. Access to employment is a key measure of social inclusion and facilitating pathways to employment is important for all young people to feel that they are a valued part of society (Takacs, 2006). This objective is poorly represented in the research landscape, as it is only supported by 12 outputs.

3.4.1. Findings from international studies

Studies examining employment and inclusivity in work environments for SGM youth were sparse and presented a mixed picture. Only three non-peer reviewed empirical studies, from Scotland (Lough Dennell et al., 2018), Northern Ireland (McNamee, 2006) and Hungary (Karsay, 2015) examined conditions of employment and work experiences of SGM youth explicitly. In addition to sociocultural and political differences between these countries, differences in sample profile, methodology and presentation of results make it difficult to directly compare findings. However, certain similar aspects emerge. For example, while a majority of respondents in the studies were out at work and most felt supported, it was clear that this was not the case for everybody and that experiences of discrimination or being the subject of gossip or inappropriate behaviour were not uncommon. McNamee (2006) lists seven problems that young sexual minority men experienced in the workplace. These range from homophobic behaviour by other staff members (19.8%) to being passed over on a job promotion (2.6%). Around a third of respondents (33.9%) reported at least one difficulty in work because of their sexual orientation. These difficulties at work were associated with a higher incidence of self-harm, suicidal thoughts and attempts and internalised homophobia.

In the Scottish and the Hungarian studies, trans respondents were more likely to be unemployed and more likely to experience harassment and bullying than their cisgender counterparts, suggesting that trans young people may be disproportionately affected by employment-based discrimination and inequality. This is consistent with the findings of a Spanish study (Aparicio-Garcia et al., 2018), which found that trans and non-binary respondents were more likely than their cisgender counterparts to have felt discriminated against when looking for work.

3.4.2. Findings from Irish studies

Similar to the international findings, Irish studies in this area (Higgins et al., 2016, Mannix-McNamara et al., 2013, Mayock et al., 2009) found that a minority of respondents had experienced difficulties in work including bullying, harassment and discrimination based on their identity. For example, the most recent of the studies carried out in Ireland found that while positive experiences in work far outweighed negative ones, this was not homogenous across sub-groups, with trans and intersex respondents reporting a greater sense of not-belonging and bisexual respondents reporting that they received the least positive affirmation (Higgins et al., 2016). This aligns with the findings of Mayock et al. (2009) who reported that 27% had been called hurtful names, 15% had experienced verbal threats and 7% reported having been physically threatened by a work colleague. In addition, nine percent of respondents said they had missed work because they were afraid of being hurt or felt threatened because of their SGM status. While the numbers reporting difficulties in work due to their SGM status are small, they are nevertheless a cause of concern. Mannix-McNamara et al. (2013) found that perceived levels of acceptability in the workplace were related to the level of vulnerability felt by SGM youth.

3.4.3. Additionality and intersectionality

Young people tend to be disproportionately affected by unemployment in general, and more and better-quality research is needed in order to be able to make a meaningful comparison between SGM and non-SGM youth on equality of employment access (Takács, 2006). From both the international and Irish studies, it would appear that transgender youth experience more problems in the workplace and may be discriminated against in seeking employment compared to their cisgender peers (Aparicio-Garcia et al., 2018, Karsay, 2015, Lough Dennell et al., 2018, Mannix-McNamara et al., 2013).

3.4.4. Positive aspects and protective factors

The good news is that the majority of SGM youth do not experience problems in the workplace as a result of their SGM status. This is encouraging as there is some evidence that an inclusive work environment is a key source of social support for SGM youth (Mayock et al., 2009) and may act as a protective factor against vulnerability to mental health problems (Mannix-McNamara et al., 2013, McNamee, 2006).

3.4.5. Good practices and interventions

No examples of good practice were specifically identified in the literature. Given that a supportive work environment would seem to have a positive impact on mental health outcomes, identifying good practice and interventions should be a focus of future research in this area.

3.4.6. Knowledge gaps and recommendations for further research

It is known that young people in general are more likely to be in casual or precarious employment and are disproportionately affected by unemployment compared to the general population. Our landscape analysis did not identify any specific evidence that sexual minority youth experience additional barriers to finding employment compared to their peers. Thus in relation to equality of access to employment, there is a considerable gap in knowledge.

While a number of Irish studies have touched on the subject of SGM youth experiences in work and employment, generally speaking – and compared to other aspects of SGM young people's lives – this is an under-researched area. The existing evidence suggests that most SGM youth have a positive experience in work. For those that do not have positive experiences however, it would be worth exploring in more detail the factors involved so that appropriate interventions and policies may be developed.

3.5. Objective 5: Representation and participation

Objective 5 of the *LGBTI+ National Youth Strategy 2018-2020* states the need to provide a more supportive and inclusive environment that encourages positive LGBTI+ representation and participation in culture, society and sport, and reduces LGBTI+ stigma. It contains seven actions, ranging from developing public recognition markers for sports clubs, cultural bodies, arts organisations, youth groups and businesses; developing campaigns and leadership programmes; organising national events; to delivering programmes that address intra-community identity-based stigma and discrimination. Aspects of the literature that were relevant to this objective included: representation of LGBTI+ issues in school; visibility of LGBTI+ identities in the media and in the wider community; and participation of LGBTI+ youth in sport. We have identified 46 studies that broadly speak to this objective, meaning that it is relatively well represented in the landscape.

3.5.1. Findings from international studies

The lack of visibility of positive LGBTI+ role models and representation generally in culture and society more broadly was noted by a number of studies (Ávila, 2018, Bradlow et al., 2017, Formby, 2011). This is an issue of concern, as LGBTI+ youth that participated in many of these studies specifically identified positive representation of LGBTI+ identities as an important source of support (Bradlow et al., 2017).

The majority of the studies in this category addressed the issue of representation of LGBTI+ issues at the school level rather than at a societal level, and their general finding is that LGBTI+ issues are either under-represented in school curricula or – more often – not represented at all (Ávila, 2018, Formby, 2011, Sandor et al., 2017, Takács, 2006, Takács et al., 2008, THT, 2016). Visibility and acceptance in school and the wider community are key sources of social support for LGBTI+ youth (Black et al., 2012, Blais et al., 2015, Johns et al., 2018a, Wilson and Cariola, 2020). For instance, participants in a study in the UK stated that seeing openly LGBTI+ teachers in school helped them accept their own identities. Others described the impact of seeing LGBTI+ celebrities and other public figures as making them feel 'safe' and 'not alone' (Bradlow et al., 2017).

Including LGBTI+ issues in the school curriculum was acknowledged as a way of increasing visibility and reducing social isolation (Ávila, 2018, Formby, 2011, Wilson

and Cariola, 2020). Increased visibility and inclusion at school that promotes social solidarity can be a protective factor against adverse mental health outcomes among SGM youth (Johns et al., 2018a, Wilson and Cariola, 2020). For example, Black et al. (2012) found that students involved in GSAs reported feeling more comfortable with their identities and saw an improved academic performance at school.

Studies on LGBTI+ youth participation in sport are extremely rare. Highlighting this dearth is one study, which sought to conduct a 40-year content analysis in nine flagship journals of research related to LGBTI+ youth school athletic experiences, but found no studies that met their inclusion criteria (Greenspan et al., 2017). Other studies where sport was tangentially raised suggest that LGBTI+ youth participation in sport remains fraught with experiences of bullying, discrimination and exclusion (Bradlow et al., 2017, Metro Charity, 2016, Takács, 2006, Takács et al., 2008). As a result, many LGBTI+ youth feel unaccepted and unable to be open about their identities at the sports clubs they attend (Metro Charity, 2016). In one UK study, 14% of the overall sample specifically reported being bullied during sports lessons (Bradlow et al., 2017). Addressing these problems and encouraging greater participation of LGBTI+ youth in sport more generally would likely have a beneficial impact on their health, as there is good evidence that suggests participation in sport may decrease negative health outcomes (Blais et al., 2015).

3.5.2. Findings from Irish studies

Similar to the international studies, findings from research carried out in Ireland underscored the importance of LGBTI+ visibility as a key facilitator to acceptance and comfort with being open about one's identity (Higgins et al., 2016), and SGM young people also raised its importance (Noone, 2018). Higgins et al. (2016) identified increased visibility of LGBTI+ people as a factor in helping people come out. Specific aspects identified as helpful by participants included media coverage of LGBTI+ issues, greater visibility of LGBTI+ people in the media and in positions of power, and greater cultural representation of LGBTI+ people in cultural outputs including TV, film and literature. Participants also expressed that better representation of LGBTI+ issues and individuals in society and having more LGBTI+ positive role models, in addition to 'normalising' LGBTI+ in wider society and helping to reduce stereotypes and stigma, functioned as a source of symbolic support. Visibility and representation was further identified as a factor in making people feel safer as an LGBTI+ person in Ireland.

A view shared by a number of participants was that "visibility is vital to the coming out process" (Higgins et al., 2016, p. 75).

Similar to the findings of international studies, the lack of LGBTI+-specific content in school was specifically identified as an obstacle (Higgins et al., 2016, Mayock et al., 2009, Reygan, 2009). Mayock et al. (2009) found that 40% of school students reported 'a failure or refusal' to address LGBT issues in class, while almost a third reported negative discussion of such issues in school (p. 65). This is consistent with the findings of Reygan (2009), where half of respondents reported a negative and stereotypical portrayal of LGBT people in school.

The need for more positive and three-dimensional representations of LGBTI+ youth was noted by Bryan (2017), who acknowledged that representations of queer youth as universally vulnerable and 'at risk' were lacking nuance and may be counter-productive. This is consistent with research in the UK (Formby, 2015) and highlights the need for better representation within the curriculum (Mayock et al., 2009) and for increased training and education for teachers (Bowen, 2019).

3.5.3. Additionality and intersectionality

None specifically identified.

3.5.4. Positive aspects and protective factors

Several reviews highlighted the role of a supportive, inclusive school environment and sports involvement as protective factors against adverse health outcomes (Black et al., 2012, Blais et al., 2015, Johns et al., 2018a, Wilson and Cariola, 2020).

3.5.5. Good practices and interventions

The benefits of better representation and an improved school climate on the development of self-advocacy skills and resilience among gender variant youth is highlighted by Johns et al. (2018a). Establishing GSAs and inclusion of LGBTI+-relevant topics within the curriculum are also identified measures that can increase participation and reduce marginalisation among LGBTI+ youth in school (Black et al., 2012, Wilson and Cariola, 2020).

3.5.6. Knowledge gaps and recommendations for further research

While many of the studies in this category raised the importance of visibility and representation, few actually fully explored the relationship between social representation and LGBTI+ well-being. This may be in part because of the methodological challenges involved in measuring representation and linking this to outcomes or experiences in populations. The benefits of positive representation have been highlighted by participants in several studies. Future studies should explore how representation and discourse around LGBTI+ youth may impact their sense of self.

It is clear that LGBTI+ experiences of and participation in sport and in other contexts and spaces outside schools are extremely under-researched. This is a gap that needs to be addressed.

The evidence gathered suggests that the lack of LGBTI+-relevant material in school increases the marginalisation of LGBTI+ youth and contributes to the social **erasure** of LGBTI+ identities in society in general. Development of LGBTI+ inclusive curricula may be a fruitful area for future research.

Increasing visibility and fostering social solidarity through GSAs and other inclusion initiatives may act as a protective factor against adverse health outcomes. Research to thoroughly investigate and evaluate the effectiveness of such interventions in the Irish context is needed.

3.6. Objective 6: Supports to parents and families

This objective includes one action: To provide families and parents with online and offline resources and information, to support children and young people in their families as they come out, including specific transgender pathways. With 23 research outputs relevant to this objective, it is moderately represented in the landscape.

Until recently research concentrated on negative parental influences, as opposed to the ways in which parents might be able to positively influence LGBTI+ young people's health. This was in line with the general victimising and 'at-riskness' discourse on SGM youth. There is a clear need to identify mechanisms in the family that can protect LGBTI+ youth from negative responses to their sexual orientation or gender identity. While acknowledging that strained parent–child relationships exist for many SGM youth, there is a strong imperative to identify mechanisms that can enable parents to support their child's well-being, even in families where parents struggle to accept their child's sexual or gender minority status (Bouris et al., 2010).

Coming out to parents is one of the most difficult developmental milestones for SGM youth (Savin-Williams, 2001). Many LGBTI+ young people chose not to disclose their sexual or gender minority status to their parents or other family members due to fear of rejection or even violence. A recent review from the US emphasises that parallel to the recent societal and legislative changes, which in general reflect growing tolerance and acceptance towards SGM, the number of young people who anticipate negative reactions from their parents, is decreasing. However, rejection from the wider family remain an issue for many. These fears limit SGM young people's future career and family prospects (Patterson, 2017). While similar positive changes seem to have taken place in European countries, there still may be many young people for whom coming out to family members is a significant risk.

A study by Willoughby et al. (2008) found that many parents and other family members feel stressed when the young person tells them that they are LGBTI+. Parents who have traditional family values (e.g. for whom marriage and having children are important) or who believe that being LGBTI+ is connected with discrimination, promiscuity, and loneliness may feel concerned for their child. There may, however, be other emotions, like sadness and anger, blaming themselves, or denial of their child's same-sex attractions.

While coming out may have negative consequences and is related to stress and mental health issues, many SGM individuals confirm that they have benefitted from

coming out to family members and others in several ways, including feeling relieved from the burden of the secret, having higher self-acceptance, self-esteem and sense of authenticity, stronger and more positive identity, reduction in stress and anxiety, and better social relationships. These beneficial effects are considered to be part of **coming out growth** (Vaughan and Waehler, 2010).

These findings underscore the importance of supporting young people and their families in the coming out process. Accepting, understanding, caring and supportive families appear to have a crucial role in LGBTI+ young people's lives. Family support, at least to some extent, is protective against the distress and negative consequences of discrimination and social exclusion SGM youth experience in other social environments. Some US studies found that this buffering effect of family support reduces the association between internalised homonegativity and depressive symptoms (Feinstein et al., 2014, Shilo and Savaya, 2011). These results indicate that family acceptance may give affirmation to the young person, even if their sexuality or gender expression is contested by others.

3.6.1. Findings from international studies

The perspectives of parents and other family members of LGBTI+ young people has not been thoroughly investigated in European studies (Bouris et al., 2010). Comprehensive evidence reviews from North America (Blais et al., 2015, Newcomb et al., 2019) have documented that family rejection is strongly associated with mental health problems, substance use and risky sexual behaviour. Newcomb et al. (2019) found that parental monitoring and communication are associated with better health outcomes among adolescents in general, however monitoring and communication are likely more complex with LGBTI+ youth, as not all young people are out to parents, and not all parents have sufficient information on LGBTI+. They highlighted potential cultural and individual differences and noted that there is limited research in this area, with most evidence coming from North America.

Newcomb et al. (2019) also noted that distinct gender and sexual minorities may have different experiences related to families. This is supported by Takács et al. (2008), who reported that lesbian girls experienced more discrimination in the family than gay boys, while the opposite pattern was found in experiences within the educational system. Transgender and especially non-binary youth seem to get even less support from family and friends than their sexual minority peers, and this is associated with

their sense of isolation, unhappiness and vulnerability to substance abuse (Aparicio-Garcia et al., 2018). Mental health problems and family conflicts seem to be in a circular relationship: sexual minority Portuguese adolescents with lower levels of mental health tend to have more conflicts with their parents, felt less appreciated by their fathers and had more pessimistic families (Freitas et al., 2016).

In a study with LGBTI+ young people from Northern Ireland, only a quarter of the respondents (25%) indicated that they were out to their parents, 28% to their siblings, and 13% to members of their extended family. In contrast, 78% of the respondents came out to a friend. Around two thirds (63%) reported they could not come out to their parents, and a similar proportion (70%) indicated that they had experienced homophobic attitudes in their family. As a result, almost half of the respondents (45%) felt compelled to leave the family home (Carolan and Redmond, 2003). Similarly, a study with young men from Northern Ireland reported that around one fifth of the participants reported a negative reaction from their family, and one fifth also experienced homophobia, while two-fifths (41%) had to move out of home due to their families' negative attitudes to their sexual orientation (McNamee, 2006).

A meta-analysis of studies conducted between 1980 and 2009 (Friedman et al., 2011) aggregated findings on parental physical abuse and reported that sexual minority youth, compared to their non-minority peers, were significantly more likely to experience parental physical abuse. Bisexual youth had higher risk for parental abuse than gay and lesbian adolescents. The gender of the respondents and survey timing did not moderate this association. Sexual minority youth were also significantly more likely to report childhood sexual abuse. While the authors emphasise that such cases showed a decreasing trend, the data suggest that some SGM young people may have traumatic family experiences, and more so than their non-SGM peers.

3.6.2. Findings from Irish studies

In a review of the health and social care needs of transgender young people by Irish authors (McCann et al., 2017), one emergent topic was family relationships and supports. The review highlighted that families of transgender youth may experience a range of emotions including shock and uncertainty. The authors highlighted that in many cases there is lack of adequate information and support, which may lead to families remaining fearful, frustrated, isolated, alone and feeling guilty. Even if the family seeks assistance from professionals, experience and training may be lacking. McCann et al. (2017) argue

that adequate support systems could safeguard against challenges such as depression and anxiety which may occur not just in transgender youth but in family members as well.

In a mixed-method study with more than 1000 participants aged 14–73 (Mayock et al., 2009), many international findings were replicated. In the in-depth interviews, coming out to family was often mentioned as a critical juncture in life, and was typically associated with stress, fear of rejection or lack of acceptance by parents and siblings. The need for parent's acceptance was highlighted as an essential source of affirmation and validation. The interviewees reported that when they came out, their parents showed a wide variety of emotional reactions, ranging from outright rejection and denial, to a full acceptance of their child's identity. In some cases, the parents expressed disappointment for their child who would not fulfil heteronormative expectations, such as marrying and having children. The findings supported that negative responses from the family may be linked to mental health issues, including suicidal ideation and self-harm. An important outcome of the interviews, however, was that many respondents reflected on the long-term aspects of coming out. Their accounts pointed out that resilience is not simply a trait that some people possess and others not, but is rather an ongoing and gradually emerging feature.

A recent study with more than 700 LGBTI+ young people (Pizmony-Levy and BeLonG To, 2019) showed that about two-fifths of sexual minority youths (43%) came out to at least one parent. Only a quarter of transgender students disclose their identities to anyone. This suggests that even fewer have come out to their parents.

3.6.3. Additionality and intersectionality

Many LGBTI+ young people experience discrimination due to other reasons, additional to their sexual or gender minority status (Takács, 2006, Takács et al., 2008). In the records we identified, intersectionality related to family support was not studied or discussed. However, an important intersectional effect between area of residence and community support is illustrated in a mixed-method study by Mannix-McNamara et al. (2013), with sexual minority young people from the Midwestern region of Ireland. Participants living in rural areas perceived that their community would see lesbian, gay and bisexual people as unacceptable, while this was not reported by those living in urban areas. Respondents from rural areas were also less likely to seek support. The challenges of living in rural communities mentioned by the respondents indirectly

imply that family acceptance may be even more crucial for them. However, it may also be the case that the lack of acceptability in their community also makes coming out to family even more difficult or stressful.

3.6.4. Positive aspects and protective factors

Several pieces of evidence show that positive, warm and caring families can give affirmation and validation to LGBTI+ young people. Such a family, to some extent, can buffer the impact of negative experiences in other environments. Family optimism and a positive relationship with the father has been documented to predict better mental health in sexual minority youth (Freitas et al., 2016). Aggregated evidence shows that family cohesion (i.e. strong familial ties) was associated with higher self-esteem, higher sexual self-efficacy, and later age of first intercourse for transgender youth. Parental support was also protective against depressive symptoms and perceived burden of being transgender, and was predictive of higher life satisfaction. Transgender girls and young women with at least one supportive parent reported more consistent condom use than those without such a supportive parent, with some reporting that they and their mothers developed a new 'kinship as woman' (Johns et al., 2018a). A positive effect implied in the studies of Mayock et al. (2009) and Mannix-McNamara et al. (2013) is that with older age, LGBTI+ individuals' identity seems to stabilise, and they get more comfortable with their sexuality and gender. This was reflected in some interviewee's accounts as well as in the reported age distribution of suicidality and mental health problems.

3.6.5. Good practices and interventions

There is very limited research on parent and family-based interventions, although the few existing family-based programmes showed promising results in non-randomised trials (Newcomb et al., 2019). An example of potential interventions is to provide parents and other family members with evidence-based self-help literature that gives factual information on LGBTI+ and advice on how to handle coming out and parents' reactions. Self-help resources containing interviews with LGBTI+ young people (Savin-Williams, 2001), or where parents themselves share their experiences (Owens-Reid and Russo, 2014), may be particularly helpful.

Relationships in families with LGBTI+ adolescents cannot be understood by investigating only individuals or even families themselves. It is important to acknowledge that rejection of LGBTI+ children by their parents or other family members may be associated with structural factors, such as hegemonic masculinity and stigma associated with marginalised groups (Bryan, 2017).

Schools may also provide several ways to help and educate families (Johns et al., 2019), for instance if there are trained school staff who can provide counselling to parents who feel stressed about their children coming out.

3.6.6. Knowledge gaps and recommendations for further research

There is little evidence on how the structural determinants of stigma or inequality influence family acceptance or rejection of LGBTI+ children. This gap should be addressed, since placing the responsibility solely on individuals or family micro-systems obscure the broader structural dimensions of social inequality (Grzanka and Miles, 2016). Such structural elements include hetero- and cis-normative values, which have been found to interact with family acceptance or relationships (Ellis et al., 2020).

Supporting, educating, and providing guidance for families of LGBTI+ young people should be a priority in intervention research. Assistance should be given to parents in helping their children to navigate other systems relevant to their health (e.g. patient-provider relationships and schools) (Newcomb et al., 2019). Little peer-reviewed research on interventions to reduce family stigma and discrimination against LGBTI+ youth exist. Most efforts to improve family environments for LGBTI+ youth seem to emanate from governmental and non-governmental initiatives. Very few interventions or programmes provide any outcome data, and even fewer studies of implementation processes have been carried out (Parker et al., 2018). Newcomb et al. (2019) notes that research in this area would benefit greatly from identifying innovative methods. These include:

- Involving the parents (e.g. engage less acceptant parents/families)
- Recruiting minority families (e.g. racial/ethnic minority and rural families)
- Enrolling parent–adolescent dyads and use dyadic methods to better understand family effects
- Conducting studies with sufficient sample size to allow analyses of subgroup differences (e.g. bisexual individuals and gender minority individuals)
- Extending the studies to the wider family (e.g. other caregivers and heterosexual siblings).

Surveys should involve standardised items (preferably harmonised with other studies on national level) on family support and mental health, and report how perceptions of LGBTI+ young people and other marginalised youth groups change over time.

3.7. Objective 7: Capacity building for service providers

This objective covers actions that help service providers to improve their understanding of, and ability to engage with, LGBTI+ young people. Three actions are listed: (a) implement evidence-based LGBTI+ training, Continuing Professional Development initiatives and guidelines targeted at professional service providers and youth services. These should include a particular focus on trans- and gender-related issues; (b) provide information relating to European funding opportunities as they arise to support LGBTI+ initiatives; and (c) provide specific prevention initiatives for LGBTI+ identity-based bullying in schools. This objective is relatively well supported, with 46 studies speaking to it. However, there is a lack of information on good practices and factors that guide service providers on becoming more sensitive to and inclusive of LGBTI+ youth.

3.7.1. Findings from international studies

Most empirical studies and evidence syntheses emphasise that LGBTI+ youth need specific services and staff need appropriate training and resources to deliver such services. However, there is also a need to ensure accessibility for the most isolated members of the community and to remember that the LGBTI+ community is not homogenous. A needs analysis conducted in the UK among college students emphasised that support services should ideally have staff that are LGBTI+ themselves and/or have specialist knowledge and understanding of gender identity issues. The report recommended that staff are trained to have better awareness of LGBTI+ issues and to proactively engage the LGBTI+ community, so that SGM students feel more comfortable accessing and engaging with them (Smithies and Byrom, 2018).

When seeking to develop capacity, there is evidence of the benefits of conducting mutual needs assessments of both service providers and users. For instance, physicians are often unaware of their patients' sexual orientation (Rose and Friedman, 2013). Sherriff et al. (2011) pointed out that young people needed support, but also illustrated that barriers to providing such support lay in service providers' fears about raising issues on gender and sexuality, due to the potential for resistance or backlash from parents.

Other issues highlighted included the need for localised and individual needs assessments for specific types of service and the need to include young people in the development and delivery of training. Service providers also underscored that young people often had multiple, diverse and crosscutting needs unrelated to SGM status.

In a similar needs analysis conducted in Northern Ireland, Carolan and Redmond (2003) found that the majority of mainstream or general youth work organisations were welcoming to LGBTI+ young people and asserted that they do not differentiate between their users based on sexual orientation or gender identity. However, they also expressed uncertainty as to whether they were in a position to provide specific help to LGBTI+ youths, and whether they had sufficient information or training to do so. A priority identified by young people was that mainstream organisations "acknowledge that homosexuality exists and accept that some young people attending their youth organisation may be homosexual" (p. 95).

Another important question is whether LGBTI+ young people have access to adequate services, and whether they feel they can actually avail of them. Accessing healthcare services may be prevented by fear and anticipation of negative experiences (Zeeman et al., 2019). A qualitative study conducted by McDermott (2015) to understand lesbian, gay, bisexual and trans young people's perspectives on seeking help for suicidal feelings and self-harm. A thematic analysis of young people's online discussions revealed that they found it difficult to ask for help to articulate their emotional distress, and to 'tell' their 'failed selves'. This concept, described by McDermott (2015), refers to the observation that many LGBTI+ young people "feel they have failed to fit with the prescribed norms of young heterosexual adulthood" (p. 571). In other words, to accept that their gender or sexuality differs from what the majority expects, one must elaborate the fact that they are seen by the heterosexual / cisgender majority as failing to be 'normal', 'sane' or 'rational'. This latter finding sheds light on the emotional cost of negotiating norms connected to heterosexuality, adolescence and rationality. McDermott (2015) argued that adolescent regulatory processes include emotional restraint and disapproval of open signs of emotional distress, which themselves would be barriers to seeking help. This observation highlighted that even if appropriate services are in place, adolescents in general may have individual-level barriers to accessing them, and for LGBTI+ youth, these barriers may even be greater.

3.7.2. Findings from Irish studies

The most 'burning' issue in the lives of SGM youth in Ireland is a general lack of acceptance and understanding. Other issues, including the rights of transgender and non-binary people, the lack of inclusive mental health services, and the lack of

healthcare providers who are 'equipped to deal with queer issues' were also prioritised by young people (Noone, 2018). A needs analysis which involved SGM young people as well as service providers and educators in County Tipperary (Bowen, 2019) revealed that providers identified the following main challenges: lack of education, training and awareness on LGBTI+ issues among adults (including educators), unmet mental health needs of LGBTI+ young people, lack of local level support in rural areas, and tolerance of homophobia by teachers in schools. Young people expressed a need for more LGBTI+-friendly safe spaces in their neighbourhoods. They emphasised that they have psychological and emotional needs that are not adequately addressed, due to the dearth of psychological support for those identifying as LGBTI+, and that mental health services are not available in a timely manner. They also raised the lack of education and awareness among adults, especially teachers, homophobic abuse in school from their peers, lack of sexuality education in school, and fears for personal safety directly linked to their sexual/gender identities.

We could not identify any other primary evidence that specifically points to the experience of LGBTI+ youth in Ireland with support services. However, a whole chapter is dedicated to services in the *Supporting LGBT Lives* report (Mayock et al., 2009). According to this report, many SGM adults had accessed different types of services. Over three quarters expressed the opinion that healthcare providers need more knowledge of, and sensitivity to, LGBTI+ issues. Around a quarter concealed their LGBT identity because they were fearful of the doctor's potential reactions. A fifth of participants sought out specific LGBTI+ friendly professionals because of previous negative experiences; and a fifth felt that the healthcare professionals were not respectful of them as an LGBT person. Many interviewees talked about negative experiences, with lack of cultural competence, insufficient knowledge and understanding of LGBTI+ issues, and even some incidents of homophobia. Transgender persons reported specific barriers to healthcare such as obtaining relevant information, varied responses from providers and fears about confidentiality.

In another mixed-methods study on the mental health care of lesbian, gay, bisexual and transgender adults from Ireland (McCann and Sharek, 2014), almost two thirds of the respondents (63%) were able to disclose their SGM status to practitioners, but around the same proportion of respondents (64%) felt that mental health service providers lacked knowledge on LGBTI+ issues. Moreover, 43% felt that the

practitioners were not responsive to their needs. The authors highlight the urgent need to involve LGBTI+ related knowledge and skills in the training of mental health professionals and in more general, "tackling prejudice and discrimination while appreciating the richness and diversity of individual experiences" (p. 125).

3.7.3. Additionality and intersectionality

Many of the studies included LGBTI+ youth with another minority identity or status, including homelessness, gender and sexual orientation (Abramovich, 2012, Keuroghlian et al., 2014), young age (Dürrbaum and Sattler, 2020, Takács, 2006), religiosity (Bradlow et al., 2017, Carolan and Redmond, 2003, Karsay, 2015, Neill and Meehan, 2017, Sherriff et al., 2011), or disability (Carolan and Redmond, 2003, Duke, 2011, Sherriff et al., 2011). These potential interactions need to be considered by service providers. A narrative synthesis of 57 studies highlighted that gender, age, income, disability, sexual orientation and gender minority all contribute to the inequalities LGBTI+ individuals experience in healthcare systems. The aggregated evidence shows that young people and those who identify as bisexual or transgender are more affected by inequalities. This may lead to anticipated stress and avoiding medical treatment, including emergency healthcare (Zeeman et al., 2019).

3.7.4. Positive aspects and protective factors

Many young and adult LGBTI+ individuals report positive experiences in healthcare services (Mayock et al., 2009). If even one staff member is known to be/explicitly named as an LGBTI+ ally, it can make a positive difference. Nonetheless, to achieve consistent and sustainable changes, systematic interventions are needed (Pizmony-Levy and BeLonG To, 2019). Some young people encounter hostility, discrimination and homophobia, biphobia or transphobia in services. The evidence, however, indicates that health and social care workers and educational staff would be willing to help, if they were empowered by appropriate training and capacity building measures (Bowen, 2019, Sherriff et al., 2011). It is possible that practitioners with negative attitudes towards LGBTI+ people chose not to participate in such studies or responded in a way that they deem socially desirable.

A recent analysis of LGBTI+ acceptance across 174 countries (Flores, 2019) has demonstrated that between 1981 and 2017, societal attitudes on LGBTI+ people became more polarised, which implies that SGM youths' experiences may vary

substantially across countries. Having an LGBTI+ acquaintance and knowledge about LGBTI+ issues seem to be related to higher levels of tolerance and acceptance in service providers (Szél et al., 2020), and practitioners who received training are more likely to have LGBTI+ affirmative attitudes (Johnson and Federman, 2014).

3.7.5. Good practices and interventions

The studies discussed above investigated different LGBTI+ subgroups and gave various recommendations, which are summarised below. Especially useful resources for good practices are Polonijo (2008), Sherriff et al. (2011), and Keuroghlian et al. (2014):

- Rather than developing new services, existing ones should be improved
- Providers should treat LGBTI+ young people in an affirmative and respectful way and ensure their safety
- Be aware of the potential effects of stigma and internalised homo-, bi- and transphobia
- Be aware of the diversity across LGBTI+ subgroups, and the specific vulnerability linked to intersecting identities
- Be aware of the complexity and interrelation of health determinants that influence LGBTI+ young people's lives (e.g. that bullying may be related to health symptoms, or homelessness associated with someone's gender and sexual orientation)
- Appropriately address LGBTI+ identity during the enrolment process
- Provide clients (including stakeholders as the families of SMG young people) with LGBTI+ related information including local programmes and services
- Be prepared to discuss health-related issues and provide specific LGBTI+ health information (or guidance on where such information can be found and accessed)
- Create safe and inclusive environments
- Have explicit, written anti-discrimination policies with specific reference to sexual orientation and gender identity
- Ensure confidentiality
- Provide LGBTI+ competency training to all employees and volunteers

- Align recruitment and hiring policies
- Develop and maintain inter-agency or inter-service connections (for instance, well-established referral systems)
- Develop and maintain connections with 'enumerated' (specialist) LGBTI+ organisations and the LGBTI+ community
- Collect and evaluate data on LGBTI+ young people who access services, to inform key decision makers and ensure potential service expansion
- Training should include:
  - > education regarding the terminology commonly used to discuss LGBTI+ issues in the context of young people
  - > an overview of the broad issues that affect LGBTI+ young people in general (for example, homophobia, heterosexism, anxiety over 'coming out', lack of mobility) as well as information on the impact that multiple minority status (i.e. ethnic minority or disability) has on LGBTI+ youth's well-being, and how these issues impact overall health
  - > the specific issues, problems and scenarios that may emerge and solutions that may be needed in the given type or setting of the service (e.g. mental health services, addiction services, care for homeless or disabled youth, social care etc.)
  - > a component aimed at identifying heterosexist and homophobic practices, as well as challenging any pre-existing stereotypes or assumptions held by service providers about LGBTI+ young people
  - > an introduction to issues specific to gender identity and trans and other gender minority people, including identification of cisgenderist and transphobic practices
  - > knowledge on intersex conditions and the needs of intersex people
  - > clarification of the laws and legislation regarding the discussion of LGBTI+ issues with young people
  - > information regarding LGBTI+ sexual health
- Guidance on identification of homophobic bullying (as well as violence and abuse by which LGBTI+ youths are disproportionately affected), and practical information on how to address such cases.

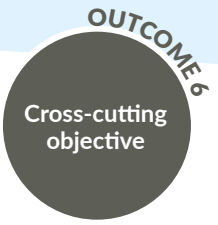
- 'warning signs' of self-harm behaviour or suicidal thoughts, and information on how to address them.
- Knowledge on protective factors, potential strengths and assets of being LGBTI+ young person, as well as ways of empowering them and facilitating their civic engagement.
- Develop recommendations on what practitioners/professionals can do to be LGBTI+ Allies, to facilitate other clients/stakeholders to become allies and make their services more affirmative and inclusive.
- Include capacity building measures with training on appropriate and legally mandated safeguarding practices to be applied when working with any vulnerable and/or marginalised group and children in particular.

3.7.6. Knowledge gaps and recommendations for further research

General services that are not primarily aimed at SGM youth may come into frequent contact with members of this group. One such example is homelessness services. Given the substantial links between homelessness and inequalities, LGBT+ youth attending these services are likely to have complex and heterogeneous needs and issues. These may include mental health and substance abuse problems. Identifying gaps in service providers' knowledge of and capacity to provide appropriate care for this vulnerable cohort is important for effective delivery of services.

All service providers would benefit from applying some general principles and knowledge/skills. LGBTI+ young people feel more included if service providers use appropriate terms and language (e.g. refer to the adolescents by the preferred name and pronouns) (Bradlow et al., 2017, Formby, 2015, Zeeman et al., 2017). It would be beneficial to identify the specific needs of both SGM youth and service providers, plan interventions that address those needs and conduct thorough evaluations to enable further learning and service development.

Such systematic changes should be supported by mapping the attitudes and needs of both service providers and young people using qualitative needs analyses that also uncover potential barriers and supporting services to set up scientifically sound indicators to assess the profile of their clients as well as satisfaction of the clients and the practitioners/providers.



3.8. Objective 8: Gaps in legislation and policy

This objective addresses gaps in current legislation and policies and ensuring inclusion of LGBTI+ young people in future legislation and policy development. It has five actions: (a) consider the nine grounds of discrimination outlined in the Equal Status Act and Employment Equality Act to establish if sufficient protection is afforded to transgender young people; (b) prohibit the promotion or practice of conversion therapy by health professionals in Ireland; (c) review current legislation to identify if gaps exist in the areas of hate crime and hate speech; (d) commence Children and Family Relationships Act 2015, specifically Parts 2, 3 and 9; and (e) recommendations arising from the review of the Gender Recognition Act 2015 in relation to gender recognition for people who are non-binary (or for people under age 18) should be advanced as quickly as possible. This objective is scarcely represented in the identified resources, with only 13 relevant studies identified.

3.8.1. Findings from international studies

Poor physical and mental well-being in LGBTI+ youth can partly be attributed to systematic transgressions of their human rights, and a lack of appropriate protective legislation (Tellier, 2017). In a study conducted in Northern Ireland, 79% of the respondents reported that they learned nothing in the school about their rights as an LGB person including civil partnership rights, anti-discrimination legislation and the age of consent (Boyd, 2011).

3.8.2. Findings from Irish studies

Only two pieces of evidence from Ireland speak to this objective. A topic LGBTI+ young people prioritised is trans and non-binary people's rights (Noone, 2018). This included gender recognition for individuals under the age of 18; the need for gender-neutral bathrooms; access to medical processes for gender transition; use of correct name and pronouns; employment for trans people; and recognising non-binary identities. In a scoping review on health and social care needs of trans young people it was highlighted that inter-professional protocols need to be established which are based on collaborations across medical, social and educational services; and sexual education and early mental health interventions need to be improved to meet young people's needs (McCann et al., 2017).

3.8.3. Additionality and intersectionality

Transgressions of LGBTI+ young people's human rights are intertwined with their experiences of being discriminated against on bases other than their sexuality or gender, including their race, ethnicity, religion, disability, or other reasons (Takács, 2006).

3.8.4. Positive aspects and protective factors

None specifically highlighted.

3.8.5. Good practices and interventions

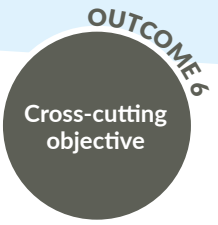
There seems to be a general agreement that teaching young people about their rights and duties as citizens, in general and related to sexuality and gender, is associated with the sense of being recognised as minority and is associated with better health outcomes (Boyd, 2011, Tellier, 2017).

3.8.6. Knowledge gaps and recommendations for further research

It was beyond the scope of this report to provide an analysis of policies and legislations around LGBTI+ youth in Ireland and other European countries. Given that the LGBTI+ National Youth Strategy 2018-2020 was the first governmental strategy specifically targeted at SGM youth, it is likely that there are many gaps in the policy and legislation around this group across the world. Research on the coherence across national policy and strategy would be valuable and should be prioritised.

There is a need to better understand the grounds on which young people in Ireland feel being discriminated against, including having certain gender or sexual orientation; and SGM young people's experiences of discrimination should be compared to those of their heterosexual and cisgender peers. It needs to be monitored whether SGM young people learn about and know their rights, related to their sexuality and gender.

We have not identified any European studies on **conversion therapies** (sometimes called reparative therapies) in SGM adolescents. These interventions generally aim to change an individual's sexual orientation to heterosexual. The consensus among medical professions is that these therapies do not have sufficiently documented efficacy, their goals raise ethical concerns, and they are associated with various negative outcomes, such as lowered self-esteem, self-hatred, depression, and suicidality (Byne, 2016).



3.9. Objective 9: Fragmentation in funding and networking for collaborative work

This objective addresses the need to better coordinate the funding of LGBTI+ organisations and services and to facilitate their networking. It contains two actions: (a) ensure a coordinated approach to the delivery of effective LGBTI+ services and funding of services for young people through inter-agency cooperation, and (b) hold an annual implementation forum to review advances in this process.

This objective, however, has the least supporting evidence, with only six relevant studies identified.

3.9.1. Findings from international studies

An analysis of LGBTI+ youth from a human rights perspective (Tellier, 2017) emphasised that there are many countries where sexual and gender minority individuals' basic human rights are violated. Health is a fundamental human right and this includes the right of LGBTI+ individuals to access adequate health and social care services. Fulfilling this right requires that services need in a coordinated, and preferably collaborative way.

In a study conducted in Northern Ireland with young people and service providers (Carolan and Redmond, 2003), the majority of mainstream youth work organisations stated that they would require assistance to make provision specifically for young LGBTI+ people and/or to address LGBTI+ issues with young people. Identified support needs included help in delivering LGBTI+ awareness training for their management, staff, volunteers and users; contact details for organisations working with young LGBTI+ people; and knowledge of the services they provide. These results show that, at least from mainstream youth work organisations, there is a clear willingness to establish coordination across services and develop inter-agency links with LGBTI+-specific youth services. Such links would also be beneficial to healthcare and social care providers.

3.9.2. Findings from Irish studies

A local needs analysis of LGBTI+ organisations and young people in County Tipperary (Bowen, 2019) found evidence that some groups collaborated with each other or indeed consulted with more established groups before setting up. Other groups

worked together on specific projects, for instance in organising the local Pride festival. The author distinguished between referrals 'in' (e.g. from schools, community workers), and referrals out (e.g. to a counsellor or other mental health services). The importance of such an inter-agency approach to tackling homophobic bullying was also emphasised by Minton et al. (2008). In a review on health and social care needs of trans youth, McCann et al. (2017) highlighted that services for trans youth need to have shared inter-professional protocols that are well coordinated.

3.9.3. Additionality and intersectionality

None specifically highlighted. It is important to note, however, that in the care for LGBTI+ youth with multiple minority or marginalised status – for example, homeless or disabled youth – a good network of inter-professional and inter-agency collaborations, such as a system of cross-referrals, seems to be vital (Keuroghlian et al., 2014).

3.9.4. Positive aspects and protective factors

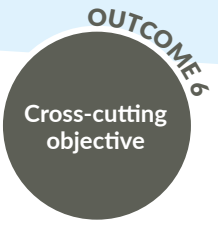
The availability of transgender health and social services in schools and neighbourhoods are important as sources of emotional support for and tangible assistance with legal and medical transitions for transgender young people (Johns et al., 2018a).

3.9.5. Good practices and interventions

None specifically highlighted.

3.9.6. Knowledge gaps and recommendations for further research

More research is needed to mapping existing collaborative work between health, social and educational service providers, mainstream youth work agencies and LGBTI+ associations, as well as understanding their attitudes on, and needs related to inter-agency collaboration and its impact on SGM youth. This could include related training needs for partnership working, and appropriate governance and evaluation protocols.



3.10. Objective 10: Inclusive environment for transgender and intersex youth

This objective includes two actions: (a) review the feasibility of including a provision for gender-neutral/single-stall bathrooms and changing rooms in the design guidelines for schools; (b) commence consultations on how to achieve universal design gender-neutral sanitary facilities in both new and existing buildings to which the public have access.

A relatively small number, 23 of the references are relevant to trans, non-binary, intersex and in general, gender minority inclusivity. Moreover, the above-mentioned two actions are only sporadically mentioned in the identified evidence. Since we have integrated gender minority perspectives and evidence to all other sections (and Objectives 13 and 14 are dedicated to the health of transgender and intersex youth), here we only briefly summarise findings on gender minority youths' experiences around inclusion and exclusion.

Gender minority individuals often face stigma and psychological distress due to prevailing cisgenderist and transphobic norms. **Cisgenderism** is the assumption that there are only two genders; that these are correlates of assigned or observed sex; and that gender cannot be changed (Ansara, 2015). It marginalises those people whose gender expression does not match traditional binary gender categories. **Transphobia** is defined as the prejudice and discrimination against transgender and gender diverse people. Cisgenderism and transphobia contribute to inequalities in transgender health, education, and community settings as well as in other domains of life (Ellis et al., 2020). Transgender and nonbinary individuals face poorer health outcomes on many dimensions of psychosocial well-being and mental and physical health. We present evidence below that demonstrates that some of these disparities are even larger than those affecting members of sexual minorities.

3.10.1. Findings from international studies

Young transgender and gender-diverse people often face exclusion and harassment in their schools and workplaces. In studies where the experiences of gender and sexual minorities are compared, a consistent finding is that transgender, gender non-conforming and other gender minority young people experience even more adversity

and severe consequences than their cisgender sexual minority peers (Aparicio-Garcia et al., 2018, Karsay, 2015, McBride and Schubotz, 2017, Takács, 2006, Takács et al., 2008). Inequalities have been documented in family support, unhappiness and feelings of isolation (Aparicio-Garcia et al., 2018), higher incidence of self-harm and suicidality than their cisgender peers (Haas et al., 2011, Rimes et al., 2017), leaving the family home of their own will because of transphobic attitudes (Neill and Meehan, 2017), and expulsion from the family home and homelessness (Keuroghlian et al., 2014, McCann and Brown, 2019). Transgender homeless youths may face more discrimination in shelters for various reasons. Most shelters are segregated by natal sex, which may lead to gender discrimination and gender violence. Shelter staff members may have minimal or no training around transgender-related issues, needs, and terminology. Staff may not have an understanding of the importance of asking trans young people what pronoun they prefer, how they wish to be addressed, or that transgender people can also identify as heterosexual (Abramovich, 2012).

Similar negative experiences are reported by trans students in colleges and pupils in schools, including negative remarks, bullying and physical attacks from their peers; feeling unable or uncomfortable with reporting such cases; feeling they cannot wear clothes representing their gender expression; failure of teachers and school staff to address them using their preferred pronouns and/or names; and feeling unable to use toilets and other facilities in which they feel comfortable (Bachmann and Gooch, 2018, Lough Dennell et al., 2018); name-calling, 'othering' and failure to consider their experiences and perspectives (Neill and Meehan, 2017). This may be related to the fact that gender identity development in childhood and adolescence is poorly covered in most school curricula, even in sexual education, and teachers' knowledge on transgender and other gender-nonconforming identities is often limited (Boskey, 2014).

Such negative experiences seem to be linked to a high frequency of mental health problems in transgender youths, including self-harm and suicidal thoughts and behaviours (Lough Dennell et al., 2018, Rimes et al., 2017, Wilson and Cariola, 2020), and feeling unhappy and isolated (Aparicio-Garcia et al., 2018).

3.10.2. Findings from Irish studies

A scoping review of 20 individual studies on trans youth by McCann et al. (2017) mirrors the main points of the international findings. The review identified five

overarching themes: (a) stigma, discrimination, and mental health; (b) family relationships and supports; (c) educational concerns; (d) health care experiences; and (e) vulnerability and health risks. The experiences and priorities of trans youth in Ireland underscore the need for improving trans and nonbinary individuals' rights, and to increase societal awareness of their needs (Noone, 2018, O'Higgins et al., 2017). A consistent finding is trans youths' elevated risk of victimisation and exposure to transphobic remarks (Minton et al., 2008, Pizmony-Levy and BeLonG To, 2019). A mixed-method study with SGM adults from Ireland (Mayock et al., 2009), with a sub-sample of 46 transgender adults, confirmed the presence of negative psychosocial determinants and health inequalities. Some interviewees recalled that in their youth, parents and other adults told them that being transgender is just a phase and that they frequently received negative comments and suffered bullying or physical assaults. They also recalled disproportionate incidences of self-harm, suicidal thoughts and suicide attempts. However, there were also some accounts of positive experiences, for instance support from doctors or counsellors.

3.10.3. Additionality and intersectionality

Due to the gendered aspects of everyday life (e.g. gendered bathrooms and changing rooms in the schools, and targeted services for women and men), non-binary or genderqueer youth may experience additional burdens to trans youth who identify as trans girls or trans boys (Perger, 2018). Non-binary young people are even more likely to suffer hate crimes than their transgender peers (Lough Dennell et al., 2018). Sex assigned at birth, as well as gender identity, may also add to health inequalities in trans adolescents, as it seems that young people assigned to female or male sex at birth have different levels of specific mental health risks (Rimes et al., 2017). Finally, some studies raise the possibility of potential link between gender dysphoria or transgender identity and Autistic Spectrum Disorders (ASD), in that there may be a disproportionately higher rate of gender dysphoria or difficulty with gender identity among those with ASD (Duke, 2011). This potential association will be further discussed in Section 3.13 (on the health of transgender youth).

3.10.4. Positive aspects and protective factors

More transgender students from Scotland rated their university experience as 'good' in 2017 (60%) than in 2012 (37%), and there was also an increase in the number of transgender students agreeing with the statement that Scotland is a good country to

live in (Lough Dennell et al., 2018). This suggests positive societal changes in Scotland, which is in line with shifts seen in many countries around LGBT acceptance between 1981 and 2017 (Flores, 2019).

Intra-individual protective factors have also been documented in studies with trans youths, these include resilience, including coping strategies, to face psychosocial adversities. Transforming negative experiences to feelings of pride and strength may facilitate dealing with discrimination and prejudice. Trans adolescents who are supported in their identities may experience less distress, feel stronger and become more resilient (McCann et al., 2017). Further protective factors and assets are discussed in Section 3.13 (on health of transgender youths) and Section 3.14 (intersex youth).

3.10.5. Good practices and interventions

Ensuring that national basic curricula and frameworks for specific subjects, mainly sexuality and relationships education, include information on gender development and gender diversity is an important step for transgender and other gender minority inclusion. Textbooks and other educational materials should also include such evidence-based information (Boskey, 2014, Karsay, 2015).

Initiatives that aim to facilitate LGBTI+ tolerance and improve school climates are called 'safe school' interventions. Besides integrating LGBTI+ issues in classroom curricula, these also include staff development and capacity building, establishing student support clubs, introducing inclusive anti-discrimination policies, and expressing support through visual displays, such as posters, flyers, or media. Such displays symbolise acceptance and affirmation of LGBTI+ people and can provide essential information on who is available, open, and safe to talk with about their concerns (Black et al., 2012). A systematic review of 18 safe school intervention studies showed that various interventions covered one or more of the above-mentioned actions. A general observation was that in schools where clear and explicit rules on discrimination and bullying had been introduced and enforced, LGBTI+ pupils felt safer and had better psychological outcomes. However, both teacher and peer support and interventions are necessary in the context of bullying or harassment (Black et al., 2012).

3.10.6. Knowledge gaps and recommendations for further research

Transgender and other gender minority young people are less visible in the landscape of LGBTI+ research than their cisgender lesbian, gay and bisexual peers (Black et al., 2012). According to Olson-Kennedy et al. (2016), this might be related to the fact that prevalence of people identifying as transgender or living with an intersex variation is difficult to ascertain and appears to be changing over time. Thus there is a need to develop appropriate measurement tools to assess discrepancy between sex assigned at birth and gender identity, and give a voice to transgender, non-binary, intersex and other gender minority youth in epidemiological research (Jones, 2019). Research on the needs of intersex youth is particularly lacking.

Singh et al. (2014) identified key factors that contribute to resilience in US trans youth, including the ability to self-define and theorise one's gender, proactive agency and access to supportive educational systems, connection to a trans-affirming community, being able to reframe mental health challenges, and navigating relationships with family and friends. Collecting evidence on the relevance, and prevalence of these factors in Ireland would be a useful direction for future research.

While inclusion of transgender and other gender minority youth was tangentially mentioned in many studies, our landscape analysis has not identified any study which specifically targeted inclusivity of trans and intersex youth, including whether they have access to gender neutral facilities in schools, colleges, public buildings, and the impact such access might have. This is a definite knowledge gap, especially so given the priority placed on these issues by Irish young people (Noone, 2018). Further research projects are needed to map gender minority youth's experiences with (the lack of) inclusion in various settings.

3.11. Objective 11: Mental health

This objective covers effective responses to the mental health needs of LGBTI+ young people. It includes two actions: (a) based on recommendations from the Pathfinder and Youth Mental Health Task Force, introduction of same day referrals and consideration of age of consent for access to mental health services and supports; and (b) development of targeted early intervention initiatives and services to reduce the risk of mental health problems for LGBTI+ young people, including suicide and self-harm. A relatively large number (56) of the identified studies, were relevant to this objective.

Besides bullying, specific mental health issues and their correlates are the most frequently studied topics within LGBTI+ research. One of the central theories which guides research on LGBTI+ health is the minority stress model (Meyer, 1995, 2003, 2007). The concept includes three mechanisms that help explain why SGM young people are exposed to disproportionate levels of stress and are therefore vulnerable to several related mental health issues. Meyer (2003) outlines three separate processes of stress, from distal to proximal:

- Objective or external stressors, which include structural or institutionalised discrimination and direct interpersonal interactions of victimisation or prejudice. In the case of SGM young people, such adverse experiences include bullying and peer victimisation, or rejection and lack of support from family members.
- SGM individuals' anticipation that victimisation or rejection will occur, and their constant vigilance related to such expectations.
- Internalising negative social attitudes (often referred to as internalised homophobia or internalised homonegativity), the process of developing negative feelings about one's own sexual or gender minority status. Individuals attracted to both genders may be affected by internalised biphobia or bi-negativity (Willoughby et al., 2010), while those identifying as transgender by internalised transphobia or trans-negativity (Bockting et al., 2019).

Theoretical advancements and an accumulation of evidence highlights the need to directly address and interrogate minority stress in the lives of SGM youth and to better understand how mechanisms of minority stress affect their well-being (Russell and Fish, 2016).

Another important theoretical concept in LGBTI+ youth mental health, closely related to minority stress, is **stigma** (described in details in Section 1.2). Hatzenbuehler and Pachankis (2016) argue that stigma affects LGBTI+ young people's lives at different levels, and it disrupts several cognitive (e.g. vigilance), affective (e.g. rumination), interpersonal (e.g. social isolation), and physiological (e.g. stress reactivity) processes that have negative health consequences.

3.11.1. Findings from international studies

Self-esteem

In a Dutch study with children and adolescents referred to a gender clinic (Alberse et al., 2019), it was found that gender diverse children and adolescents, compared to the general population of the same age, had significantly lower global self-worth (a general negative feeling about themselves) and body image (how they felt about their bodies). Some gender differences were found, with young people who had been assigned females at birth reporting more positive self-perceptions than their peers assigned male at birth.

Stress and anxiety

In a systematic review of 73 articles, Schneeberger et al. (2014) found that LGBTI+ populations showed high prevalence of stressful childhood experiences, including sexual, physical and emotional abuse, and physical or emotional neglect. These were associated with different negative outcomes, including psychiatric symptoms and disorders, as well as physical health problems. The authors note that the majority of these studies were carried out in the US, and more research is needed in other countries. Stressful events also include school bullying and peer victimisation (Fedewa and Ahn, 2011). A review of 21 Canadian studies (Blais et al., 2015) revealed that psychological distress was affecting 21% to 70% of sexual minority young people. Females were more likely to report psychological distress than males. In a meta-analysis of seven studies (Dürrbaum and Sattler, 2020), minority stress and adverse mental health outcomes showed a statistically significant, robust, medium-sized association (with an aggregated correlation coefficient of r = .25). The association was stronger in females than in males. However, there was not a sufficient number of individual studies to compare whether the association is different in lesbian/gay versus bisexual youths.

In a birth cohort study conducted in the United Kingdom (Jones et al., 2017), sexual minority young people had a significantly higher risk for anxiety disorder than their heterosexual counterparts, and this association was barely influenced by ethnicity, maternal occupation, and mother- or child-reported gender nonconformity. Adjustment for bullying experiences reduced the risk ratios, but the overall association remained significant for both boys and girls. This indicates that anxiety disorders can partly, but not fully, be explained by bullying experiences.

Little evidence is available on stress and anxiety in European transgender and other gender minority youth. However, Ignatavicius (2013) notes that female-identified transgender young people face numerous potential stressors and as a consequence are more likely to experience negative mental health outcomes than cisgender girls. Reasons for this include lack of support, lack of perceived safety, limited access to supports, and lack of like peers. We may generalise these observations to transgender youth who identify as male, since many of these stressors are likely to affect them as well.

Substance use

Sexual and gender minority youth are disproportionately affected by different types and forms of substance use. A meta-analysis of 18 studies (Marshal et al., 2008) found that sexual minority adolescents reported significantly higher substance use than heterosexual adolescents. The effect was greater for girls than boys and for bisexual adolescents than their lesbian and gay peers. Slightly larger effect sizes were observed in school samples (e.g. in the Youth Risk Behavior Survey) than in high-risk samples (e.g. those seeking mental health treatment, homeless youth, or prison populations). The associations were also influenced by definitions of sexual orientation: self-identified sexual minority status was related to higher risk than romantic attraction or sexual behaviour. However, an international comparison of the Health Behaviour in School-aged Children (HBSC) study from eight European countries (Költő et al., 2019b) demonstrated that romantic attraction to same- and especially to both-gender partners was related to higher risk of substance use (smoking cigarettes, consuming alcohol, getting drunk, using cannabis, or involvement in multiple forms of substance use in the last 30 days). The pattern of results remained similar after adjusting for country, gender and family affluence, which implies that this mental health disparity affects sexual minority young people irrespective of their country, whether they identify as girls or boys, and their socio-economic status.

A systematic review of Canadian investigations (Blais et al., 2015) as well as individual studies conducted in Sweden (Donahue et al., 2017) and the Netherlands (Kuyper et al., 2016) also demonstrate sexual minority young people's elevated vulnerability to substance use. A meta-analysis of 12 studies of LGB youth pointed out that the strongest risk factors for substance use were victimisation, lack of supportive environments, psychological stress, internalising/externalising problem behaviour, negative reactions to coming out, and housing status (Goldbach et al., 2014). In general, most of the studies link substance use issues in SGM youth to mental health problems and psychosocial determinants such as lack of social support, discrimination, rejection, bullying and abuse (Marshal et al., 2008, McDonald, 2018). An Italian study of lesbian and gay young adults found associations between heavy drinking and negative responses to coming out to others (Baiocco et al., 2010).

Psychosomatic symptoms and self-rated health

An investigation with 15-year-old adolescents from eight European countries and regions demonstrated that those young people who have been in love with same- or both-gender partners were more likely than those in love exclusively with opposite-gender partners to rate their health poor and report frequent psychosomatic symptoms. These associations were not influenced by country, gender or family affluence (Költő et al., 2020a).

Depression

A study with Belgian sexual minority young people (Vanden Berghe et al., 2010), found that stigma consciousness, internalised homonegativity and LGB-specific unsupportive social interactions predicted depressive mood, while having LGB-specific support from a confidante was protective against it. Both stigma consciousness and internalised homonegativity independently predicted depression. The size of the negative impact of LGB-specific unsupportive interactions on depression was substantially larger than the positive impact of LGB-specific confidant support. According to a meta-analysis of seven studies, minority stress in lesbian, gay and bisexual youth correlated more strongly with depression than with trauma or general mental health problems. The effect was greater for females, with no effect of race, age or study quality (Dürrbaum and Sattler, 2020).

A review of 15 studies (Connolly et al., 2016) demonstrated that transgender adolescents are more likely to have moderate to severe depressive symptoms, or

be diagnosed with depression, than their cisgender counterparts. While depressive symptoms in transgender and other gender minority young people may be related to gender dysphoria, the authors emphasised that many transgender young people received psychiatric treatment for other reasons than gender dysphoria.

Suicide and self-harm

Systematic reviews of the evidence show that LGBTI+ individuals have significantly higher risk for suicide than heterosexual and cisgender populations (Haas et al., 2011). A meta-analysis of 24 studies, specifically with young people (Marshal et al., 2011), demonstrated there was a significantly higher risk for suicidality among sexual minority youth in comparison with their heterosexual peers. The disparity increased with the severity of suicidality. Sexual and Gender Minority youth had approximately two times higher odds for suicidal ideation and intent or plans, around three times higher odds for suicide attempts and four times higher odds for suicide attempts that required medical attention, compared to their heterosexual peers. Those who identified as bisexual (or reported romantic or sexual attraction to or having sex with both-gender partners) had around five times higher odds of suicidality compared to their heterosexual peers.

Although the available evidence, especially comparisons of cisgender and transgender individuals, is very limited, the existing studies indicate that transgender and gender nonconforming youth are even more likely to be affected by suicidal ideation and suicide attempts than their sexual minority peers (Haas et al., 2011). In a qualitative, community-based study with a racially and ethnically diverse sample of transgender youth in US, Canada and Ireland (Hunt et al., 2020), thematic analysis identified four key topics around suicidality in transgender youth:

- Belongingness, a feeling of being connected to others and cared for by other people
- 'Thwarted belongingness': a lack of caring relationships and feeling rejection and isolation, including lack of care, feeling of disconnection, rejection of gender or sexual identity, abuse, bullying and being forced into mental health treatment
- Embodiment, comprising issues related to participants' bodies and sense of self, including stress associated with bringing the body and sense of identity into alignment
- Self-preservation, which reflected resilience.

A phenomenon closely related to suicidal ideation and suicide attempts is self-harm. Available evidence demonstrates that SGM youth are also disproportionately affected by different forms of self-harm (Irish et al., 2019, McDermott, 2015, Oginni et al., 2019). Transgender youth seem to be especially vulnerable to both suicidality and self-harm (Connolly et al., 2016). Suicidality and self-harm, just as substance use, seems to be related to internalised homophobia (McNamee, 2006) and stigma related to gender nonconformity (Baams et al., 2013). This can be compounded by the difficulties experienced by trans youth in identifying and asking for help (McDermott, 2015).

It should be noted, however, that some results in the international literature are conflicting. For example, even if suicidal ideation is higher in SGM youth, there is little evidence that actual suicides are more frequent amongst them than their cisgender/heterosexual peers (Rivers and Carragher, 2003), which warrants more methodologically and conceptually rigorous research. Documenting differences between sub-groups at post-mortem is difficult, especially when the family or friends are not aware of young people's SGM status. Nevertheless, the synthesised evidence shows that different subgroups within SGM are not equally affected by mental health problems: girls and bisexual youth, for instance, are disproportionately affected than boys and those identifying as gay/lesbian respectively (Cox et al., 2009).

Well-being and positive mental health

Despite the term 'well-being' often appearing in the identified evidence (Baams et al., 2013, Bradlow et al., 2017, Priebe and Svedin, 2012, Vanden Berghe et al., 2010, Witcomb et al., 2019), in all of these studies the negative aspects of well-being were examined, or it was pointed out that negative psychosocial factors (e.g. victimisation) are associated with lower levels of well-being. The only exception was the work of Sandor et al. (2017), who argued that the presence of supportive teachers and other school staff, and including positive LGBTI+ related information in the curriculum were directly linked to students' well-being at school; however, they do not outline how (positive) well-being was measured.

Other terms around positive mental health that emerged in the records were resilience and coping. In the only international dataset we identified, a collection of semi-structured interviews and focus groups (Roen et al., 2006), resilience was elaborated as resistance to self-destructive behaviour, and included strategies such as moving to a city that was perceived to be gay-friendly, or seeking out LGBTI+ organisations.

In a qualitative study with transgender youth, resilience was characterised as attempting to connect with loved ones for support and through self-awareness of mental states, including by regulating behaviours the participants perceived to adversely affect their mental health (Hunt et al., 2020).

3.11.2. Findings from Irish studies

As in other subsections, we have found that the results of Irish investigations largely mirror findings from reviews and individual studies conducted in other European countries. Several examples of how different aspects of mental health are connected with each other and various psychosocial determinants are provided in the *Supporting LGBT Lives* study report (Mayock et al., 2009). For instance some interviewees talked about the links between alcohol consumption, psychological distress and depression. In another study, religion was perceived to be associated with the prevailing homophobic culture, and caused an internal conflict to some sexual minority young people (Mannix-McNamara et al., 2013).

While there is a dearth of available datasets and published evidence on their basis, it is important to note that data from the Growing Up in Ireland study (ESRI, 2014), the My World Survey (Dooley and Fitzgerald, 2012, Dooley et al., 2019), and the Health Behaviour in School-aged Children study (Költő et al., 2018) all include various aspects of sexual or gender minority status and mental health and are therefore suitable for secondary analysis.

Stress and anxiety

In a study with lesbian, gay, bisexual, transgender and queer participants under 24 (Kelleher, 2009), the three components of minority stress (sexual identity distress, stigma consciousness, and heterosexist experiences) were independently associated with psychological distress. Four-fifths of respondents indicated that they have been the subject of verbal insults during their life for their SGM identity, and they also recounted several stress-inducing events from school, work and other settings. Many SGM adults directly linked stress and alcohol use in a qualitative study (Mayock et al., 2009).

Substance use

Sarma (2007) reported on a mixed-methods study with lesbian, gay, bisexual, unsure orientation and transgender young people; the majority of respondents (60%) had taken drugs over the preceding 12 months, with a significant minority (8%) having

done so on more than 60 occasions in that period. Lifetime prevalence of drug use was reported at: 56% for cannabis; 44% for poppers; 33% for ecstasy, and 32% for cocaine. In comparison with two other national-level surveys, SGM respondents in this study were more likely to engage in multiple substance use. During the qualitative part of the study, various short-term negative consequences of drug use were raised (i.e. unprotected sex, sexual assault while incapacitated, and underperforming at or missing from work). Although alcohol use was not studied, many participants asserted its frequent use by SGM individuals. In a large-sample mixed-methods study with both younger and older LGBTI+ individuals (Mayock et al., 2009), more than 40% of the respondents reported that their alcohol consumption made them 'feel bad or guilty', and more than 60% felt they should reduce their alcohol intake. Standardised measures of alcohol consumption suggested that a significant minority of the respondents exceeded the thresholds of problematic or hazardous drinking. The qualitative findings illustrated that regular or heavy drinking was associated with distress and used as a way of coping or self-medication.

Psychosomatic symptoms and self-rated health

No evidence was identified in the records that spoke directly to these outcomes. Irish LGBTI+ youth listed mental health, and access to healthcare, as topics of priority that need to be addressed.

Depression

The My World Survey (Dooley and Fitzgerald, 2012) on youth mental health in Ireland found that 62% of heterosexual respondents aged between 17 and 25 reported within the normal range of depressive symptoms, compared to 51% of gay and lesbian respondents, 34% of bisexual respondents and 39% of respondents that were unsure of their sexuality. Conversely, of the respondents that reported very severe depressive symptoms, 7% were heterosexual, 10% were gay or lesbian, 18% were bisexual and 17% were unsure. These results indicate that sexual minority adolescents are disproportionately affected by clinical levels of depressive symptoms.

Suicide and self-harm

Mayock et al. (2009) found significant associations between lifetime suicidal ideation and having been subjected to verbal insults, physical threats, or physical attacks. Around half of the respondents who had ever attempted suicide reported that it was

related to their sexual or gender minority identification. Many interviewees recalled suicidal ideation or attempts that happened when they were school-aged, and some of these thoughts or attempts were directly related to negative experiences in school. They also note, however, that 74% of their survey respondents have rarely or never contemplated suicide, which reinforces the argument that LGBTI+ identity *per se* is not a risk factor for suicidality.

Well-being and positive mental health

Despite the fact that "LGBT people's lives are negotiated under varying degrees of adversity" (p. 24.), Mayock et al. (2009) concluded that in contemporary Ireland, LGBTI+ adult people, on the whole, are rather more happy than unhappy with their lives. From the narratives of the interviewees and written feedback of their online survey respondents, four key sources of social support emerged that could be understood as sources of resilience. These were: support from friends and family; being member of LGBTI+ communities; and schools or workplaces. Some participants recalled an individual schoolteacher who was empathetic and supportive of them.

Positive and protective factors that influence LGBTI+ health are interrelated. This is clearly demonstrated by Mannix-McNamara et al. (2013). They found that sexual minority young adults were more comfortable with their sexual identity if they felt that their family and community accepted them. The more comfortable someone was with their sexual identity, the more probable it was that they came out to others, sought support, and were aware of the available support services. If their family, friends or community were more accepting of them, it was more likely that they also felt accepted by other stakeholders and sought support.

For further positive results from Irish studies, please see Section 3.15.2.

3.11.3. Additionality and intersectionality

Although data are not often analysed for possible intersecting minority identities, in some studies there are descriptive analyses on such variables. For instance, in Bradlow et al. (2017), disabled versus non-disabled, ethnic minority versus non-minority lesbian, gay, bisexual and transgender youth were compared, as were those that attend different types of schools, those with or without faith, and those that received or did not receive free meals at schools. In a relatively large number of studies, the statistical analyses were controlled for socio-demographic variables, including gender, race,

ethnicity, residence, socio-economic status or disability (Dürrbaum and Sattler, 2020, Irish et al., 2019, Jones et al., 2017, Költő et al., 2019b, Kuyper et al., 2016, Mannix-McNamara et al., 2013, Marshal et al., 2008). While the results are mixed, in general we can say that girls, ethnic minority young people and youth from disadvantaged families have an additional burden of mental health problems. A few studies generally conclude that many SGM young people have experienced discrimination based on grounds other than their sexuality or gender expression (e.g. Sandor et al., 2017). Homeless LGBTI+ youth are also more likely to be affected by various mental health issues – including substance abuse – than those having homes (Abramovich, 2012, Keuroghlian et al., 2014).

3.11.4. Positive aspects and protective factors

Research on protective factors that may buffer the negative consequences of psychological distress in LGBTI+ youth, is very limited (Newcomb et al., 2019). Existing evidence and perspectives of future research in this area will be further discussed in Section 3.16. It is worth mentioning though, that despite the dominant 'victimising' and 'at-riskness' narratives, there are many SGM young people who have happy and balanced lives, even if they have had adverse experiences (Mayock et al., 2009, Saewyc, 2011). The so-called 'after-queer' stream of research emphasises the diversity of LGBTI+ youths' lived experiences, their capacity for joy, pleasure, agency, and creativity, and the possibilities that popular culture offers for imagining gender, sex and sexuality differently. After-queer scholars warn that the 'at risk' discourses, which tend to focus on individual experiences or characteristics, may deflect attention from heteronormative and cisgenderist culture which pervade schools and the wider society.

Factors that enhance coping and mental health in lesbian adolescents include individual constitutional factors, such as strong sense of self and a positive world view, healthy relationships and support networks, social-environmental factors (e.g. moving to an LGBTI+ inclusive city) and strong familial ties (Kulkin, 2006). The author also notes that many lesbian youth report post-traumatic growth and increased resilience. Maladaptive behaviours are usually a consequence of, and a response to, negotiating a lesbian identity living in a homophobic and heterosexist society. Many of these observations can be generalised to other subgroups of SGM youth; a common positive process in their lives seem to be that of coming out. The long-term positive changes associated with coming out is supported by the findings of Mayock et al. (2009).

3.11.5. Good practices and interventions

In a systematic review, Coulter et al. (2019) summarised interventions and their effectiveness in preventing or reducing substance use, mental health problems, and violence victimisation among SGM youth. They identified nine effective interventions for mental health, two for substance use, and one for violence victimisation. One examined coordinated mental health services. Five interventions for sexual minority youth included multiple state-level policy interventions, a therapist-administered family-based intervention, a computer-based intervention, and an online intervention. Three interventions specifically aimed at gender minority young people included transition-related gender-affirming care interventions. All interventions improved mental health outcomes, two reduced substance use, and one reduced bullying victimisation. The three interventions carried out in European countries were all aimed at transitioning transgender young people (two in the Netherlands, and one in the UK). The other included studies examined interventions in the US or New Zealand.

The authors raise an important ethical dimension of such studies. Without a control group it is impossible to know whether any positive changes are attributable to the intervention, or if the participating young people would have improved anyway (for instance, due to pubertal maturation or increasing societal tolerance). However, there are profound ethical implications involved in withholding medical, psychological or any other type of professional help from young people that need it. The main conclusion of this study is that the number of interventions for SGM young people that have a documented effect are very low.

Any interventions should be preceded by thorough needs analysis in order to design and implement actions that meet the needs of LGBTI+ young people and other stakeholders. Such a needs analysis was carried out by Smithies and Byrom (2018). They aimed to understand the experiences of LGBTI+ college students and gather the views of university and Students' Union support staff on how to best identify and support LGBTI+ students to look after their mental health. In relation to what would render a peer support programme successful, respondents most frequently mentioned that it needed to be genuinely peer-led, accessible and mindful of subdivisions within the LGBTI+ community.

Gender-affirming medical therapy and supported social transition in childhood have been shown to correlate with improved psychological functioning for gender-variant children and adolescents. A review by Connolly et al. (2016) suggests that adolescents

who live and present according to their gender identity, rather than their natal sex have mental health outcomes comparable to their cisgender peers.

Community-level support also appears to improve the mental health of LGBTI+ children. Among sexual minority adolescents from British Columbia (Canada) it was found that after adjustment for student characteristics, including sexual orientation and age, various elements of a LGBTI+ supportive environment (e.g. high frequency of LGBTI+ related events, supportive community resources, the presence of organisations specifically serving LGBTI+ youth, and the supportiveness of general youth organisations) were negatively associated with lifetime illegal substance use in both girls and boys, and in lifetime marijuana and tobacco use in girls (Watson et al., 2020a). Drawing on the same dataset, Saewyc et al. (2020) demonstrated how more supportive communities were associated with lower levels of self-harm, suicidal ideation, and suicide attempts among sexual minority adolescent girls, but not among boys. These results demonstrate that (the presence or the lack of) LGBTI+ supportiveness of the local community, even in such a country as Canada where the general attitude towards LGBTI+ is rather favourable, can have a substantial effect on various aspects of mental health and well-being in sexual minority youth.

3.11.6. Knowledge gaps and recommendations for further research

In our landscape analysis, no evidence emerged on the substance use patterns in transgender, non-binary or other gender minority youth, despite the fact that their elevated risk is supported by many North American studies (Reisner et al., 2015a). This is an area that requires further investigation.

Similarly, studies on self-rated health and the frequency of psychosomatic symptoms in SGM youth, compared to their heterosexual and cisgender peers, are largely missing despite the fact that there is solid evidence for such health disparities in adult populations (e.g., Cochran and Mays, 2007, Cochran et al., 2003). Studies on self-esteem and life satisfaction were also rare or entirely lacking, despite these being important indicators of adolescent mental health.

Longitudinal and trend analyses that study the same indicators in SGM and heterosexual/cisgender young people over longer time periods are largely missing from the European research landscape. The only exception identified is an Icelandic study, in which the whole population of Year 10 Icelandic adolescents (aged 16

years) were investigated within the national HBSC study (Thorsteinsson et al., 2017). The authors compared sexual minority young people with their heterosexual counterparts on a variety of outcomes including suicidal ideation and behaviour, bullying experiences and satisfaction with school, level of social support from friends and family, overall life satisfaction, general health, and drug use. Sexual minority youth were generally worse off than their heterosexual peers. However, they found that the gap between them closed across many indicators between 2010 and 2014. The authors associate these changes with the unanimous passing of the gay and lesbian marriage law in Iceland, which happened in 2010. Nevertheless they emphasise the need to improve schools to become (more) supportive and protective environments for sexual minority students.

In both international and Irish studies there are many examples of studies investigating poor mental health outcomes and related psychosocial factors. However, positive aspects such as resilience, coping and sense of coherence are rarely mentioned. Similarly, other well-established concepts from positive psychology, such as flourishing, hardiness, resourcefulness, learned hopefulness, optimism, or self-efficacy (Snyder and Lopez, 2009) appear not to have been researched in European LGBTI+ youth populations. On the contrary, there seems to be an over-emphasis on discourses of risk, victimhood and vulnerability that problematise LGBTI+ identities and contribute to the disempowerment of SGM youth. North American studies have documented that a relevant source of potential resilience is religion. Results are, however, mixed on whether religiosity is protective for mental health or exacerbates mental health issues among LGBTI+ youth (Saewyc, 2011, Taylor and Cuthbert, 2019, Taylor and Snowdon, 2014).

Interventions to improve SGM young people's mental health and studies on the efficacy of such interventions are almost entirely missing from the European landscape. It is essential that before intervention programmes take place (and at least at two follow-up points), mental health indicators in participating or potentially affected SGM and heterosexual/cisgender youth are monitored in standardised ways. Good practices that have demonstrable efficacy should be acknowledged and shared with other stakeholders, especially educational and youth settings.

3.12. Objective 12: Sexual health

This objective of the Strategy aims to strengthen sexual health services and education to respond to the needs of LGBTI+ young people, including in the area of sexual consent. It includes seven actions: (a) improve accessibility of sexual health services to LGBTI+ youth; (b) improve accessibility and availability of HIV prevention strategies including **PrEP** and **PEP**; (c) include issues of gender identity and sexual orientation in the National 10 Day Foundation Programme in Sexual Health Promotion; (d) ensure that the education and information on sexual health, sexual consent and coercion, and sexual violence includes LGBTI+ experiences and also provides LGBTI+-specific education and awareness including, but not limited to, men who have sex with men; (e) ensure that in communications for sexual health, the needs of young LGBTI+ people are included with particular regards to men who have sex with men; (f) review international best practice on the issue of blood donation from men who have sex with men; and (g) ensure equal treatment for LGBTI+ people under the proposed assisted human reproduction legislation. Despite the wide range of actions, this aim was rather poorly covered by evidence. Only twenty-one pieces of evidence identified in the literature were relevant to this objective.

In the US literature, however, it is well documented that sexual minority young people are disproportionately affected by negative sexual health outcomes including HIV and other sexually transmitted diseases (STDs). SGM youth are more likely to engage in sexual risk behaviours such as early or very early sexual initiation, multiple sexual partners and suboptimal frequency of condom and/or contraceptive pill use (Armstrong et al., 2016). This indicates the importance of addressing sexual health disparities between SGM and heterosexual/cisgender youth.

3.12.1. Findings from international studies

A Canadian review (Blais et al., 2015) found that sexual minority youth were 1.3–3.5 times more likely to be engaged in condom-less sex than their heterosexual counterparts. They also found evidence that young men engaged in condom-less anal intercourse with men whose HIV serostatus was positive or unknown. The results indicated that sexual minority youth were also 1.8–3.6 times more likely to have an unplanned pregnancy. Possible explanations for this are lower contraceptive use, unplanned sexual intercourse with opposite-gender partners, engaging in heterosexual

sexual behaviours or choosing pregnancy to avoid being identified as sexual minority and targeted for homophobia/biphobia, or a lack of sexual education that properly engages LGBTI+ youth by responding to their needs.

European studies also confirm that LGBTI+ adolescents are disproportionately affected by risky sexual behaviour, for instance engaging in sexual intercourse before the age of 14 or having been offered money or gifts for sex (Priebe and Svedin, 2012). A review of the literature (Leonardi et al., 2019) estimated that the risk of adolescent pregnancy involvement for LGB youth is between 2 and 10 times higher than that of heterosexual youth. The term 'pregnancy involvement' reflects that this involves both young people involved in the conception, without assuming their gender identity. Epidemiological data from Canada, New Zealand and the United States were unequivocal in that among sexually active lesbian and bisexual female youth, the rates of pregnancy were higher than among their heterosexual peers. Similarly, gay and bisexual young males were significantly more likely to be involved in conceiving a pregnancy than their heterosexual peers. The authors link this to the broad range of sexual health risks experienced, including earlier age of sexual initiation, exposure to sexual abuse, and a higher number of sexual partners. For transgender and gender-nonconforming youth, the conflict with their gender identity, and potentially their sexual orientation, may be an additional burden. The authors suggest that their experience is likely similar to cisgender lesbian, gay and bisexual adolescents as it pertains to reproductive health considerations. Transgender and other gender minority young people may also experience an added challenge of fertility preservation. We identified no European evidence comparing pregnancy rates between SGM and non-minority youth.

A common barrier to positive sexual health raised in different studies is that SGM adolescents report a lack of sexual health education in school, or that sexuality and relationships education do not cover LGBTI+ related issues (Bradlow et al., 2017, Karsay, 2015). Starting age-appropriate LGBTI+ inclusive sexuality and relationships education early and sustaining it throughout the duration of school life improved young people's evaluation of such education (THT, 2016). Providing information on HIV, sexually transmitted diseases, or pregnancy prevention information relevant to LGBTI+ youth, and covering these issues in school curricula may also serve as an intervention against structural stigma (Hatzenbuehler and Pachankis, 2016).

A mixed-methods study with lesbian, gay and bisexual young people from the UK (Formby, 2011) investigated their views on sex and relationships education and sexual health. A general experience reported by participants was that same-sex relationships and homophobia were excluded from sexuality and relationships education. Sexuality was largely conceptualised and presented in a biomedical frame, thus neglecting more holistic understandings of sexuality that would include discussions on sexual pleasure or 'healthy' relationships. Students felt that safer sex and sexual risk were depicted as being related to concepts of stigma, visibility/appearance and sexual ill-health. For example, there was a common misconception that HIV was more likely to affect black and older gay men (Formby, 2011). Some participants recounted that they were not practising safe sex because of embarrassment, lack of confidence or communication skills. Problems around the availability of appropriate sexual health information, access to safer-sex supplies, and barriers to service provision were also raised. These all point to sexual health disparities that need to be tackled in a comprehensive way, requiring concerted effort from different stakeholders.

Evidence shows that SGM youth have more difficulties obtaining sexuality information than their heterosexual and cisgender peers. A systematic review of the health information-seeking practices of lesbian, gay and bisexual adolescents (Rose and Friedman, 2013) found that the most commonly cited source of health information was healthcare providers. However, many sexual minority young people found it hard to build trustworthy relationships with their healthcare providers. The authors found that the Internet was a major source of sexual health information for sexual minority youth, perhaps due to the anonymity that enables users to access information on sensitive sexual health issues, seek online support groups and get 'expert' health information. Parents were the least likely source of sexual health information for lesbian, gay and bisexual adolescents (Rose and Friedman, 2013). Overall, targeted health information was scarce, and lack of trust between patients/clients and providers and fear of breaching confidentiality were the most commonly cited barriers that prevented sexual minority youth from accessing health information.

Violence and abuse victimisation is a greater risk for SGM youth than for their heterosexual/cisgender peers. This may seriously compromise their mental and sexual health (Priebe and Svedin, 2012). In a representative sample of Swedish high school seniors, sexual minority students were significantly more likely to report different

forms of offline sexual abuse than heterosexual students. Both sexual minority boys and girls reported almost three times more often than their heterosexual peers that they experienced problematic sexual meetings off-line with person(s) they had met online. Such encounters included attempts to persuade or force them to have sex against their will or offers of money or gifts to have sex. Sexual minority girls were more likely than boys to report coercion with money and gifts in this way. Sexual victimisation, sexual orientation and gender contributed independently to poor mental health indicators, such as more psychiatric symptoms, lower self-esteem and a weaker sense of coherence. The pattern of results was similar whether sexual orientation or sexual/emotional attraction was used to determine sexual minority status. The authors attributed sexual minority youth's increased vulnerability to sexual abuse to a number of factors including increased experiences of hate crime, and the theory that changes in sexual identity may encourage experimentation and risk-taking behaviour (Priebe and Svedin, 2012).

Compared to heterosexual and cisgender adolescents, SGM youth are at elevated risk of physical aggression, emotional abuse, and sexual violence from dating partners (Reuter and Whitton, 2018). Transgender youth are even more vulnerable to both physical and sexual violence perpetrated by their partners than sexual minority youth. The underlying mechanisms for this increased risk remain unclear, though some evidence shows that these phenomena may be explained by the minority stress model (Reuter and Whitton, 2018). Romantic stress may also contribute to sexual minority adolescents' elevated risk for substance use (Költő et al., 2019b) and poor self-rated health (Költő et al., 2020a).

Existing knowledge on the psychosexual development of transgender adolescents is limited (Olson-Kennedy et al., 2016). However, a retrospective analysis of young transgender patients (aged 12–29) in a US adolescent and young adult urban community health centre demonstrated that they are disproportionately affected by various STDs and report high levels of unprotected anal and/or vaginal sex. The latter was reported by 52% of the male-to-female and 44% of the female-to-male young people. Trans girls and trans boys have different pathways to sexual health disparities. Unprotected sex in male-to-female youth was associated with younger age, being white (non-Hispanic) and reporting a primary sex partner; in female-to-males, predictive factors were having casual sex partners and reporting concurrent alcohol use (Reisner et al., 2015b).

Transgender and gender-nonconforming adolescents are also disproportionately affected by sexual violence. A study from the United States reported that 22% had experienced rape, and 33% reported being sexually harassed. Being a victim of sexual harassment and bias-based peer victimisation, problematic drug use, and female sex assigned at birth all predicted sexual victimisation. Sexual victimisation was significantly associated with suicidal ideation (Marx et al., 2021).

These findings present a negative picture of the sexual health of LGBTI+ adolescents, suggesting that transgender and other gender minority youth are in an especially challenging situation. The reasons for such sexual health disparities indicate issues beyond lack of access to adequate relationship and sexual health information and may be structural in origin.

3.12.2. Findings from Irish studies

We have found only tangential evidence on LGBTI+ adolescents' sexual health in Ireland, despite the fact that inclusive sex and relationships education is the second most highly prioritised issue for SGM youth (Noone, 2018). The My World Survey 2 (Dooley et al., 2019) reports sexual initiation broken down by sexual orientation. Bisexual students were most likely to report ever having had sex (72%), while those who preferred not to disclose their sexual orientation were the least likely to be sexually initiated (10%).

However, it is important to note that adolescent population health surveys could provide sufficient data for such analyses. For instance, the My World Survey 2 (Dooley et al., 2019) contains items on sexual activity, number of sexual partners, age at first sexual intercourse, condom and contraceptive use, pornography use, and sexual consent – all of which could be analysed across sexual orientation and gender identity groups. The Growing up in Ireland Child Cohort Wave 3 dataset (ESRI, 2014) contains items on sexual orientation and gender identity as well as perceived easiness of talking to parents about sex, current and past (romantic) relationships, sexual behaviour, pressure to have sex and number of sexually active friends. In addition, the Health Behaviour in School-aged Children study (Költő et al., 2020) asks about romantic feelings (whether the respondent is attracted to or in love with opposite-, same- or both-gender partners) and sexual initiation, condom and contraceptive pill use at last sexual intercourse, age of the respondent and the partner at first sexual intercourse,

and circumstances of the first sexual intercourse (contraceptive use, having alcohol or drugs before the intercourse, and feelings on timing of the first intercourse).

3.12.3. Additionality and intersectionality

Sexual and gender minority status, sex assigned at birth and gender identity creates intersections that highlight the disproportionate burden on cis and trans girls and young women. Being a woman, being trans and being lesbian or bisexual are independent factors for sexual violence victimisation (Priebe and Svedin, 2012). According to US studies, elevated risk of unprotected sex, STIs, HIV-positive status and poor antiretroviral treatment adherence are documented in transgender youth (Reisner et al., 2015b), and trans girls have greater risk of engaging in sex work, compared to cis girls (McCann et al., 2017). Some studies highlight that the sexual needs of SGM youth with specific types of disabilities are often incorrectly perceived and / or their sexual needs and desires are not recognised. For instance, youth with Down syndrome may be perceived as asexual, or youth with learning disabilities or attention deficit disorder are viewed as having the same sexual needs and desires as their non-disabled peers (Duke, 2011). The identified European studies lack consideration of potential intersectionality in LGBTI+ youth's sexual health.

3.12.4. Positive aspects and protective factors

Research on positive dimensions and protective factors for sexual health in LGBTI+ youth is rare and confined to some subgroups and cultures. For instance, in their systematic review, Armstrong et al. (2016) had to narrow their scope to young men who have sex with other men in the US, due to the lack of sufficient evidence on protective factors in sexual minority young women and a similar lack of studies from other countries. Their findings indicated that subjective peer norms and attitudes about condom use were consistent protective factors in cross-sectional analyses. Findings on the predictive value of self-efficacy, self-esteem and clear and positive identity were more mixed. In some studies, self-efficacy, normal levels of self-esteem and being comfortable with others knowing that the respondent was gay or bisexual were associated with lower levels of risky sexual behaviours, but in other studies no such significant associations were found. This observation implies that the relationship between sexual identity and risky behaviours are influenced by community-level factors. In other words, examples of other gay and bisexual men (and maybe, in general, other LGBTI+ individuals) in the community may have an impact on young people's behaviour.

The findings of Armstrong et al. (2016) suggest that attitudes and subjective peer norms related to condom use are promising intervention targets for young men having sex with men. The authors, however, emphasise the need for longitudinal research to confirm these protective effects as well as more studies among other sexual and gender minority groups. They also note that skills and competencies linked with sexual health have been insufficiently studied among sexual minority youth.

3.12.5. Good practices and interventions

In a systematic search of interventions preventing or reducing substance use, mental health problems and violence victimisation among SGM youth, Coulter et al. (2019) highlighted just one intervention which tangentially mentioned sexual harassment. This highlights the general lack of evaluated interventions to promote sexual health and help improve the quality of romantic and sexual relationships of LGBTI+ youth. Indeed, the needs of SGM youth around sexuality and relationships education and health promotion are rarely investigated. A notable exception is the work of Formby (2011). In their qualitative study, some sexual minority respondents emphasised lack of visibility of LGBTI+ patients in health materials. Female participants reported lack of access to appropriate information, while some male participants felt sexual health promotion efforts were too intrusive at their socialising spaces. Formby argued that sex educators and sexual health services are well-suited to address some of the knowledge and information gaps in relation to SGM youths' sexual health needs, particularly those of girls, using a broad and holistic concept of sexual health.

3.12.6. Knowledge gaps and recommendations for further research

The lack of good quality evidence on the sexual health of LGBT+ youth in Ireland may be linked to the sociocultural context of Ireland, which has traditionally had a sexually repressive culture (Inglis, 2005). However, there is a general dearth of evidence in this area across Europe. Researchers and other stakeholders may make good use of the suggestion of Formby (2011): first we may have to tackle our own reticence to talk openly and frankly about sex.

While the elevated prevalence of risky sexual behaviours in SGM youth is relatively better documented, evidence on what factors may protect and improve their sexual health seem to be extremely scarce. This includes the support needs of victims of sexual abuse or violence (Priebe and Svedin, 2012). Another area where population

health estimates are urgently needed is on pregnancy involvement in SGM youth. This evidence gap underlines the need for detailed and clear indicators of SGM status in youth health surveys in Ireland and other European countries. A third area where evidence is largely missing is mapping of specific sexual health needs of transgender and other gender minority adolescents (McCann et al., 2017).

A second wave of research is needed which transcends describing individual factors and seeks to understand the structural and psycho-developmental trajectories which lead to sexual ill-health as well as good sexual health and well-being. Intervention studies, preferably in the form of quasi-randomised trials, should be developed to monitor the efficacy and sustainability of sexual health initiatives. These should include pre-, short- and long-term post-intervention measurement and cover various indicators, such as prevalence of STIs and unplanned pregnancy, psychological well-being and satisfaction with romantic relationships, perceived self-efficacy and sexual competences.

Priorities for methodologies to be employed in studies of sexual health in SGM youth were identified by Mustanski (2015):

1. The need for innovative approaches and interventions, using online and mobile platforms.
2. More studies are needed that concentrate on structural (societal and eco-developmental) determinants of sexual health instead of individual factors.
3. Translational research needs to be prioritised, given that there is a relatively large body of evidence on sexual health disparities, but considerably less is known about the underlying mechanisms, particularly, beyond the individual level. Effective approaches to combat these disparities are also not investigated and understood in sufficient depth.

3.13.Objective 13: Health of transgender youth

Objective 13 of the *LGBTI+ National Youth Strategy 2018-2020* concerns the need to improve the physical and mental health and well-being of trans youth in Ireland. Actions in this objective include (a) ensure that appropriate resources are available for HSE developing and providing appropriate care services to support trans young people; (b) develop a policy to ensure all health programmes take account of young people who have transitioned; (c) provide clear guidelines to health practitioners on referral pathways for trans youth and their families; (d) work with youth and parents seeking to access healthcare outside the state. This objective is fairly well represented in the identified resources, with 41 relevant studies identified.

Estimating the number of trans identifying people in Ireland and elsewhere poses a challenge. Estimates based on retrospective analysis of treatment-seeking trans people range from 4.6 per 100,000 in Europe (Arcelus et al., 2015) to 350 per 100,000 in the United States (Meerwijk and Sevelius, 2017). There is evidence, however, that this is a growing population, with increasing numbers of young people presenting for care at specialised gender identity services worldwide (de Graaf et al., 2018, Delahunt et al., 2018, Kaltiala-Heino et al., 2015).

There is also some evidence that the demographic composition of the trans population is changing, with the sex ratio of young people attending such services shifting from predominantly male to female to predominantly female to male (Aitken et al., 2015, de Graaf et al., 2018). In the UK, the number of adolescent girls (female to male) seeking treatment for gender dysphoria has increased twenty-two-fold – from 48 in 2010 to 1071 in 2016 – while the number of adolescent boys (male to female) seeking care during the same period increased approximately ten-fold from 44 to 426 (de Graaf et al., 2018). Existing evidence suggests that this is a population with complex health needs and mental health co-morbidities. In Finland, 75% (35/47) of applicants to one gender identity clinic had been or were undergoing psychiatric treatment for something other than gender dysphoria and 26% (12/47) were on the spectrum for autistic disorders (Kaltiala-Heino et al., 2015). In interpreting these findings, it is important to remember that the participants are drawn from clinical samples, not the general population, and that findings can be strongly influenced by only including participants who are accessing clinics. High-quality population level studies would be necessary to investigate the nature of any relationships between gender dysphoria, mental health problems and ASD.

Despite the growing population, there is still much that is unknown or unclear about the health, well-being and development of trans young people and the changing profile of trans youth presenting for care complicates the picture substantially (Olson-Kennedy et al., 2016). In respect of all health domains, trans health is still a very under-researched area and there is a considerable need to improve the evidence base (Connolly et al., 2016).

3.13.1. Findings from international studies

The vast majority of relevant literature identified relates to mental health considerations for transgender and gender diverse youth, and two reviews touched on the issue of medical care for transitioning youth. The findings of those reviews are presented here alongside the mental health care literature but are offered with the proviso that they likely provide an incomplete picture. This is because the search parameters of this review did not specifically seek information related to medical interventions for gender transitioning youth.

Mental health considerations

Trans-identifying youth experience higher rates of depression, self-harm and eating disorders than their non-trans peers (Connolly et al., 2016). They report significantly lower health-related quality of life than their peers from a normative adolescent sample, and low quality of life is associated with internalising problems and body dissatisfaction (Röder et al., 2018). There may be a number of reasons for this pattern. Children and adolescents often feel negative about their bodies and have low self-worth (Alberse et al., 2019). This may be compounded by the social stigma and accompanying minority stigma that is reported by trans youth (Hatzenbuehler and Pachankis, 2016).

Further exacerbating the challenges is a general lack of social support and social inclusion. For example, a study in Spain found that trans and non-binary adolescents receive less support from family and friends and participate less in social activities than their cisgender peers (Aparicio-Garcia et al., 2018). The lack of support manifests in the finding that more than one third of trans post-primary students have not spoken to anyone in their school about their gender identity (PACEC, 2017). Other factors that may adversely impact on the mental health of trans youth include increased exposure to dating violence (Reuter and Whitton, 2018), as well as high levels of bullying and victimisation (Witcomb et al., 2019).

In general, the international evidence suggests that trans youth are disproportionately affected by serious mental health problems (including self-harm, suicidality, alcohol use and victimisation experiences) compared to their cisgender peers (Connolly et al., 2016, Ignatavicius, 2013, Rimes et al., 2017, Wilson and Cariola, 2020). While it is generally accepted that this is a population that may be at greater risk of suicide, assessing the prevalence of the problem is fraught with difficulties. Challenges with suicide research methodologies and significant gaps in current knowledge mean that it is practically impossible to reach generalisable conclusions about suicidal behaviour or suicide risk in the trans population (Haas et al., 2011, Haas and Lane, 2015).

Physical health considerations

A review of the World Professional Association for Transgender Health's standards of care for children and adolescents with gender identity disorder (De Vries and Cohen-Kettenis, 2009) summarised the state of the field at the time of publication in respect of phenomenology, diagnosis and treatment options for children and adolescents experiencing gender dysphoria.

1. Phenomenology: Gender atypical behaviours, which are non-specific to trans identity, are unlikely to persist beyond childhood. However there is a dearth of good quality longitudinal research in Europe which documents developmental pathways in gender identity. The authors also note that sex differences exist: more boys are affected than girls during childhood, although the ratio evens out in adolescence (However, as we have noted in the introduction to this section, this trend has reversed significantly since this review was published). The authors further assert that children that were not dysphoric can develop dysphoria with the onset of puberty.
2. Diagnosis: Clinicians should consider a variety of contextual factors that may impact a child's behaviour. These may include general information about the child's gender behaviour, feelings and development as well as aspects of the child and the family's functioning. The diagnostic phase should not only be used to gather diagnostically relevant information, but also to inform the applicant and family about the possibilities and limitations of gender reassignment/affirmation, as well as other kinds of treatment, to prevent unrealistically high expectations.

3. Treatment: No medical interventions are recommended in pre-pubertal children. Psychotherapy and counselling are recommended for adolescents who are confused about their gender identity, or whose desire for gender re-assignment is driven by factors other than gender identity.

Medical intervention for gender dysphoric youth falls into three categories: 1) pubertal suppression with hormones; 2) cross-sex hormones to feminise or masculinise; 3) surgical intervention (De Vries and Cohen-Kettenis, 2009). The authors conclude that there are arguments for and against medical intervention for adolescents. They cite a small number of studies that have found improved outcomes, while acknowledging that concerns exist over the potential adverse impact of hormone therapy on bone density, cognitive development, fertility and growth. As such, they recommend that medical intervention in adolescents should be carefully considered and certain rigorous criteria should be met in assessing eligibility and suitability. Irreversible surgical interventions are not recommended before the age of 18. It is important to note that there have been multiple developments since this work was published in 2009, but even authors of more recent reviews (e.g., Busa et al., 2018) emphasise that we do not fully understand the medical, psychological and psychosocial impact of these interventions. New clinical guidelines are needed in this area.

The second study in our sample that investigated medical interventions systematically reviewed the effects of hormonal therapy in young people with gender dysphoria (Chew et al., 2018). Thirteen studies met the inclusion criteria for the review, and the evidence for physical, psychosocial, and cognitive effects of different hormonal therapies in transgender youth was evaluated. In relation to physical effects, the authors found that most treatments successfully achieved their intended physical effects, with gonadotropin-releasing hormone agonists and cyproterone acetate (puberty blockers) suppressing sex hormones, and oestrogen or testosterone (cross-sex hormones) causing feminisation or masculinisation of secondary sex characteristics. Treatment with gonadotropin-releasing hormone agonists was found to decrease lumbar bone mineral density significantly in all but one study. Bone density appeared to increase with treatment with cross-sex hormones. In relation to psychosocial effects, the authors found that treatment with puberty blockers was associated with improvement across multiple measures of psychological functioning but not gender dysphoria itself. The research on the cognitive effects of puberty blockers was extremely limited and non-generalisable. No research was found for

the review which assessed the psychosocial or cognitive effects of gender affirming treatment in trans youth with cross-sex hormones. It should also be noted that three of the 13 studies included in the review were funded by the pharmaceutical industry. The authors ultimately conclude that treatment appears relatively safe in the short-term, however it is not without potential adverse side-effects and little is known about the impact on cognitive and physical development, fertility or on longer term effects in respect of other outcomes.

3.13.2. Findings from Irish studies

The findings from Irish studies focused on mental health issues of trans adolescents, reporting relatively high levels of self-harm and suicidal behaviours. For example, Mayock et al. (2009) found that 44% of trans participants had self-harmed at some point in their lives and that a quarter of trans participants had indicated that they had attempted suicide at least once. Similarly, Higgins et al. (2016) reported that trans participants were the second most likely, after intersex-identified participants, to report that their mental health had worsened in the past five years. In relation to self-harm, 67% of trans 14-18 year olds and 54% of trans 19-25 year olds had ever engaged in self-harm behaviours. Thirty-eight percent of trans 14-18 year olds and 38% of trans 19-25 year olds reported ever attempting suicide. Kelleher (2009) found that stigma consciousness was strongly predictive of adverse psychological outcomes. This is supported by the findings of a review from McCann et al. (2017), which reported that experiences of stigma and discrimination were associated with increased susceptibility to mental health difficulties. Findings on body dissatisfaction were replicated in an international study that contained data from Canadian, US and Irish transgender youth (McGuire et al., 2016).

3.13.3. Additionality and intersectionality

Much of the literature indicates that trans youth are disproportionately affected by mental health difficulties, including self-harm and suicidal behaviours (Connolly et al., 2016, Haas et al., 2011, Higgins et al., 2016). Transgender adolescents may be particularly vulnerable to homelessness, which can negatively impact on health in a myriad of ways (Keuroghlian et al., 2014). Stigma and minority stress can contribute to a disproportionate burden of negative physical and mental health outcomes for trans youth, including acting as a barrier to accessing and engaging with services (Hatzenbuehler and Pachankis, 2016). It has also been documented that young trans

and LGB people with disabilities often receive inadequate sex education – or are completely excluded from it – and thus may be at a higher risk of STIs (Duke, 2011).

There is some evidence suggesting sex differences in the experiences of trans youth. For example, greater numbers of assigned female at birth (AFAB) trans young people report bullying than assigned male at birth (AMAB) trans youth, and AFAB youth are more likely to report negative effects on their family and social lives (Witcomb et al., 2019). Similarly, a UK study (Rimes et al., 2017) found that AFAB trans youth, including AFAB non-binary participants, were more likely to report a current mental health condition and history of self-harm than AMAB participants. AFAB participants (binary and non-binary) were also more likely to report childhood sexual abuse than AMAB participants (binary and non-binary), however AMAB participants were at greater risk of lifetime physical assault related to gender identity. For further details on transgender (and other gender minority) youths' experiences on inclusion, please consult Section 3.10 of the present report on inclusive environments for transgender and intersex young people.

3.13.4. Positive aspects and protective factors

Several reviews have identified protective factors for trans youth health. Zeeman et al. (2017) identified increased social inclusion, participation in sport, meditation, artwork, social support in youth clubs and group identification as increasing confidence among trans youth. Johns et al. (2018a) identified 27 unique protective factors at the individual, relationship and community level within a socioecological model. Individual level factors were related to skills/competencies, such as problem-solving and self-advocacy, and beliefs/perceptions, such as self-esteem and self-efficacy. Relationship-level protective factors included strong family relationships, particularly parent-child connectedness, in addition to generalised social support and other social relationships with peers and other trusted adults. Community-level protective factors included community visibility, school policies and organisational resources, among others. These findings correspond with those of Blais et al. (2015), who reported that school and family connectedness, parental support, school safety and involvement in sports decreased the odds of adverse health outcomes among transgender youth.

3.13.5. Good practices and interventions

A review by McCann et al. (2017) noted the need for early mental health interventions, however none of the studies they included assessed or evaluated the efficacy of the recommended interventions. Amodeo et al. (2018) evaluated a group training

programme designed to increase resilience among trans youth, finding that the intervention was linked to increases in identify affirmation, self-recognition and self-acceptance. The group was recognised as a source of support by participants and there were also statistically significant increases in resilience from pre-intervention to three months post intervention. The small sample size (n = 7), however, means the results are not generalisable. Similar beneficial effects were demonstrated by a group therapeutic intervention for gender diverse (mostly AFAB) young people (Davidson et al., 2018). Ignatavicius (2013) observed that parental support may be the most important intervention and as such highlights the need for education, support and counselling targeted at parents and families. Research on interventions, as indeed with other aspects of trans lives, is under-developed.

3.13.6. Knowledge gaps and recommendations for further research

The evidence base for many aspects of transgender youths' lives is very thin. In a review of the research priorities for gender non-conforming and transgender youth, Olson-Kennedy et al. (2016) assert that much remains unknown about the aetiology and developmental pathways of gender dysphoria and there is a lack of clinically useful information on developmental pathways. They also highlight the need to develop more appropriate measuring tools to assess gender non-conformity and transgender status.

Trans youth are disproportionately affected by adverse health outcomes, including self-harm and suicidal behaviours. In general, however, trans health and well-being remains poorly researched and understood and these gaps need to be addressed. The evidence base for interventions is quite poor, although parental support appears to be a strong protective factor. High quality intervention and evaluation research is needed.

Some authors cite evidence for potential links between gender dysphoria and autism spectrum disorders (Duke, 2011, Olson-Kennedy et al., 2016). A comprehensive investigation of these associations seems to be all the more urgent, given the growing numbers of adolescents on the autism spectrum that are presenting for treatment for gender dysphoria (Kaltiala-Heino et al., 2015). The lack of high-quality, replicated and representative research makes it difficult to provide evidence-based and ethically sound recommendations to inform practice and policy, especially in a rapidly changing social landscape. Many questions in respect of the safety, effectiveness and long-term impact on a range of outcomes remain unanswered. There is lack of evidence

in respect to the short and long-term effects of puberty blockers and cross-sex hormones across a variety of health domains, which is probably linked to the fact that there is an ongoing debate on whether puberty blockers should or should not be used (Giovanardi, 2017). This research gap must be addressed using an interdisciplinary approach. Ethical principles and clinical considerations relevant to decisions about medical interventions for minors should be consistent across population sub-groups.

3.14. Objective 14: Intersex youth

Objective 14 of the *LGBTI+ National Youth Strategy 2018-2020* relates to enhancing understanding of and responding to the health and welfare needs of young people with intersex conditions. It contains one action: establishing a working group on intersex healthcare for children and young people. This objective has the second poorest coverage in the research landscape, with only 11 studies of the research speaking to it, and only one study that actually included a sample of intersex youth.

Before outlining the findings, it is necessary to clarify a number of issues related to terminology and conceptualisation. 'Intersex' is an umbrella term used to describe people that live with conditions that are known medically as '**Disorders of Sexual Development**' (DSD). These have been defined as "congenital conditions in which development of chromosomal, gonadal, or anatomic sex is atypical" (Lee et al., 2006, p. e488). In this context, the authors appear to be referring to binary sex categories.

It is important to note that the terminology used to describe intersex/DSD conditions has shifted over the past number of decades and remains contested to this day. In 2006, the Lawson Wilkins Paediatric Endocrine Society and the European Society for Paediatric Endocrinology released a consensus statement in which they proposed use of the term 'Disorders of Sexual Development' or DSD (Lee et al., 2006). This term, however, is considered pathologising and stigmatising by some and is often not adopted by people affected by intersex conditions (Lundberg et al., 2018).

Indeed, the term 'intersex' is very often disapproved of by some young people, who rather use different terms in different contexts depending on need (Lundberg et al., 2018). Research in the UK and Sweden found that people unaffected by DSD were more likely to use the term 'intersex' than young people living with intersex variation. An advocacy group called the Accord Alliance (See www.accordalliance.org) have opted to re-fashion DSD to the more neutral 'Differences of Sexual Development,' which is considered more acceptable (Lundberg et al., 2018).

The picture is further complicated by the fact that there are individuals who may *identify* as intersex as a gender or political identity but do not have a DSD, and yet others that live with DSD but do not self-identify as intersex (Jones, 2016). However, Jones (2018) has highlighted "the need in health research to limit the group to only

those with somatic intersex variations (regardless of gender/political identity), due to their distinct medical experiences" (p. 2).

3.14.1. Findings from international studies

No international studies met the inclusion criteria for the landscape analysis.

3.14.2. Findings from Irish studies

Only one study in the sample classified respondents with intersex conditions. The *LGBTIreland Report* (Higgins et al., 2016) is the largest study of LGBTI+ people in Ireland to date. Although the study was not limited to people under the age of 26, we retained it in the landscape review because of its importance. At the time of writing, it is the largest study of mental health and well-being of LGBTI+ people in Ireland and also the only study that has included a sample of intersex people. Moreover, with over 40% of the sample aged between 15 and 24, omitting it from the review would have rendered an incomplete picture of the LGBTI+ youth research landscape in Ireland.

Of the total sample of 2,264, just over 2% were identified as intersex. No distinction appears to have been made between those living with specific DSDs and those self-identified as intersex as a political or gender identity. In terms of sexual orientation, intersex people in the sample described themselves as: 26% lesbian; 20% bisexual; 13% gay; 13% pansexual; 7% queer; 9% heterosexual/straight; 9% questioning/ not sure; 2% 'other'. Intersex identified respondents had the youngest mean age of awareness of their identity – at age 12 - and, along with transgender respondents, were more likely to tell others about their identity at a younger age.

Intersex respondents were more likely to report not feeling safe reading an LGBTI+ publication and were most likely to not check an LGBTI+ website on a public computer. They were also more likely than other cohorts to feel unsafe seen leaving or going to an LGBTI+ venue/club. A high proportion (79%) reported being verbally hurt and were more likely than other cohorts to report having hurtful things written about them on social media (40%). At 42%, intersex respondents were also the cohort most likely to report being threatened with being outed. Intersex respondents were the third most likely to report being threatened with violence (36%) after gay males (42%) and transgender respondents (41%). Intersex respondents (24%) were second only to gay males (29%) to report having been attacked physically, with 11% reporting having been attacked with a weapon. Furthermore, intersex respondents (30%) were the

cohort with the highest reported incidents of sexual violence.

Of the almost 40% of respondents that had attended school within the previous five years, 21 identified as intersex. These 21 respondents were significantly more likely to have experienced gender or sexuality-related bullying at school (at 75%) than other LGBT+ cohorts and, with transgender participants, were more likely to have considered leaving school early (57% and 36%, respectively). Indeed, the intersex group had the highest proportion of respondents (14%) who reported having left school early due to negative treatment.

Of the total sample of respondents that were in University or college, 21 identified as intersex. Similar to their experiences in school, intersex respondents were more likely than their non-intersex peers to give their university or college a low rating in relation to LGBTI+-friendliness, were significantly more likely (at 19%) to feel like they did not belong and significantly more likely to report that they did not receive positive affirmation at college/university. A relatively high proportion of intersex respondents (24%) also reported LGBTI+ bullying at university/college, with an equal number reporting having skipped or missed university/college to avoid negative treatment related to being LGBTI+.

Intersex respondents had lower self-esteem than other cohorts and their mean scores for happiness and satisfaction were lowest among the sample as a whole and among 14 to 25-year-olds specifically. Intersex respondents also scored highest on scales that measured depression, anxiety and stress. At 84%, intersex respondents were more likely to have considered taking their own lives and were considerably more likely than other groups to have attempted suicide (58%, as compared to the next highest rate of 35% among transgender respondents). The authors suggested that the comparatively high rates of mental distress among intersex respondents may be attributable to the also comparatively high levels of victimisation experienced among this group. This may be compounded further by the fact that intersex respondents were more likely to employ negative coping strategies than other cohorts. The authors concluded that intersex respondents were at particularly high risk of developing significant mental health issues.

Intersex participants (40%) were the group most likely to report having had a bad experience of mental health services and most likely (24%) to report that they knew of someone who had a bad experience. They were the second most likely after trans participants to think that services were not LGBTI+ friendly although they were less

likely to report being afraid of stigma. Nevertheless, intersex respondents were most likely to feel that services were unable to help them. Given that the above findings are from one single study, it should be a priority to conduct further studies on the lived experiences and health of intersex youth and adults in Ireland.

3.14.3. Additionality and intersectionality

None specifically highlighted.

3.14.4. Positive aspects and protective factors

None specifically highlighted.

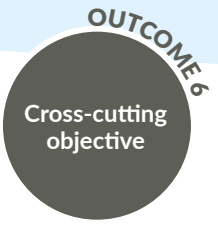
3.14.5. Good practices and interventions

None specifically highlighted.

3.14.6. Knowledge gaps and recommendations for further research

In general, health concerns of people with intersex conditions have been overlooked in research, and knowledge gaps exist across all health domains (Jones, 2018). The conflation of intersex as a political/gender identity with intersex as a physiological or medical condition further complicates matters (Jones, 2016, 2018). Although the *LGBTIreland* report (Higgins et al., 2016) is an important first step towards addressing the neglect of young intersex people in health research in Ireland, it is also indicative of the methodological challenges inherent when taxonomies of identification are blurred. The distinct and sometimes traumatising medical histories of people with intersex variation require special attention by health researchers. This is because the basis for their victimisation – which may intersect with other political/gender identities – has a specific physical and material basis separate and apart from that identity. Jones (2018) recommends that intersex research participants are recruited by using direct and active strategies, such as liaising with intersex groups and organisations, to overcome tendencies toward 'pink-washing' or assuming intersex people are included when they are not (UN, 2012).

These issues have not been adequately investigated in Ireland and little else is known about the health and well-being needs of intersex young people and their families or of their experiences within the healthcare system.



3.15.Objective 15: Research

Objective 15 states the need to "enhance the quality of LGBTI+ data and commission research to ensure evidence-informed policy and service delivery" (DCYA, 2018, p. 31). It lists seven actions: (a) conduct a commissioned landscape analysis of existing research, and use this information to complete a research needs analysis based on the gaps identified; (b) develop and implement research to address the identified data gaps; (c) include LGBTI+ matters in the review of Relationships and Sexuality Education; (d) commission a review of international and Irish best practice study on appropriate language and ways to ask about gender identity and sexual orientation in surveys and/or Census; (e) maintain, develop and enhance the Irish Queer Archive; (f) develop research on factors that support positive mental health in LGBTI+ youth; and (g) explore Growing Up in Ireland Wave 3 data on sexual orientation and other relevant information.

The present landscape and knowledge gap analysis forms a key part of fulfilling this objective, responding specifically to Action (a) within the objective (conducting a commissioned landscape analysis and identify research gaps). As this report provides an overview of the overall research and data landscape, this section will specifically address Action (f), which highlights the need to "develop research into the factors that support positive mental health for LGBTI+ young people and ascertain how these positive factors can be replicated" (ibid. p. 31). This objective was poorly represented, with 16 of studies speaking to it.

Scholars studying SGM youth health are increasingly recognising the value in shifting the discourse on SGM mental health away from an emphasis on being at risk as the defining feature and narrative of SGM lives, and rather focus on the positive aspects of SGM identities (Bryan, 2017, Bryan and Mayock, 2012, Rasmussen, 2006). This does not mean neglecting or minimising negative aspects and adverse experiences. Indeed, positive aspects of LGBTI+ identities have emerged in the literature. These include authenticity, resilience and coming out growth, which is the process of how hardships due to one's gender or sexual minority status can be transformed into assets. An overview of the positive aspects associated with LGBTI+ identities is provided by Riggle and Rostosky (2012).

While the majority of SGM youth in Ireland report good mental health generally (Higgins et al., 2016, Mayock et al., 2009), they are also disproportionately affected by mental health issues compared to their heterosexual peers (Dooley and Fitzgerald, 2012, Dooley et al., 2019). These results are outlined in Section 3.11.2.

At the same time, SGM youth are not a homogenous cohort and sexual or gender minority status alone is not necessarily a predictor of adverse mental health outcomes (Eisenberg and Resnick, 2006). By shifting the paradigm away from 'at-riskness' and focusing on enhancing protective factors, researchers and policy-makers can help to address the mental health disparities experienced by SGM youth whilst also challenging the dominant narrative of SGM victimhood (Bryan, 2017, Marshall, 2010).

Protective factors refers to individual level characteristics, behaviours, relationships or conditions at the individual, community and structural levels, that help an individual avoid or mitigate poor outcomes (Johns et al., 2018b). The subsections below summarise findings from the landscape analysis that referred specifically to protective factors for SGM youth mental health and well-being within the literature. While protective factors were identified in other areas (e.g. against discrimination or poor physical and sexual health outcomes), we have found much less evidence for these than in the context of mental health and well-being. Within the preceding sections 3.1-3.14 dedicated sub-sections on positive aspects and protective factors relevant to the given strategy objective are provided.

3.15.1. Findings from international studies

Protective factors were identified at the individual and community levels of social interaction across the international literature (Bouris et al., 2010, Coulter et al., 2019, Freitas et al., 2016, Hatzenbuehler and Pachankis, 2016, Johns et al., 2018a, McDonald, 2018, Newcomb et al., 2019, Russell and Fish, 2016).

A systematic review of protective factors among transgender and gender variant youth (Johns et al., 2018a) identified a total of 27 unique factors protective against various health, academic and behavioural outcomes. They reported on nine factors at each of the individual, relationship, and community levels of the socioecological model (Bronfenbrenner, 1979). Among these were:

- Individual-level protective factors, such as beliefs and perceptions (for example, self-esteem) and skills and competencies.

- Relationship-level protective factors, which included parents and families, trusted adults, peers, generalised social support and romantic or sexual partnerships.
- Community-level protective factors, including school policies, organisational resources and practices, and community visibility.

At the individual level, family support in particular was highlighted as a protective factor in the health of SGM youth (Bouris et al., 2010, McDonald, 2018). Parental-child connectedness is associated with better health outcomes across all health domains (Bouris et al., 2010). In relation to mental health and well-being specifically, parental knowledge of LGBTI+ information, a supportive and caring parent-child relationship, acceptance of the child's identity, and a strong relationship with both parents were identified as key protective factors that promoted positive health outcomes. Conversely, parental disapproval of or a negative reaction to a child's sexual orientation, and parent-child conflict were associated with adverse outcomes. These findings are discussed in Section 3.6 on supports to parents and families.

Highlighting the need for specific SGM school policies at the community level, inclusive, protective and affirming school environments are identified as an important factor across a number of reviews and studies. These demonstrate that the ability to be open about one's identity is an important protective factor, and SGM youth that are out of their own will and decision at school report lower levels of depression and greater overall well-being in young adulthood. In contrast, concealment of one's identity or status is associated with poorer mental health outcomes (Hatzenbuehler and Pachankis, 2016, Johns et al., 2018b, Russell and Fish, 2016). Characteristics of LGBTI+ inclusive educational environments are outlined in Section 3.2.

3.15.2. Findings from Irish studies

Respondents to the *LGBTIreland study* on SGM youth in Ireland (Higgins et al., 2016) were asked to identify aspects of their lives that had a positive impact on their mental health (Higgins et al., 2016). Interestingly, where the international literature lacked a focus on macro-level structural protective factors, the answers provided by respondents give an insight into specific societal level factors which they perceived to have had a major positive benefit to their mental health. These included cultural representation in the media and on TV (89%) and changes in legal frameworks such

as the Gender Recognition Bill (83%) and the Civil Partnership Bill (83%). Almost three quarters (71%) said that engaging with mental health services had a positive impact on their mental health, and 72% had gained a benefit from visiting an LGBTI+ centre. In line with international findings, other positive impacts that were identified included interpersonal/relationship level factors such as: friendships with other LGBTI+ youth (89%), coming out to friends (86%), coming out to family (73%) and joining an LGBTI+ group (82%). However, it must be noted that the research base on the representation of SGM youth in sports, culture and in society is very thin.

3.15.3. Additionality and intersectionality

Hatzenbuehler and Pachankis (2016) dissected the issue of group-specific and general processes while exploring stigma as a social and structural determinant of health among SGM individuals. LGBTI+ hate crime is identified as one of the group-specific processes that adversely affect SGM youth mental health. However the evidence base is not well-developed. It is unclear whether there are differences in respect of protective factors for individuals that experience compound stigmatisation/ marginalisation as a result of intersecting identities.

3.15.4. Positive aspects and protective factors

These are outlined in full in this section as a whole.

3.15.5. Good practices and interventions

Although parent-child connectedness has been highlighted across numerous reviews and studies as a protective factor that leads to better outcomes across many domains, no interventions were found by Bouris et al. (2010) in their review. Hatzenbuehler and Pachankis (2016) note that complex multicomponent interventions are likely to be most effective in reducing the negative health consequences of exposure to stigma among SGM youth. Specifically they identify systems-level interventions, such as implementation of policies to foster a protective and supportive environment at the school level, as steps that may improve health and well-being outcomes of SGM school-goers. In general, however, further research and development is needed in relation to interventions aimed at bolstering protective factors for mental health among SGM.

3.15.6. Knowledge gaps and recommendations for further research

Parental support is vital for SGM youth, and measures to strengthen such connections need to be better understood and facilitated (Johns et al., 2018b). Little is known, however, about the perspectives and needs of the parents of SGM youth (Bouris et al., 2010). This may be a fruitful starting point in any research effort to develop and implement interventions. Moreover, research on parent and family-based interventions is limited, as non-randomised trials and sub-group analyses are generally lacking (Newcomb et al., 2019). Innovative methods may need to be pursued, particularly in relation to participant recruitment, given that parents that engage with research studies are generally already supportive (Newcomb et al., 2019).

Serious gaps remain in knowledge regarding mental health for transgender, gender variant and intersex youth. This is of concern given that sexual minority youth in Ireland fare disproportionately worse than their heterosexual peers (Dooley and Fitzgerald, 2012, Dooley et al., 2019), and trans and intersex youth seem to experience even more mental health issues than their LGB counterparts (Higgins et al., 2016).

More research evidence is needed on protective factors across the European context, on all five levels of Bronfenbrenner's ecological model. For instance, evaluating how self-esteem functions similarly or differently across SGM subgroups may facilitate better understanding of how to encourage and foster this protective factor.

Similarly, understanding of the health effects of stigma and the potential efficacy of structural interventions have extensively been investigated in North America (Hatzenbuehler and Pachankis, 2016, Veale et al., 2017). Whether these findings can be replicated in European countries needs further investigation and evaluation. Such research should include the assessment of the extent to which such structural interventions can act as macro-level protective factors against adverse mental health outcomes.

Significant knowledge gaps remain on promoting mental health among SGM youth (Johns et al., 2018b). There is a need to parse out the experiences of distinct cohorts within the group as a whole. For example, strong evidence indicates that bisexual youth have higher rates of compromised mental health, and more research and theory

are needed to understand these patterns (Bouris et al., 2010, Higgins et al., 2016, Russell and Fish, 2016). Similarly, intersectional approaches are needed to better understand the interplay of sexual orientation and gender identity with race and ethnicity, social class, gender, and culture (Russell and Fish, 2016).

It is important to remember that key constructs in LGBTI+ research, such as sexual orientation, gender identity, and family acceptance, cannot be randomised. This makes some models of intervention research (i.e., randomised controlled trials) impossible. Involving underage SGM participants' parents, or bonding SGM youths' participation to parental consent, poses ethical concerns due to home and safety situations that can arise from employing typical study procedures with youth who have a stigmatised identity (Schrager et al., 2019)

4. Discussion

4. Discussion

This report presents the findings of a landscape and knowledge gap analysis we carried out to provide a map of existing evidence and knowledge gaps for the Irish *LGBTI+ National Youth Strategy 2018-2020*. Using a multi-method searching technique and a scoping review approach, 126 pieces of empirical evidence that speak to the 15 objectives of the LGBTI+ National Youth Strategy were identified. This evidence consisted of primary studies and datasets from Ireland and other European countries and synthesised evidence from Europe and North America. Implications for policy, practice and research will be set out in Section 5. In this section we summarise the findings and formulate some conclusions.

4.1. A varied landscape

There is large diversity in research conducted with LGBTI+ health, which is reflected by the outputs, including articles in peer-reviewed journals, reports by specialist LGBTI+ youth work organisations or mainstream services, datasets and pieces from the media such as magazine articles. Our review identified research from many individual European countries, but the number of cross-national comparisons are limited. The outputs also represent research projects with divergent quality. There was also large diversity in the scope, research questions or hypotheses, sample and recruitment, methods, analytic techniques and approaches, and approaches to knowledge translation. Most studies analysed data from sexual minority (lesbian, gay and bisexual) young people, based on their self-identified sexual orientation. There were fewer studies that observed other dimensions of sexuality, including romantic attraction, sexual behaviour, or gender of the romantic/sexual partners. Gender minority young people were also less frequently studied, and most investigations classified them based on their self-identified transgender status. There are countless ways in which a person may identify their sexuality or gender (Lee et al., 2016, Watson et al., 2020b). Therefore, future studies should at least differentiate between lesbian/gay and bisexual (or same-gender versus both-gender attracted) adolescents, and consider dimensions of sexual orientation, such as identity, attraction and behaviour (Geary et al., 2018, Priebe and Svedin, 2012). Good practice also includes measuring participants' sex assigned or observed at birth as well as their gender identity, allowing for options other than the male/female and man (boy)/woman (girl) binaries (Jones, 2019). Such practices would provide a more nuanced approach to sexuality and gender, and would give voice to SGM individuals, beyond those identifying as lesbian, gay, bisexual or transgender, who have been somewhat overlooked in research thus far.

There is increasing emphasis on LGBTI+ youth, therefore the corpus of evidence is rapidly growing. Youth are coming out at earlier ages than they did before (Russell and Fish, 2016). However, our review identified only one output from a study using a longitudinal approach (Jones et al., 2017), and three studies where temporal comparison from cross-sectional rounds of data collection were made (Bradlow et al., 2017, Ellis and High, 2004, Lough Dennell et al., 2018). Further longitudinal and trend analyses in Ireland and other European countries are needed in order to understand whether indicators and determinants of SGM young people's health change over time.

The fifteen objectives of the *LGBTI+ National Youth Strategy 2018-2020* have uneven evidence coverage. As illustrated in **Figure 1**, some objectives have a relatively large evidence base, while others are poorly supported by research outputs. Objective 1 (on supportive and inclusive environments in formal education settings) and Objective 2 (safe environments) were supported by the most evidence: 15% and 14% of the identified outputs spoke to them, respectively. Objective 11 (mental health) had 11% coverage, while 10% of the outputs spoke to Objective 5 (supportive and inclusive environments that encourages LGBTI+ representation and participation) and 9% to Objective 7 (capacity building for service providers).

This, however, does not mean that we have a comprehensive understanding of those areas. Most of the outputs relevant to Objectives 1 and 2 represented research on bullying victimisation and exclusion of LGBTI+ youth, while studies relevant to mental health were largely concerning poor mental health outcomes. The majority of these frequently focused on minority stress and depression. One of the most methodologically rigorous studies we identified was that of Dürrbaum and Sattler (2020). They demonstrated that the aggregated correlation between minority stress and adverse mental health was 0.25, a statistically significant moderate association. Therefore, there is robust empirical evidence to conclude that the minority stress experienced by SGM youth is linked to a burden of poor mental health outcomes, primarily to depressive mood.

Similarly strong, meta-analytic evidence indicates that sexual minority young people experience significantly more bullying and victimisation than their heterosexual peers. These experiences contribute to suicide attempts, mental health problems, hostile school climates, lack of school belonging, absence of support from friends and family,

and externalising and behavioural problems among sexual minority youth (Fedewa and Ahn, 2011). However, the evidence on positive and protective factors, as well on prevention and amelioration of adverse health effects is less well-developed. Intervention research, especially on the potential effects of social support (McDonald, 2018), is sparse and scattered. Poor research coverage was found for Objective 9, on how to address fragmentation in funding and support collaborative work of organisations that help LGBTI+ youth (1%); Objective 14, on the physical and mental health needs of intersex young people (2%); and Objective 4, on equal employment opportunity and inclusive work environment (2%). Evidence on legislation and research (3% for each) were also scarce.

4.2. How specific or generic are the findings?

Various intersections have been observed in the reviewed evidence. In studies that involved gender a general finding was that girls fared worse. Where such a distinction was employed, bisexual youth had poorer outcomes than heterosexual or lesbian/gay participants. It seems that gender minority status is associated with more adversity and worse outcomes than sexual minority status, but their relative burden is hard to disentangle.

Indeed, these factors seem to work in a complex and interconnected network. Inequalities in sexual and gender minorities are interwoven with universal gender inequalities. Gay and bisexual boys seem to face more hostility, but lesbian and bisexual girls are more likely to be seen as sexualised and objectified (Galan et al., 2008).

An additional, gender-specific burden for sexual minority boys might stem from status and competition within the community. A recent extension of the minority stress model – the intra-minority gay community stress theory – posits that gay and bisexual men might face unique, status-based competitive pressures, since their social and sexual relationships often occur with other men, who are known to compete for social and sexual gain (Pachankis et al., 2020). While this model still has to be tested in countries other than the US and with adolescent boys, these stressors may be universal, and affect youth as well as older men.

Age also adds to the interrelated and intersecting effects. Even within adolescence years, relatively small age differences can make a difference, given that both sexual and gender identities are established in adolescence, and usually the time of coming out overlaps with this developmental stage (Russell and Fish, 2016). In studies that investigated age effects, or grouped primary evidence by age groups, younger SGM individuals had more risk and poorer outcomes than their older peers (Cox et al., 2009, Dürrbaum and Sattler, 2020, Fedewa and Ahn, 2011, Higgins et al., 2016, Vanden Berghe et al., 2010). This may be linked to the fact that younger children are more likely to be involved in bullying (both as perpetrators, victims or bully-victims) than older youth (Walsh and Cosma, 2016).

Beside gender and age, the most frequently studied intersecting identities were ethnicity or race, various measures of socio-economic status (e.g. family affluence, family income, social class, parental occupation, homelessness), religion, or disability. Some studies included language, citizenship, school type, care experience, health status, asked students to give any other reason(s) for discrimination, or considered specific subgroups (e.g. black LGB students). In some cases, these variables were integrated into the analysis as classifying or control variables. In other studies, questions were formulated in ways that would identify the reasons additional to SGM status for participants feeling discriminated against or unsafe in school. Many of the reviewed research outputs mentioned one or more such variables, but the data were not analysed or presented using these classifying variables. A significant barrier to carrying out such analyses is that even single minority status participants may represent a low number, and often the number of participants with multiple/ intersecting minority identities is only a small fraction of the sample (e.g., Molcho et al., 2008). Despite these methodological challenges, the results generally demonstrated that young people with multiple marginalised statuses or intersecting minority identities are faring worse. They are more likely to be bullied or excluded, and consequently experience disproportionate health inequalities.

It is important to acknowledge, however, that minority stress may affect other marginalised groups even if they are not sexual or gender minorities, and we do not know the relative psychosocial burden of belonging to one group or the other. Sexual and gender minority individuals are often discriminated against on grounds other than sexual orientation or gender identity (Takács et al., 2008). Therefore, it is important

to better understand to what extent, and on what grounds, young people who are SGM and also belong to another marginalised group, or have intersecting minority/marginalised identities, experience discrimination. While it may sound unfeasible to compare a sexual minority and, for instance, an ethnic minority youth, they might have common and separate causes of stress as well as universal and specific resources of resilience.

Irish datasets, such as those from the Growing up in Ireland study, the My World studies and the Irish HBSC studies contain relevant markers of sexual minority status, and often include measures of other minority statuses. Therefore, there is existing potential to conduct detailed analyses that would help meet some of the research gaps identified. Other targeted research projects (e.g., Pizmony-Levy and BeLonG To, 2019) also have large potential for further, in-depth, intersectional analyses.

4.3. Bullying and exclusion

Our landscape analysis revealed ample evidence that SGM youth are disproportionately affected by bullying-victimisation. At the same time, it is important to acknowledge that the excessive emphasis on a discourse of victimhood does not capture the whole picture of LGBTI+ youths' experiences. Indeed, such an approach may create assumptions of victimisation among both young people and support workers and teachers (Formby, 2015). A similar mechanism works in the discourses of 'at-riskness' of LGBTI+ youth (Bryan, 2017). These discourses render a distorted view of LGBTI+ youth lives and create a sense of inevitability where there may not be one. Bryan and Mayock (2016), for instance, have highlighted that framing LGBTI+ youth as in need of protection and lacking self-agency constructs an identity of passive victimhood. Such an imbalanced portrayal overlooks the positive aspects of LGBTI+ identities and fails to challenge dominant social and cultural structures that reproduce the conditions that led to victimisation and a victimisation narrative. Additionally, this over-emphasis may result in other issues and complex determinants being over-looked. For instance, when we talk about the self-agency of SGM youth, we have to consider that they are more likely to be involved in bullying than their heterosexual peers not only as victims but also as perpetrators (Költő et al., 2019a); there is a considerable evidence gap in this regard to such self-agency.

Nevertheless, it is also clear that bullying and social exclusion continues to affect LGBTI+ youth and most studies that spoke to Objectives 1 and 2 (supportive and inclusive environment in formal education settings, and safe environments for LGBTI+ young people, respectively) of the strategy were concerned with these issues. The evidence leads to the unequivocal conclusion that LGBTI+ students are more vulnerable to bullying victimisation, social exclusion and discrimination and is important in demonstrating the universality of this phenomenon. However, it seems that "often we re-confirm what we know already" (Laaser et al., 2016, p. 4.), instead of moving towards offering effective and sustainable help. Thus, while Objectives 1 and 2 have relatively good coverage, this does not mean that we have substantial evidence on *what* makes educational settings supportive and inclusive, and *what* should be done to make environments safer for LGBTI+ youth.

Bullying is closely linked to social and structural stigma, which is both reproduced by and reflects deeply embedded socio-cultural norms. Such norms are shaped by representation (or lack thereof) and discourse, and the type of language used in such discourses (Vaughan, 2019). Concerted efforts are needed of policymakers, practitioners, researchers, other stakeholders, and young people themselves to challenge the dominant victimising and 'at-riskness' narratives on LGBTI+ youth. In the future, small-sample, descriptive studies on LGBTI+ youths' bullying victimisation will be unlikely to add substantial novel knowledge to the existing research. Capacities should rather be used to better understand what would help young people to respond adaptively and with resilience to bullying, and how teachers, fellow students and other stakeholders can be empowered to actively intervene if they witness bullying.

School-based research with LGBTI+ youth should prioritise intersectionality, supportive adults in schools, and in-school programmes to increase inclusivity and tolerance (Johns et al., 2019). Well-designed intervention and evaluation research is also necessary in order to address the issue of bullying in earnest.

4.4. Health

Minority stress associated with being LGBTI+ has direct and documented effect on SGM individuals' health. While such negative effects can be traced back to negative experiences in adolescence (Cochran and Mays, 2007, Cochran et al., 2003), the causal

mechanisms are not yet entirely understood. However, there is mounting evidence that minority stress in sexual minority individuals is related to poorer biomarkers of health. A systematic review of 26 studies (Flentje et al., 2020) investigated the link between specific aspects of minority stress (prejudice, anticipated prejudice, concealment of sexual orientation, and internalised stigma) and various biological outcomes (such as overall physical health, immune response, and HIV-specific, cardiovascular, metabolic, cancer-related, and hormonal outcomes). The authors found that in 42% of the analyses, a statistically significant relationship was detected, which they deem to be substantial evidence for the health consequences of minority stress. They, however, emphasise the need to identify those measures and outcomes that have the most rigorous and replicable results. This observation from 'hard' data is in line with subjective reports from SGM youth.

Due to minority stress and intra-community stress, many LGBTI+ young people have an elevated psychophysiological strain. Juster et al. (2017) gives a detailed account on how psychosocial stress in LGBTI+ individuals can contribute to 'wear and tear' on the brain and body, including an altered response of the hypothalamic-pituitary-adrenal (HPA) axis and other elements of the stress system. Further studies are needed to better understand how chronic stress experienced by SGM individuals take a toll on their health and how such negative psycho-neuro-immunological mechanisms can be buffered.

There remains a question about how LGBTI+ health disparities are developed throughout the individuals' lives and why adolescence is a critical life stage for SGM individuals. Mustanski and Espelage (2020) suggest that a life-course perspective is useful in understanding these developmental trajectories and improving SGM youths' lives. The life-course approach takes into account that positive and negative effects accumulate throughout different life stages. Thus repeated episodes of bullying have different effects on youth than a single episode. The authors emphasise that such an approach can also help us plan timely interventions, which optimally take place before stress-inducing life events happen. They also highlight the need for a health equity *versus* health disparity perspective thereby recognising that SGM youth may need more support in some areas than their heterosexual/cisgender peers to achieve optimal health.

4.5. Specific needs of trans and intersex youth

While the term 'LGBTI+' implies sexual and gender minorities belong together – and gender and sexual orientation are, as we outlined in Section 4.2, deeply interwoven, determinants of their health and well-being partly overlap but partly diverge. There are even some fault lines within LGBTI+ communities. There is evidence from the US that suggests that transphobia is present among sexual minority individuals (Weiss, 2003), which indirectly implies that young people who identify as lesbian, gay, bisexual or other sexual minority, also need education on gender identity development and gender diversity (Boskey, 2014). Trans, intersex and other gender minority children – either identifying as a girl, or a boy, or prefer using another identity term – may be attracted to members of one or more gender, may refuse to link attraction to gender, or may rather identify themselves in terms of how their romantic feelings and sexual attractions are bound to each other (**demisexual**). It seems, however, that gender minorities have an even larger burden of adversity and subsequent negative health outcomes than their sexual minority cisgender peers, which can partly be attributed to familial and societal reactions to gender non-conformity rather than to the identity itself. However, gender dysphoria and the stress associated with developing and disclosing someone's (trans) gender identity can also add to this burden. It is therefore possible that initiatives which improve understanding of and tolerance towards trans and other gender minorities could have a positive effect on their health and well-being (Boskey, 2014).

In general, research on gender minority adolescents is considerably less developed than that on their sexual minority peers, and there is urgent need for a better understanding of their complex health and social needs (Connolly et al., 2016). Evidence on medical interventions to assist transitioning of trans young people, especially research on pubertal blocking and administration of cross-sex hormones, is scarce, and their long-term impact on cognitive and physical development, fertility or on other outcomes remains understudied (Busa et al., 2018, Chew et al., 2018, De Vries and Cohen-Kettenis, 2009).

Research on young people with an intersex variation is even scarcer. They are barely represented in studies, and much more work is needed to understand their needs (Jones, 2016, 2018). This is signified by the fact that we were unable to identify any international studies on intersex young people that have met the inclusion criteria for the landscape analysis.

4.6. Promoting protective factors and resilience

Despite the overarching victimisation and at-risk narratives (Bryan, 2017, Bryan and Mayock, 2012, Formby, 2015), there are many LGBTI+ young people who live in warm and caring families, have supportive social networks, attend a school where they feel safe, and in general have a happy and fulfilling life (Riggle and Rostosky, 2012, Saewyc, 2011). The existing literature on coming out growth and resilience shows that even SGM individuals who experienced adversities in their childhood and adolescence may even benefit from these in the long term (Vaughan and Waehler, 2010).

While there is ample evidence for bullying victimisation among SGM youth, there is less understanding about how they develop resilience in the face of bullying (Zeeman et al., 2017), and what factors enable them to employ adaptive coping strategies (van Bergen and Spiegel, 2014). As Saewyc (2011) outlines, there are number of protective factors, or positive developmental assets, that have been shown to promote healthy developmental outcomes and reduce risk behaviours among the general population of adolescents. These include supportive and nurturing family relationships, supportive friends, having other caring adults such as teachers and coaches, school connectedness, and religiosity or spirituality.

On the other hand, there are some LGBTI+-specific resources of resilience, for instance involvement in, and volunteering for, the community, in LGBTI+ support groups, or in GSAs at school. The good news is that there is robust and consistent evidence for GSAs reducing bullying, victimisation and associated mental health burden in LGBTI+ youth (Marx and Kettrey, 2016), and heterosexual/cisgender students also appear to benefit from having such initiatives in the schools (Li et al., 2019). A gender-sexuality alliance club, however, is not sufficient on its own, and may not suit all schools (for instance those with a very low number of students). Enabling, health-promoting, inclusive and safe environments for SGM young people can be created by adopting a complex approach that considers different determinants of well-being, characteristics of the given setting, and the pre-existing attitudes and needs of all stakeholders. Such an approach, translated to schools, should also include policies on bullying, harassment and exclusion, LGBTI+ relevant curricula in classrooms, with associated training provided in schools, as well as celebration of LGBTI+ along with other minorities within schools and, where possible specially trained staff who can provide dedicated support for SGM students (Black et al., 2012).

A general problem is that interventions and programmes that can be deemed 'good practice' are extremely rare, and in many cases their efficacy is not documented by high quality evidence. There are five interrelated barriers to such initiatives:

- They can be costly in terms of time, money and workforce
- They need non-judgemental and highly committed staff
- They require complex actions that go beyond only including LGBTI+ material in the curricula or introducing adequate policies
- They need to be flexible and adapted to settings that may have very divergent sociocultural characteristics
- They need to involve children (both LGBTI+ and non-LGBTI+) and other stakeholders, such as parents, siblings, teachers and all other school staff, healthcare, social care providers and youth workers from inception to evaluation. Even in tolerant and acceptant societies, some of these stakeholders may hold prejudices against and be hostile with LGBTI+ individuals, which may be a considerable barrier.

Nevertheless, there are some examples of programmes that have been documented to have positive effect (Black et al., 2012, Johns et al., 2019, Newcomb et al., 2019), and there are some elements of good practices in Ireland which can serve as basis for future initiatives (Mayock et al., 2009, Pizmony-Levy and BeLonG To, 2019).

4.7. Policies

The very fact that no synthesis of European evidence has been conducted so far signifies the lack of political support for systematic LGBTI+ youth research. The *LGBTI+ National Youth Strategy 2018-2020*, in this sense, is a pioneering initiative that could serve as an example to other countries.

It is important to note that even if LGBTI+ inclusive policies are developed and enforced, it does not guarantee that services will automatically become inclusive (Takács, 2006). Studies from Ireland (Pizmony-Levy and BeLonG To, 2019) and other countries (Acciari, 2014, Bachmann and Gooch, 2018) suggest that even if a service has anti-bullying and anti-discrimination policies that explicitly mention sexuality and

gender, there still may be providers who are neglectful, dismissive and not intervene when an LGBTI+ young person is being bullied. Nevertheless the introduction of such policies is associated with LGBTI+ young people feeling better and safer in school (Sandor et al., 2017). Policies should provide general guidelines and also assure that sexuality and gender are explicitly outlined in service-level policies. It is also important that the local communities and stakeholders are invited to participate in setting the rules. This guarantees that the policies are not seen as imposed from higher authorities but the whole community can identify with their core values (Fylling et al., 2020). Such 'bottom-up' processes should be encouraged in addition to developing all elements of the safe school/youth initiatives and settings-based health promotion programmes. Specific policy recommendations will be provided in Chapter 5.

4.8. Knowledge gaps

- The majority of the studies used convenience (e.g. community) sampling, and recruited young people who identify as LGBTI+. This poses an ethical and methodological problem, since research with underage participants in many countries requires parental consent (Schrager et al., 2019). As a consequence of this restriction, only young people who are out to their parents will be represented in such community samples (Jones, 2019). There is no straightforward solution, but anonymous population health surveys that contain items on sex assigned at birth, gender identity and different dimensions of sexual orientation may, to some extent, help address this issue. The Growing Up in Ireland longitudinal study (ESRI, 2014) has relevant information which could be subjected to secondary data analysis.
- Comparisons between sexual minority and heterosexual youths were very rare (e.g., Irish et al., 2019, Jones et al., 2017, Priebe and Svedin, 2012), even rarer are pieces where gender minority youths are compared to their cisgender peers (Aparicio-Garcia et al., 2018, Röder et al., 2018, Smithies and Byrom, 2018). Infrastructural and financial barriers and methodological difficulties can help explain this. However, having LGBTI+ samples without comparing their data to their non-SGM counterparts does not provide sufficient information on their relative risk of adverse life events or health and well-being outcomes.

- In some areas the existing body of research is large and contains high quality outputs (e.g. bullying victimisation, suicidality, mental health outcomes). On the other hand, there were many objectives of the *LGBTI+ National Youth Strategy 2018-2020* that are poorly covered by empirical evidence. This is not surprising in respect of certain objectives. Nevertheless, evidence is required and objectives with poor evidence coverage should be prioritised
- Irish and European research should be prioritised on a range of issues. For instance, studies are needed to map the experiences and needs of parents and other family members (e.g. grandparents and siblings) of LGBTI+ youth. Given that family members often experience stress when a young person comes out (especially if there had been no other known LGBTI+ person in the family) they may need specific and targeted support. Their needs should be mapped using qualitative approaches (e.g. interviews, focus groups, creative approaches). Intervention studies may utilise self-help literature and services which aim to help families of LGBTI+ youth to test efficacy of interventions.
- A significant knowledge gap in Irish and other European countries concerns the health and well-being of trans youth and their needs. A first step to address this gap is to ensure that population health studies contain age-appropriate items to classify trans young people and compare their health indicators with their cisgender peers. Further, qualitative studies are needed to map their specific needs, for instance around inclusivity in schools and other settings (including the availability of gender-neutral facilities). Experiences around medical and pharmacological interventions assisting young people in their gender transitioning after puberty also remain to be fully documented, interpreted and understood.
- Resilience, protective factors and empowerment among LGBTI+ youth are also areas that require better understanding. This is a key step in challenging the prevailing at-riskness, vulnerability and victimising narratives on SGM young people, which provides a simplified and distorted picture of their identities, life experiences and perspectives. To the same end, researchers should strive to engage youth and other stakeholders in all stages of research studies, most especially in their conceptualisation and planning.

- While our landscape analysis identified some studies in which trans youth participated, other gender minority youth (e.g. those who identify as genderqueer or non-binary) are almost entirely neglected. It must be ensured that youth population surveys are equipped with items that enable categorisation of these young people (e.g. by adding an open-ended question on gender identity).
- Given the low prevalence of SGM youth (and the fluidity in LGBTI+ identity formation over adolescence), traditional sampling methods for population studies may not be sufficient in capturing an adequate subsample size. This may potentially be addressed by oversampling or conducting the survey with auxiliary community samples. Consideration of commissioning booster-samples should be seriously considered.
- An alternative solution to overcome the sample imbalance between sexual minority/heterosexual and gender minority/cisgender youth is the use of case-control matching (Molcho et al., 2008). However, this technique can also have methodological challenges, for instance the low sample size may be associated with low statistical power.
- Research on intersex youth is practically non-existent. Given the very low prevalence of intersex variations and the finding that some people use the term to define themselves even if they would not have been medically diagnosed as having an intersex variation, it does not seem feasible to include intersex in population health studies. Their lived experiences and specific needs should rather be mapped in qualitative studies; with samples drawn from clinical settings or specialised community organisations.
- An important knowledge gap in Irish and other European countries is the sexual health of LGBTI+ youth. North American studies suggest that use of protection methods (e.g. condom and contraceptive pill) is lower in SGM youth than their heterosexual/cisgender peers, and pregnancy rates in some SGM groups are also higher than among their non-minority counterparts. These studies need to be replicated, with cross-cultural and longitudinal comparisons, using uniform indicators. These could build on existing methodological developments

- The landscape analysis identified many studies that applied descriptive methods. Further studies would benefit from more rigorous and complex methodology, with more ambitious objectives (e.g. analysing the causal mechanisms between discrimination, minority stress and negative health, or monitoring the efficacy of interventions). The European research landscape also largely lacks trend and longitudinal analyses that would help understand time and cohort effects in LGBTI+ young people's experiences and outcomes.
- Methodological issues which need special attention include parental consent. Research with young people under legal age usually requires parental consent. However, considering that many young people are still exploring their sexual or gender identity and are not ready to disclose it to their parents, requesting parental consent will inevitably exclude those youth who have not yet came out to their parents, or it may put them in a potentially dangerous situation. This could introduce severe biases to the results and raise the question whether it is in line with ethical principles to exclude young who are not out to their parents (Mustanski, 2011). A potential solution for this issue is waiving parental consent (Smith and Schwartz, 2019), or being less specific in the consent information provided to parents, either of these would require careful ethical analyses and negotiation with institutional ethical review boards.
- Intersectionality and multiple marginalisation in SGM youth, as well as specificity and additionality, remain areas where further research projects are needed. Studies are largely missing on seldom heard youth groups (e.g. intersex, non-binary or asexual/aromantic), and the majority of the existing studies – even if they contain ample information on potentially intersecting identities – failed to consider how being SGM and simultaneously belonging to other minority groups impact the outcomes. Existing data should be better utilised to address these gaps, and further studies are needed to better understand seldom heard SGM groups and intersecting/additional minority statuses. The relative risk of SGM young people compared to other marginalised groups, such as those living with disabilities or chronic illness, young carers and those from ethnic or racial minorities, in respect of poor health outcomes also deserves further exploration; it is important to have a better understanding of both the unique issues for SGM young people and the issues that are shared with other sub-populations of young people.

4.9. Strengths and limitations

To our knowledge, this is the first study that attempted to draw a landscape and uncover gaps in research on LGBTI+ young people in Ireland and other European countries, and also integrate evidence syntheses from North America. The present report is based on a scoping review of 126 research outputs produced over a 19-year period and therefore it provides a reasonably comprehensive picture of research SGM youth.

There are, however, some limitations. Due to language barriers, our study has not explored published studies and grey literature in languages other than English. There is likely to be valuable evidence available that has not been published in peer-reviewed scientific publications in English but were either published as pieces of grey literature in local language(s) or have not been published at all. A series of rapid reviews on LGBTI+ healthcare inequalities pointed out that there are many pieces of evidence in languages other than English (Sherriff et al., 2019). Being LGBTI+ can have largely different meanings in other continents, and a mapping exercise that would cover the more geographic regions was beyond our scope. It would be important that Asian, Australian and South American studies are also synthesised. Given the dramatic change in the acceptance of LGBTI+ issues and the rapid growth in relevant research since the 1990s, the time range of the search could have been wider or narrower, either of which would have impacted on our findings. In evidence synthesis, breadth and depth need to be balanced against each other. The breadth of the present work was determined by the five outcomes of the BOBF framework and the fifteen objectives of the National LGBTI+ Youth Strategy 2018-2020, which inevitably limited the depth of assessment, and excluded many important pieces of evidence on SGM youth. There is also a chance that despite our best efforts, some outputs that would have been relevant to the landscape and knowledge gap analysis have not been identified in the searching process.

5. Implications for Research

5. Implications for Research

Table 5 presents a summary of the knowledge gaps identified in the analysis and recommendations for researchers on how to address these gaps.

Table 5. Summary of research gaps and recommendations for the fifteen objectives of the *LGBTI+ National Youth Strategy 2018-2020*

Objective	Knowledge gaps	Recommendations
Objective 1: Supportive and inclusive environments in formal education	• What makes schools more inclusive? • Documenting school-based interventions and monitoring their efficacy • Trend analyses and longitudinal studies assessing the impact of inclusive policies	• Better utilisation (secondary analysis) of existing data • Equipping national and international surveys with inclusive items assessing sexual orientation and gender identity
Objective 2: Safe environments	• Experiences of violence and perceived safety outside school settings • Interventions to improve the safety of SGM youth • Comparison of SGM youth and their non-minority peers • Studies using longitudinal or repeated cross-sectional design • Intersectionality is rarely explored	• Beside focused studies with SGM youth, nationally representative studies are needed which have the capacity to compare minority and non-minority youth • Multidimensional assessment of SGM status: birth-registered sex and gender identity as well as romantic attraction, sexual orientation and sexual behaviour • Consideration of methodological requirements (e.g. sample size and items) for mapping intersectionality
Objective 3: Inclusive youth services	• SGM youth's experiences with services	• Local needs analysis of SGM youth and their families
Objective 4: Equal employment and inclusive work environment	• Barriers experienced by SGM young people in finding employment • Work experiences of SGM youth	• Qualitative studies that map SGM youth's perspectives on and experiences in employment
Objective 5: Representation and participation	• Associations between LGBTI+ representation and well-being • Participation in sports and other settings outside schools	• Addressing the methodological challenges of measuring participation – especially the potential of qualitative approaches
Objective 6: Supports to parents and families	• Experiences of family members with 'coming out' • Needs of families (parents, grandparents, siblings) around supporting their SGM children • Documenting interventions to help families and assessing their efficacy	• Involvement of families in the research process • Recruiting minority families • Innovative method (e.g. dyadic techniques) • Extending studies to the wider family

Objective	Knowledge gaps	Recommendations
Objective 7: Capacity building for service providers	• Knowledge gaps and training needs of service providers who potentially cater for SGM young people	• Mapping and matching the attitudes and needs of service providers and users
Objective 8: Gaps in legislation and policy	• Country-level and international analysis of laws and policies related to LGBTI+ young people • Discriminatory experiences of SGM young people • SGM young people's knowledge of their rights • Studies on the prevalence of conversion therapies	• National and international studies on existing policies and their coherence with strategies and actions
Objective 9: Fragmentation in funding and networking for collaborative work	• Documentation of existing (or lacking) collaboration and co-ordination across services	• Attitudes and needs related to inter-agency collaboration, and required infrastructure to co-ordinate collaboration
Objective 10: Inclusive environment for transgender and intersex youth	• Gender minority youth are less visible than sexual minority youth • Experiences and needs of intersex youth • Resilience-promoting factors in gender minority youth • Inclusivity and rights of trans and non-binary people	• Apply standardised items in surveys to assess birth-registered sex, gender identity and their alignment • Consider oversampling to account for gender minority youth • Local, qualitative studies with intersex youth
Objective 11: Mental health	• Substance use in gender minority youth • Self-rated health and psychosomatic symptoms in SGM youth • Self-esteem, life satisfaction, well-being and resilience among SGM youth	• Challenge 'at-riskness' and victimising narratives on SGM youth • Orient research topics towards resilience and developmental assets • Instead of focused studies with SGM youth, compare mental health indicators in minority young people with that of their non-minority peers

Objective	Knowledge gaps	Recommendations
Objective 12: Sexual health	• Factors that protect and improve sexual health in SGM youth • Pregnancy involvement of SGM youth • Development, monitoring and evaluation of sexual health promotion interventions	• Map the structural and psycho-social determinants of good and poor sexual health in SGM youth • Efficacy studies with pre-, post- and long-term measurement points • Prevalence of sexually transmitted infections, unplanned pregnancy, sexual relationships etc. • Consider using online and mobile data collection platforms • Develop translational research
Objective 13: Health of transgender youth	• Aetiology and developmental pathways of gender dysphoria • Appropriate measures of gender non-conformity and transgender status • Intervention studies, with particular emphasis on facilitating parental support • Potential links between gender dysphoria and autism spectrum disorders • Short- and long-term effects of puberty blockers and cross-hormone treatments	• An interdisciplinary approach and a large suite of different methods are required
Objective 14: Intersex youth	• Research on intersex young people is in general overlooked	• Address the methodological challenges (e.g. conflation of intersex conditions and political identities) • Direct and active strategies should be used for recruitment, such as liaising with intersex groups and organisations
Objective 15: Research	• Needs and perspectives of parents and other family members • Mental health of gender minority youth • Protective factors and resilience • Complex models of stigma, minority stress and health inequalities • Intersectionality	• Consider how waiving parental consent in LGBTI+ youth research can be navigated and negotiated with institutional research ethics committees

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Appendices

Appendix A. Glossary[5]

Note. Terms marked with an asterisk are adapted from Ellis et al. (2020).

Additionality The excess burden of sexual or gender minority status on the top of the normative burden and problems of child and adolescent development.

Adultism Prejudice and discrimination against young people, and biases favouring adults at the expense of youth.

Biphobia Negative attitudes to and discrimination against homosexuality.

Bisexual Sexual and/or romantic attraction to both female and male partners.

***Cisgender** Having a gender that normatively relates to assigned sex, in a social context where the normative assumption is that penis = male =boy/man, and vagina = female = girl/woman.

***Cisgenderism** The ideology that delegitimises people's own understandings of their own gender and body. The assumption that assigned sex determines gender. The assumption that there are only two genders.

***Coming out** This means both coming to recognise ones gender or sexuality and disclosing that information with others (often referred to as 'coming out of the closet').

Coming out growth The process of personal growth achieved through disclosure of being LGBTI+. This concept is analogous with posttraumatic growth.

Conversion therapy (or **Reparative therapy**) A psychotherapeutic intervention that attempts reverting someone's lesbian, gay or bisexual orientation to heterosexual. Conversion therapy has no supporting scientific evidence, but as the result of such interventions many clients develop stress, anxiety and other mental health problems.

5 The authors are aware of that terminology in this area is evolving quickly and varies by jurisdictions and sometimes population subgroups. This Glossary is therefore situated in time and place.

Demisexual A sexual orientation defined by only being sexually attracted to those persons with whom an emotional bonding already exists.

***Disorders of Sexual Development (DSD)**: A medical and psychological term used to refer to intersex variations. Often seen as a pathologising term. Sometimes differences of sex development is used as a less pathologising alternative.

Erasure Neglecting or denying that someone belongs to a minority group, misidentifying the person as non-minority, excluding minority individuals or groups from historical records, or replacing the minority individual(s) with non-minorities.

Gay A label often used (by others and by themselves) to identify homosexual men.

Gender expression How someone presents their gender externally, for example through clothes, appearance and behaviour.

Gender identity Someone's internal perception of their gender – how they feel inside about their gender.

Gender minority An umbrella term for those individuals who are not cisgender.

***Heterosexism** Systematic bias in societal customs and institutions (e.g. religion, education, and the legal system) that results in the erasure and denial of sexual diversity, customs, and history. It includes privileging heterosexual experiences, customs and history.

Heterosexual A person who is exclusively attracted (romantically and/or sexually) to members of the opposite sex.

Homophobia Negative attitudes to and discrimination against homosexuality.

Homosexual A person who is exclusively attracted (romantically and/or sexually) to members of the same sex.

Intersectionality Belonging to multiple minority groups; the overlap between race, class, gender, colour, ethnicity, religion, sexual orientation, gender identity or other social categories which renders the person subject to multiple marginalisation within their community.

Intersex A term used to describe people born with physical or biological sex characteristics that do not fit the typical definitions for male or female bodies.

***Intersex variations** Where a person's genitalia and/or a chromosomal pattern do not conform to standard definitions of 'male' or 'female'. For example, the presence of testes in the abdomen along with a vulva and vagina and a standard XY (i.e., male) chromosomal pattern; or a small penis and testes, the growth of breasts in puberty, and a non-standard XXY chromosomal pattern occurring together.

Lesbian A label often used (by others and by themselves) to identify homosexual women.

Minority stress The psychophysiological pattern related to negative experiences due to belonging to one or more marginalised groups.

Monosexism The belief that exclusive heterosexuality or homosexuality is superior to bisexuality. It often includes prejudices towards and discrimination against bisexual individuals.

Non-binary (or **Gender non-conforming**) Gender identities that are not exclusively masculine or feminine.

Objectification Seeing and treating a living entity as an object.

Outing Disclosing another person's sexual orientation or gender to others without the person's consent.

Queer An umbrella term for gender and sexual minorities who do not identify as cisgender and/or heterosexual.

PEP Post-exposure prophylaxis, a medical treatment following after being exposed to HIV virus in order to prevent the person from contracting HIV infection.

PrEP Pre-exposure prophylaxis, a medical treatment to prevent persons who are exposed to HIV virus from being infected.

Sexual minority An umbrella term for those individuals whose sexual orientation is not heterosexual.

Sexual orientation Refers to the attraction people feel towards others based on their gender.

Stigma A characteristic which serves as a reason for an individual or group to being prejudiced, discriminated and marginalised.

Trans A commonly used shorthand version of transgender.

Transgender An umbrella term for anyone whose gender identity or gender expression is different from the biological sex they were assigned at birth.

Transitioning The process of transitioning from one sex or gender to another. It can include dressing in different clothes, changing the way you talk, using make up, changing your hair, changing your name, taking hormones, or surgery. Transitioning does not always involve all of these steps and is ultimately up to how an individual feel about themselves.

***Transphobia** Prejudice against transgender and gender diverse people. It may comprise a perception that being transgender or gender diverse is not normal/ natural, negative stereotyping of transgender and gender diverse people, or actions to undermine or deny a person's gender.

Appendix B. Search terms

The search terms cover 1) Sexual and Gender Minority, 2) Children and adolescents, 3) The five outcomes of the Better Outcomes Brighter Futures – The national policy framework for children and young people.

An additional search was conducted in Google for pieces of grey literature.

Search terms: BOBF Outcome 1 (Active and healthy, physical and mental wellbeing)

((TI lgbt) OR (TI lgbt or lgbtq or lgbtqi or lgbtqia) OR (TI gay) OR (TI lesbian) OR (TI transgender) OR (TI bisexual*) OR (TI "sexual minorit*" or "gender minorit*") OR (TI queer) OR (TI intersex)) AND ((TI child*) OR (TI adolescen*) OR (TI teen*) OR (TI "young people") OR (TI youth) OR (TI minors)) AND ((TI health) OR (TI "physical health") OR (TI "mental health") OR (TI "health behavio*") OR (TI "health outcomes") OR (TI "psychosocial health") OR (TI wellbeing OR well-being OR well being)) AND YR 2001-2019

Search terms: BOBF Outcome 2 (Achieving full potential in all areas of learning and development)

((TI lgbt) OR (TI lgbt or lgbtq or lgbtqi or lgbtqia) OR (TI gay) OR (TI lesbian) OR (TI transgender) OR (TI bisexual*) OR (TI "sexual minorit*" or "gender minorit*") OR (TI queer) OR (TI intersex)) AND ((TI child*) OR (TI adolescen*) OR (TI teen*) OR (TI "young people") OR (TI youth) OR (TI minors)) AND ((TI educat* OR *school* OR teach*) OR (TI training) OR (TI developmen*) OR (TI learning) OR (TI academic achievement or academic performance or academic success)) AND YR 2001-2019

Search terms: BOBF Outcome 3 (Safe and protected from harm)

((TI lgbt) OR (TI lgbt or lgbtq or lgbtqi or lgbtqia) OR (TI gay) OR (TI lesbian) OR (TI transgender) OR (TI bisexual*) OR (TI "sexual minorit*" or "gender minorit*") OR (TI queer) OR (TI intersex)) AND ((TI child*) OR (TI adolescen*) OR (TI teen*) OR (TI "young people") OR (TI youth) OR (TI minors)) AND ((TI abuse) OR (TI neglect*) OR (TI violence) OR (TI exploit*) OR (TI bullying) OR (TI isolat*) OR (TI harm*) OR (TI discriminat*) OR (TI stigma*) OR (TI social problems) OR (TI domestic violence) OR (TI child abuse) OR (TI antisocial behav*) OR (TI delinquen*)) AND YR 2001-2019

Search terms: BOBF Outcome 4 (Economic security and opportunity)

((TI lgbt) OR (TI lgbt or lgbtq or lgbtqi or lgbtqia) OR (TI gay) OR (TI lesbian) OR (TI transgender) OR (TI bisexual*) OR (TI "sexual minorit*" or "gender minorit*") OR (TI queer) OR (TI intersex)) AND ((TI child*) OR (TI adolescen*) OR (TI teen*) OR (TI "young people") OR (TI youth) OR (TI minors)) AND ((TI poverty) OR (TI social exclusion) (TI low-income or poverty or low socioeconomic status) OR (TI poverty areas) OR (TI deprivation) OR (TI poverty threshold or poverty line) (TI marginali*) OR (TI social deprivation) OR (TI housing) OR (TI economic insecurity) OR (TI economic security)) AND YR 2001-2019

Search terms: BOBF Outcome 5 (Connected, respected and contributing to their world)

((TI lgbt) OR (TI lgbt or lgbtq or lgbtqi or lgbtqia) OR (TI gay) OR (TI lesbian) OR (TI transgender) OR (TI bisexual*) OR (TI "sexual minorit*" or "gender minorit*") OR (TI queer) OR (TI intersex)) AND ((TI child*) OR (TI adolescen*) OR (TI teen*) OR (TI "young people") OR (TI youth) OR (TI minors)) AND ((TI community) OR (TI civic engagement or community engagement or civically engaged or community involvement or community participation or civic participation) OR (TI social capital) OR (TI social inclusion or social participation or social inclusive) OR (TI connectedness or connection or belonging) OR (TI social support or social networks or social relationships or social inclusion or social exclusion or social isolation) OR (TI environmenta*) OR (TI awareness of rights) OR (TI social responsibility)) AND YR 2001-2019

Search terms: Grey literature and datasets

((data OR dataset OR survey OR database) OR report) AND (LGBT OR LGBTIQ OR LGBTQIA OR GLBT OR lesbian OR gay OR trans OR transgender OR intersex OR gender and sexual minority OR sexual and gender minority) AND (youth OR young people OR adolescents) AND (health OR well-being OR learning OR education OR safety OR security OR development)

Appendix C. List of the studies identified in the landscape analysis

The table contains the identification number and full reference to each publication featured in the LGBTI+ Landscape and Knowledge Gap Analysis. Pink cells in the columns 'NYS-1' to 'NYS-15' indicate that the given publication is relevant to the given objective of the *LGBTI+ National Youth Strategy 2018-2020*.

ID	Full Reference	NYS-1	NYS-2	NYS-3	NYS-4	NYS-5	NYS-6	NYS-7	NYS-8	NYS-9	NYS-10	NYS-11	NYS-12	NYS-13	NYS-14	NYS-15
513	Abramovich, I. A. (2012) 'No safe place to go – LGBTQ youth homelessness in Canada: Reviewing the literature', *Canadian Journal of Family and Youth/ Le Journal Canadien de Famille et de la Jeunesse*, 4 (1), pp. 29–51. https://doi.org/10.29173/cjfy16579		■	■				■								
209	Abreu, R. L., Black, W. W., Mosley, D. V. and Fedewa, A. L. (2016) 'LGBTQ youth bullying experiences in schools: The role of school counselors within a system of oppression', *Journal of Creativity in Mental Health*, 11 (3), pp. 325–342. https://doi.org/10.1080/15401383.2016.1214092	■	■					■								
320	Acciari, L. (2014) *Education beyond the straight and narrow: LGBT students' experience in higher education*. London, United Kingdom: National Union of Students. Available at: https://www.nus.org.uk/Global/LGBT%20research%20report_web.pdf (Accessed: 4 March 2020).	■	■													
133	Alberse, A.-M. E., de Vries, A. L. C., Elzinga, W. S. and Steensma, T. D. (2019) 'Self-perception of transgender clinic referred gender diverse children and adolescents', *Clinical Child Psychology and Psychiatry*, 24 (2), pp. 388–401. https://doi.org/10.1177/1359104518825279											■		■		

ID	Full Reference	NYS-1	NYS-2	NYS-3	NYS-4	NYS-5	NYS-6	NYS-7	NYS-8	NYS-9	NYS-10	NYS-11	NYS-12	NYS-13	NYS-14	NYS-15
204	Amodeo, A. L., Picariello, S., Valerio, P. and Scandurra, C. (2018) 'Empowering transgender youths: Promoting resilience through a group training program', *Journal of Gay and Lesbian Mental Health*, 22 (1), pp. 3–19. https://doi.org/10.1080/19359705.2017.1361880		■			■		■						■		
108	Aparicio-Garcia, M. E., Diaz-Ramiro, E. M., Rubio-Valdehita, S., Lopez-Nunez, M. I. and Garcia-Nieto, I. (2018) 'Health and well-being of cisgender, transgender and non-binary young people', *International Journal of Environmental Research and Public Health*, 15 (10), p. 2133. https://doi.org/10.3390/ijerph15102133	■	■		■	■	■				■			■		
114	Armstrong, H. L., Steiner, R. J., Jayne, P. E. and Beltran, O. (2016) 'Individual-level protective factors for sexual health outcomes among sexual minority youth: A systematic review of the literature', *Sexual Health, 13* (4), pp. 311–327. https://doi.org/10.1071/SH15200												■			
232	Ávila, R. (2018) *LGBTQI Inclusive Education Report*. Brussels, Belgium: The International Lesbian, Gay, Bisexual, Transgender, Queer & Intersex (LGBTQI) Youth and Student Organisation (IGLYO). Available at: https://www.iglyo.com/wp-content/uploads/2018/05/Education_Report_April_2018-4.pdf (Accessed: 4 March 2020).	■	■	■		■										
107	Baams, L., Beek, T., Hille, H., Zevenbergen, F. C. and Bos, H. M. W. (2013) 'Gender nonconformity, perceived stigmatization, and psychological well-being in Dutch sexual minority youth and young adults: A mediation analysis', *Archives of Sexual Behavior*, 42 (5), pp. 765–773. https://doi.org/10.1007/s10508-012-0055-z					■						■				

ID	Full Reference	NYS-1	NYS-2	NYS-3	NYS-4	NYS-5	NYS-6	NYS-7	NYS-8	NYS-9	NYS-10	NYS-11	NYS-12	NYS-13	NYS-14	NYS-15
229	Bachmann, C. and Gooch, B. (2018) *LGBT in Britain: University Report*. London, United Kingdom: YouGov and Stonewall. Available at: https://www.stonewall.org.uk/lgbt-britain-university-report (Accessed: 4 March 2020).	■	■			■					■					
304	Baiocco, R., D'Alessio, M. and Laghi, F. (2010) 'Binge drinking among gay, and lesbian youths: The role of internalized sexual stigma, self-disclosure, and individuals' sense of connectedness to the gay community', *Addictive Behaviors*, *35* (10), pp. 896–899. https://doi.org/10.1016/j.addbeh.2010.06.004		■													
309	Baiocco, R., Laghi, F., Di Pomponio, I. and Nigito, C. S. (2012) 'Self-disclosure to the best friend: Friendship quality and internalized sexual stigma in Italian lesbian and gay adolescents', *Journal of Adolescence*, 35 (2), pp. 381–387. https://doi.org/10.1016/j.adolescence.2011.08.002	■	■			■										
514	Beattie, K. (2008) *PRIDE (Promoting Respect, Inclusion and Diversity in Education) Evaluation Report*. Belfast, Northern Ireland: Save the Children, Shout and The Rainbow Project. Available at: https://www.dropbox.com/sh/9byh9z6zwwerqg2/AACf7e6PltIRsFDiT4cHnEzMa?dl=0&preview=Final+PRIDE+Evaluation+May+2008.pdf (Accessed: 4 March 2020).	■	■					■								
203	Black, W. W., Fedewa, A. L. and Gonzalez, K. A. (2012) 'Effects of "safe school" programs and policies on the social climate for sexual-minority youth: A review of the literature', *Journal of LGBT Youth*, *9* (4), pp. 321–339. https://doi.org/10.1080/19361653.2012.714343	■				■		■			■					

ID	Full Reference	NYS-1	NYS-2	NYS-3	NYS-4	NYS-5	NYS-6	NYS-7	NYS-8	NYS-9	NYS-10	NYS-11	NYS-12	NYS-13	NYS-14	NYS-15
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