

Understanding lesbian, gay,
bisexual and trans (LGBT)
adolescents' suicide, self-harm and
help-seeking behaviour

Final Report



Queer Futures

Understanding lesbian, gay, bisexual and trans (LGBT)
adolescents' suicide, self-harm and help-seeking
behaviour

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Executive summary

Background

International research demonstrates that LGBT¹ youth are at much higher risk of suicide and self-harm compared to their heterosexual or cisgender² counterparts. Evidence in the UK is sparse and only beginning to establish sexual and gender identity as a risk factor for adolescent suicide and self-harm, and as a result of this research scarcity we also know very little about help seeking behavior. The Suicide Prevention Strategy (2012) has identified LGBT youth as a high risk group but currently there is limited evidence to develop effective suicide prevention policy and practice.

Aim

This study aimed to provide national evidence on LGBT youth suicide, self-harm and help-seeking behaviours in order to support the implementation of the Suicide Prevention Strategy (2012) and reduce the risk of suicide in LGBT young people.

About the study

The study was a two staged, sequential mixed methods design that used online and face-to-face methods. The first stage consisted of 15 online and 14 face-to-face qualitative interviews with LGBT young people (aged 15-25 years old). The second stage of the research consisted of an online LGBT youth questionnaire completed by 789 participants with experience of self-harm or suicidal feelings, and an online questionnaire completed by 113 mental health service staff.

Key findings

Understanding LGBT youth self-harm and suicide

Similar to findings from other studies on youth suicide, those who had self-harmed and/or had a disability had an increased likelihood of planned or attempted suicide. Gender identity was also a risk factor for self-harm and suicide. Those who were gender diverse (Trans/unsure) were nearly twice as likely to have self-harmed and one and a half times more likely to have planned or attempted suicide than cisgender participants. Cisgender males were the least likely to plan or attempt suicide, or self-harm compared to other gender identities.

There were five interconnecting areas which explained the elevated risk of suicide and self-harm in LGBT youth: 1) homophobia, biphobia or transphobia; 2) sexual and gender norms; 3) managing sexual orientation and gender identity across multiple areas of life; 4) being unable to talk and; 5) other life crises.

¹ The authors of this report acknowledge that the term ‘LGBT’ does not represent all young people in, or targeted by this study. The term ‘LGBT’ is used throughout the report as short-hand for the wide variety of terms and identities for gender and sexuality.

² We have utilised the term ‘cisgender’ throughout the report to refer to those people who identify with the gender identity that they were assigned at birth.

1. Homophobia, biphobia and transphobia

The majority (70.8%, n=527) of the sample had experienced direct abuse or negative interactions about their sexual or gender identity when they were self-harming or feeling suicidal. A great number of these incidents had occurred in schools but the participants experienced this hostility across all areas of life e.g. in public, leisure spaces, work, religious places and on the internet. Those who experienced abuse were one and a half times more likely to plan or attempt suicide.

Bisexual participants were least likely to experience abuse compared to other sexual orientation groupings. Trans and disabled participants were twice as likely to experience abuse related to their sexual orientation/ gender identity than those who were not. They were also more likely to indicate that the abuse influenced their self-harm and suicidal feelings. Those who reported they were affected by homophobic abuse had double the odds of planning or attempting suicide.

2. Sexual and gender norms

Sexual and gender norms that made many participants feel that something was wrong with them (because they were not heterosexual or cisgender), without being told or abused directly, also caused distress. Almost half the questionnaire participants felt negative about their sexual or gender identity during the time they were self-harming or felt suicidal; a far lower proportion felt positive about their sexual orientation or gender identity. Gender diverse participants were most likely to feel negative, and bisexual young people least likely to feel negative, about their sexual orientation and gender identity. Those who felt negative about their sexual and/or gender identity were more likely to have planned or attempted suicide.

3. Managing sexual orientation and gender identity across multiple areas of life

Making decisions about whether to disguise or hide their sexual orientation or gender identity in different contexts (e.g. school, home, public, internet, leisure places) and to a variety of people, impacted negatively on the participants' mental health. The majority of young people found hiding their sexuality and gender identity distressing.

Gender diverse participants were over three and a half times more likely to feel distressed about hiding their sexual orientation/gender identity compared to cisgender young people. Bisexual participants were significantly less distressed than other sexual identity groupings. Those who found hiding their sexual orientation and gender identity distressing were nearly two times more likely to self-harm. Young people who reported that keeping their sexual orientation/ gender identity a secret strongly affected their self-harm and suicidal feelings were significantly more likely to attempt or plan suicide.

4. Being unable to talk

Almost three quarters of participants (74.1%, n=533) indicated that not being able to talk about their feelings and emotions (in relation to their mental health, sexuality and gender identity) strongly influenced their self-harm and suicidal feelings. Those young people who felt more affected by not being able to talk about their emotions had significantly higher rates of self-harm and were nearly two and a half times more likely to report they had attempted or planned suicide.

5. Other life crises

Participants experienced a range of additional reasons for distress that were unrelated to sexual orientation/ gender identity. The most common were academic pressure, problems with friends,

bullying, family breakdown, participant illness, financial problems, romantic relationships ending, and previous experiences of abuse.

LGBT youth and help-seeking

Asking for help

Over three quarters of participants had asked for help for their self-harm and suicidal feelings but nearly a quarter had not asked for help. LGBT young people most commonly looked for support when they were at crisis point. When asked why they asked for help, over half of the questionnaire participants selected 'I was no longer coping'. When asked why they did not ask for help the response chosen by almost half of respondents was 'I didn't want to be seen as attention seeking'. Just less than one quarter of participants selected 'I did not want anyone to know about my sexual orientation/ gender identity'.

Participants who had planned or attempted suicide, had self-harmed or had experience of abuse related to sexual orientation/ gender identity were significantly more likely to seek help.

From who and where do LGBT youth seek help?

Help was sought most frequently from friends and on the internet. Just less than one third of participants had accessed their GP, and a fifth had sought help from NHS mental health services. NHS services had higher rates of access than other 'informal' sources like parents or boyfriend/girlfriend.

Experiences of support and help

Participants had the most positive experiences when asking for help online, from friends or from LGBT youth groups. Parents were seen as helpful approximately half the time, as were school counsellors. Teachers and youth workers had slightly higher ratings of helpfulness than parents and school counsellors.

99.5% of questionnaire participants indicated that they used the internet when they were self-harming or experiencing suicidal feelings for a range of reasons including distraction, information, connecting with friends and community, to find out about their feelings and to get support. Only 6.5% of participants responded that the internet was unhelpful when they had suicidal feelings or wanted to self-harm.

GPs and NHS mental health services had low ratings of helpfulness. Only half of those who accessed a GP indicated that they had found the experience helpful, while 35% indicated that it had been unhelpful. This compares similarly with NHS mental health services, which 47.2% of participants found helpful, while 36% found unhelpful. Cisgender participants were more likely to indicate that NHS Mental health services were 'helpful' compared to those that were gender diverse. In the interviews, young people recounted poor experiences with CAMHS and difficulties with accessing gender identity clinics or specialist trans consultants.

Preferred sources and modes of help

Participants indicated they would be most likely to ask for help from LGBT individuals or youth groups (53.3%), followed by mental health professionals (47.2%) and peers (46.2%). Participants were least likely to ask for help from school/ teachers (71%) and family (63.8%) and youth groups (57%).

Most participants would prefer to access help through the internet, followed by face-to-face and mobile (SMS/texting) forms of support. Talking on the phone was the least preferred option of the sample. Gender diverse participants were more likely to indicate that they would use the internet than cisgender participants. Older participants were less likely to want to use mobile or texting and more likely to prefer face-to-face methods, while younger participants were more likely to prefer mobile as a mode of help.

Mental health staff knowledge, attitudes and practice

Knowledge and attitudes

Participating mental health service staff had a good level of knowledge about LGBT youth and self-harm and suicide. For example, the majority believed that LGBT youth experienced more emotional distress because they felt isolated by their sexual orientation/ gender identity.

Mental health service staff indicated that there were barriers to LGBT youth accessing their services such as ‘lack of information about mental health services’, ‘fear of not being understood’, and ‘the stigma of mental health diagnoses’. Participants were also aware of a number of reasons that prevented LGBT young people from disclosing their self-harm and suicidal feelings to mental health staff such as ‘fear of parental/ carer/ family involvement’ and ‘fear of being misunderstood’.

Training and practice

Those who had received training with a focus on LGBT awareness were more likely to state that they routinely discussed issues of sexual orientation/ gender identity with all their clients, more likely to feel that their organisation was supporting them, and that they had access to adequate skills training that supported their work with self-harming or suicidal LGBT youth.

Those who had received training with a focus on self-harm and suicide were significantly more likely to agree that they felt confident in their ability to work effectively with young people and less likely to find it frustrating when young people did not take their advice about self-harm.

Approximately half of participants did not believe that they had access to adequate skills training or support and supervision from their organisation to support their work with distressed LGBT youth.

Engaging LGBT youth in mental health services

When asked about the best way to engage LGBT youth in the services, the largest proportion of the sample chose ‘mandatory awareness training for staff’.

Conclusions

To develop effective public health policy to prevent suicide in LGBT young people, the social factors that heighten risk need to be addressed, and supportive services put in place. As a priority this would entail tackling homophobic, biphobic and transphobic abuse in schools, addressing the continuing sexual and gender norms which marginalise those who are not heterosexual and cisgender, and providing support and space for LGBT youth to disclose and discuss their emotions and experiences in secure environments. Key policy areas to focus upon are schools and education, the role of the internet, increasing LGBT youth provision, developing online and face-to face LGBT youth specific mental health support, and improving mental health and gender identity NHS services.

Section 1: Study aims and background

1.1 Introduction

International research demonstrates that LGBT youth are at a much higher risk of suicide and self-harm compared to their heterosexual counterparts (King et al., 2008, D'Augelli et al., 2005, Chakraborty et al., 2011, Grossman and D'Augelli, 2007, Haas et al., 2010, Reisner et al., 2015). Research over the last four decades has shown that LGBT youth rates of suicide attempts can be between four and seven times those of their heterosexual peers (Haas et al., 2010). A recent meta-analysis of studies comparing suicidality in young people found that 28% of sexual-minority youth reported a history of suicidality compared to 12% of heterosexual youth, and this disparity increased as the 'severity' of suicidality increased (Marshall et al., 2011). While trans youth have been studied less, research shows high rates of self-harm and suicide attempts (Grossman and D'Augelli, 2007, Reisner et al., 2015, Yadegarfar et al., 2013). This evidence is mainly from the USA, Canada, Australia, New Zealand and Europe. Evidence from the UK is sparse and only beginning to establish sexual and gender identity as a risk for adolescent suicide and self-harm. Stonewall research found that half of lesbian and bisexual women participants under the age of twenty had deliberately harmed themselves and sixteen percent had attempted to take their life (Hunt and Fish, 2008). More recently, two UK national research reports both found that LGBT young people were more likely to have attempted suicide than heterosexual participants (Nodin et al., 2015, Metro, 2014). Both also found that gender diverse (trans) young people were more at risk of suicidal feelings (and self-harm) than cisgender LGB youth.

Part of the difficulty of generating evidence is that estimates of the prevalence of LGBT people in the population have only occurred more recently. The Office for National Statistics (ONS) now includes a sexual identity question (not gender identity) on some population surveys. In these surveys 1-2% of the UK adult population identify as lesbian, gay or bisexual (Joloza et al., 2010) and 5% as non-heterosexual (Hayes et al., 2012). However, some caution needs to be applied to these estimates which remain skewed towards those who have higher levels of education and income (Joloza et al., 2010). The prevalence measures of young people's sexuality and gender are particularly problematic because research indicates that young people identify with a wide range of sexuality and gender labels, and for some there is a resistance to any categorisation at all. The UK's ONS Sexual Identity Project found when they sought young LGB people's views on the validity of the sexual identity question that they suggested other categories should be included such as 'unsure', 'questioning', 'confused', 'experimental' and 'queer' (Betts, 2009). The evidence underlines the continuing relevance of the categories of straight, lesbian, gay and bisexual and trans to young people but some young people are living their sexual and gendered lives in a much more varied way, which the current measure does not capture (McDermott, 2010).

Partly as a consequence, the UK evidence base is limited (and despite this population's higher risk and manifest health inequality), and there is an insufficient understanding of why LGBT adolescents may be at a higher risk of suicidal feelings and self-harm. Public Health England has identified the prevention of LGBT youth suicide as important to reducing health inequalities in LGBT population groups but there is a paucity of research to develop effective policy and practice. Furthermore, research on LGBT adolescent help seeking behaviours which will be important in planning services to tackle the problem, is non-existent (Chakraborty et al., 2011). This scarcity of research evidence makes it difficult to develop suicide prevention policy, deliver appropriate and effective mental health services, and tailor interventions to prevent suicide for this group. This

study aimed to provide the first in-depth and comprehensive data in England on LGBT youth suicide, self-harm and help-seeking behaviours.

1.2 Background

1.2.1 Risk factors associated with suicide and self-harm

Prevalence rates of adolescent and young adult self-harm and suicide attempts vary and are dependent upon the definition utilized, the type of sample assessed and the method of measurement (Stallard et al., 2013). However, it is clear that self-harm and suicide attempts in adolescents is a significant problem with European community surveys indicating that between 3-10% report at least one episode of self-harm in the past year, and lifetime rates of between 9-14% (Kokkevi et al., 2012, Madge, 2011, Moran, 2012). In the UK, gender has been found to be associated with suicide risk and self-harm. Evidence demonstrates that young men complete suicide at greater rates than young women (DH, 2012), and young women self-harm at higher rates than young men (Hawton et al., 2006).

King et al.'s (2008) systematic review of sexual orientation and mental health research found that the higher risk of suicide and self-harm in LGB populations is likely to be related to social hostility and stigma (see also Chakraborty et al., 2011). Survey evidence has repeatedly suggested that the key factors behind LGBT youth suicide and self-harm are homophobic and transphobic abuse, social isolation, early identification of sexual or gender diversity, conflict with family or peers about sexual or gender identity, inability to disclose sexual or gender identity and common mental health problems (Haas et al., 2010).

The family and school are two environments in which discrimination and victimization influence LGBT young people's mental health. School has proved to be a particularly high-risk environment and studies repeatedly show that school-based homophobic, biphobic, and transphobic bullying and harassment can increase the likelihood of suicidal feelings and self-harm in LGBT youth (Bontempo and D'Augelli, 2002, Rivers and Cowie, 2006, Duong and Bradshaw, 2014, Ploderl et al., 2010, D'Augelli et al., 2005, McDermott et al., 2015, McDermott et al., 2008). For example, Rivers et al.'s (2000) research demonstrated that 'repeated exposure to violence or harassment can have detrimental effects upon psychological well-being' (p.147). Of the LGB survey respondents in their UK study, 19% had attempted suicide once and 8% had attempted suicide more than once due to distress caused by their sexual orientation. For those who were bullied at school, however, this figure rose dramatically, with 30% having engaged in multiple suicide attempts. There has been great deal of debate about defining homophobia, biphobia and transphobia this often depends of different disciplinary approaches and theoretical perspectives. These terms are generally taken to mean the negative expression, verbal or physical, against those who are non-heterosexual and those who do not fit in the gender- binary of male/female (Agius and Tobler, 2012). Heteronormativity refers to the privileging and presumption that heterosexual and the gender-binary (male/female) are the only natural and normal sexualities and genders (Clarke et al., 2010b).

Previous research has also indicated a link between negative family experiences and suicidal distress in young LGBT people (Grossman et al., 2011, Ryan et al., 2009, Simons et al., 2012). D'Augelli et al. (2005) found a strong association between suicidality amongst LGBT youth and parental mistreatment and abuse. Studies have shown that family rejection is a significant predictor in reported levels of depression and suicidal thinking in transgender and cisgender adolescents (Yadegarfar et al., 2014), and White and Latino LGB youth (Ryan et al., 2009). Lack of family

support is also a risk factor for suicide in LGB young people (Needham and Austin, 2010). In contrast, family acceptance has been found to be a protector of risk of suicide for LGBT young adults (Ryan et al., 2010).

Inability to disclose sexual or gender identity (D'Augelli et al., 2001), and the stress related to decisions about disclosure (or coming out) in school, at home, to friends, family, peers and significant others have also been associated with suicidality and depression in LGBT youth (Baams et al., 2015, Hegna and Wichstrom, 2007). It is, therefore, unsurprising that positive school climate and parental support have both been found to protect LGB and questioning students against depression (a risk factor for suicide)(Espelage et al., 2008). In a US study, inclusive school anti-bullying policies were significantly associated with a reduced risk for suicide attempts among lesbian and gay youths. LGBT young people were 2.25 times more likely to attempt suicide when they were living in areas that did not have inclusive anti-bullying policies (Hatzenbuehler and Keyes, 2013).

1.2.2 Help-seeking behaviour

There have been no studies specifically investigating LGBT youth help-seeking behaviour for suicidal feelings and self-harm in the UK, and international research on the topic is equally a rarity (McDermott and Roen, 2016, McDermott et al., 2015). There is also a paucity of research on the difficulties LGBT youth may have accessing mental health services and gender identity clinics.

Compared to adults, young people are generally less likely to seek help for mental health problems (Gulliver et al., 2010). The Chief Investigator's research indicates that LGBT youth are reluctant to seek help due to shame and stigma, and instead they attempt to deal with emotional distress through minimizing its importance and trying to cope alone (McDermott, 2015, McDermott et al., 2015, McDermott et al., 2008, McDermott and Roen, 2016). Such coping strategies may make LGBT youth vulnerable to suicide and self-harm and represent barriers to accessing mainstream mental health services. Although research suggests LGBT adolescents may be reluctant to access formal mental health services, some do seek help online (PACE, 2010, McDermott and Roen, 2012, McDermott et al., 2013, McDermott et al., 2015). The Chief Investigator's recent online research suggests LGBT youth want help with, for example, difficulties and confusion about sexual orientation and gender identity, how to deal with homophobia and transphobia, how to stop self-harming, how to deal with suicidal thoughts and emotional distress, and how to ask for help and get help (McDermott and Roen, 2016, McDermott et al., 2013, McDermott et al., 2015).

1.2.3 Mental health services

King et al. (2007) argue that there is an urgent need for mental health services to develop LGBT sensitive services. While the acknowledgement of this need is a vital first step, the problem is that there is only limited evidence on the effectiveness of mental health services for LGBT youth who self-harm and/or feel suicidal. Research suggests that mainstream mental health services such as CAMHS may not always be helpful (McDermott et al., 2013, PACE, 2010) and that LGBT youth are less likely to use school-based services (Williams and Chapman, 2011) than LGBT organisations for suicidal distress (McDermott et al., 2008, Scourfield et al., 2008, Johnson et al., 2007). There is also some evidence that LGBT young people are reluctant to seek help from mainstream mental health services and if they do seek help, it is via the internet and LGBT youth groups (Johnson et al., 2007, McDermott et al., 2013, PACE, 2010). This indicates there may be significant barriers to LGBT adolescents accessing services. At this point it is unknown what

proportion of LGBT youth ask for help with their suicidal feelings and self-harm, where they ask for help, who they approach for support and whether they receive effective support and advice when asking for help.

In addition, there is almost nothing known about mental health service staffs' experiences and perspectives on delivering appropriate and effective care to distressed LGBT youth. In a recent US study which explored clinicians experiences of providing care to transgender youth, the principle barriers to the delivery of care were lack of training and experience with young transgender patients, and the availability of qualified mental health practitioners (Vance et al., 2015).

1.2.4 Public health policy and preventing suicide and reducing self-harm

This study is directly relevant to the Suicide Prevention Strategy (DH, 2012a), No Health Without Mental Health (DH, 2011), Healthy Lives, Healthy People (DH, 2010), Mental Health: Priorities for Change (DH, 2014) and the Future in Mind (DH, 2015) recommendations. The findings of the research will provide crucial evidence with which to develop suicide prevention interventions, mental health services and social care for this high-risk population group.

1.3 Aims and objectives

This study focused on LGBT adolescents who are a population group identified within the Suicide Prevention Strategy (DH, 2012) as a 'high risk group' in terms of age, sexual orientation, gender identity and mental health. The programme of work was intended to provide a coherent understanding of suicide and self-harm in relation to LGBT adolescents, with a clear focus on the perspectives of LGBT youth themselves.

Aim

Provide evidence to support the implementation of the Suicide Prevention Strategy and reduce the risk of suicide in LGBT adolescents.

Objectives

1. Provide evidence on why LGBT adolescents may be at risk of suicide and self-harm to inform suicide prevention policy.
2. Provide evidence on the relationship between self-harm and suicidality in LGBT adolescents to inform interventions to prevent suicide.
3. Increase understanding of LGBT adolescents' help-seeking behaviour in relation to suicidal feelings and self-harm to support the development of policy and service provision.
4. Capture LGBT adolescents' views and experiences of suicide, self-harm and help-seeking behaviour to better understand how policy and services can reduce the risk of suicide.
5. Provide evidence on why and how LGBT adolescents who self-harm and/or experience suicidal feelings use the internet to inform effective suicide prevention policies and services.
6. Capture mental health service staff views on LGBT youth and suicide prevention interventions.

Research questions

1. In what ways are sexual orientation and gender identity related to the experience of suicidal feelings and self-harm?
2. In what circumstances does LGBT adolescent self-harm lead to suicidal behaviour?

3. In what circumstances do LGBT adolescents seek help for suicidal feelings and self-harm?
4. Who and where do LGBT youth seek help for suicidal feelings and self-harm?
5. What are LGBT youth experiences on receiving successful and appropriate help for suicidal feelings and self-harm?
6. What are mental health service staff views on appropriate suicide prevention interventions for LGBT youth?
7. Why and how do LGBT adolescents use the internet when they experience suicidal feelings?

Section 2: Methods

2.1 Study design

This was a sequential mixed method study that employed face-to-face and online methods in two stages over 23 months. Stage one involved 29 semi-structured interviews with LGBT adolescents, half online (n=15), and half face-to-face (n=14). The aim was to generate in-depth, exploratory data from the perspectives of LGBT adolescents. Drawing from the results of stage one, stage two utilized two online questionnaires: i) a LGBT youth questionnaire employing a community-based sampling strategy; ii) a mental health service staff online questionnaire sampling across three NHS Trusts.

The nature of this research precluded the possibility of recruiting a representative sample. The rationale for utilising community-based sampling strategies (online and face-to-face) for the youth interviews and questionnaires rather than an exclusive clinical sample was two-fold. Firstly, much self-harming is hidden and does not result in medical attention and similarly suicide ideation does not always lead to clinical intervention in adolescents and young people (Hawton et al., 2006). Secondly, there is some evidence that LGBT youth are hesitant to use mainstream mental health services. In other words, clinical-based samples exclude a significant proportion of young people who self-harm and/or have suicidal feelings. This study was particularly interested in understanding those LGBT youth who have not accessed services.

2.2 Ethics

The study recruited young people who were potentially vulnerable and a priority throughout the research was to ensure that no harm came to those participating. All participants had access to support through LGBT youth or mental health workers (face-to-face interviews), and mental health and LGBT-specific support via telephone and the internet (online interviews and online questionnaire). Confidentiality and anonymity were crucial to ensuring that LGBT respondents were able to participate safely. Online methods have been highlighted as beneficial for helping to preserve the anonymity of vulnerable participants thus enabling them to be included in social research (Liamputtong, 2007).

A procedure for reporting risk and adverse events was in place. An adverse event was defined as serious if it was life-threatening to the participant or a significant other (e.g. partner, child, etc.), and a risk was defined as an immediate risk if it could result in death or significant harm to self/others. In the event that a research participant involved in the study was assessed as at risk, it would have been necessary to break confidentiality. No such incidents occurred during the research. In fact, many participants who took part in the interviews and the questionnaire thanked the researchers for listening and taking an interest in their life difficulties.

For interviewees, informed consent was gained through a written (or electronic) signature. The informed consent process was facilitated by the Queer Futures Project website (www.queerfutures.co.uk) which allowed potential participants to access a range of information relating to the study. The LGBT Youth Advisory Group helped to ensure that the information and design of the project website used appropriate language and covered all the issues relevant to young LGBT people. A notice that taking part in the questionnaire meant that participants were consenting to the use of the data was also included. All data was anonymised and stored electronically on a

password protected secure drive on Lancaster University's server. Only the Chief Investigator and Study Co-ordinator had access to the secure drive.

2.3 Stage 1: Qualitative semi-structured interviews

2.3.1 Method

Stage one involved 30 semi-structured interviews, half online (n=15) and half face-to-face (n=14) in three locations: North West England, North East England and Southern England. Both the online and face-to-face interviews used the same semi-structured interview schedule. These interviews were exploratory, and the questions were designed to be open-ended so that they elicited the experiences of the participants. The interview schedule contained seven broad sections: gender identity and sexual orientation; sources of emotional distress; self-harm and suicidal feelings; coping with emotional distress; help-seeking behaviour; experiences of mental health services; and demographic questions. The schedule was piloted online and face-to-face, and the interviews were conducted by two members of the research team.

2.3.2 Sampling

The target population for stage one interviews were LGBT young people aged between 16 and 25 years old, living in England, who had experienced self-harm and/or suicidal feelings. Purposeful sampling techniques were employed to ensure a diverse range of participants in terms of age, social class, ethnicity, sexual orientation, gender identity, geographical location, and mental health status. Attempts to recruit participants were made for the online and face-to-face interviews via both non-NHS and NHS sites. These were:

- a. LGBT Youth Voluntary organisations (non-NHS sites) in North East, North West and Southern England:
 - LGBT youth organisations and networks e.g. LGBT Youth North West, Queer Youth Network, Imaan- LGBT Muslim organisation.
 - Mental health organisations with a specific focus on LGBT youth e.g. PACE, MindOut
 - LGBT youth online social networks and other media e.g. twitter, tumbler, Facebook
- b. NHS community mental health services in two trusts:
 - Manchester Mental Health & Social Care Trust
 - Leeds & York Partnership NHS Foundation Trust

Despite significant efforts, no participants were recruited from the NHS trusts.

2.3.3 Data analysis

The face-to-face interviews were transcribed and the online interviews electronically archived and both were inputted into the data analysis software Atlas.ti/6. Guided by the research questions, the interview data was coded descriptively and conceptually (Miles and Huberman, 1994). The process of analysis proceeded through thematic analysis (Mason, 2002).

The findings generated from the stage one qualitative data analysis were utilised to design two online cross-sectional questionnaires that asked questions based on LGBT youth perspectives and experiences.

2.4 Stage 2: Youth questionnaire

2.4.1 Method

Stage two of the research involved designing and distributing two online questionnaires; one for LGBT youth, the second for mental health service staff. The LGBT youth questionnaire contained question sections on demography; gender identity and sexual orientation; self-harm and suicidal feelings; sources of emotional distress; disclosure of sexual orientation and gender identity; attitudes towards help-seeking; help-seeking behaviour and experience of services.

Measuring key variables

Age was measured by asking participants how old they were in years. Participants who responded that they were 26 or over were advised that they were ineligible to complete the questionnaire and subsequently ejected with a thank you message and explanation for their exclusion.

Measures of suicidal feelings and self-harm used previously validated survey questions that had been employed for investigating adolescents and self-harm in the UK (Hawton et al., 2006). Self-harm was measured by asking participants whether ‘they had ever tried to harm themselves in some way’ (yes/ no). Suicidality was measured using the Suicide Behaviors Questionnaire-Revised (SBQ-R) (Osman et al., 2001). Participants were asked “Have you ever thought about or attempted to kill yourself?” and then provided with five options; “no, never”, “Yes, it was a brief passing thought”, “I have wanted to stop existing, but did not want to kill myself”, “I have made a plan to kill myself at least once”, and “I have attempted to kill myself”.

Social class was measured through educational qualifications, parents university education (Y/N), reception of free school meals (Y/N) and university aspiration/ experiences.

Ethnicity was measured using the Office for National Statistics (ONS) recommended ethnic group question for use on a questionnaires in England (Office for National Statistics, 2015). Disability was also measured using the recommendations from the ONS (White, 2009). Questions pertaining to religion and parent/carer religion were drawn from the 2011 census in England and Wales (Office for National Statistics, 2009).

A sexual identity measure was used that included eight closed-option responses - ‘lesbian’, ‘gay’, ‘bisexual’, ‘heterosexual’, ‘queer’, ‘pansexual’, ‘questioning’, ‘unsure’, and one ‘other’- open ended response. This acknowledged that some young people define their sexual identity using conventional categories, while others do not, and others still reject sexual identities altogether (McDermott, 2010).

The measurement of gender identity is in its infancy. We piloted the Equality and Human Rights Commission recommend question which measures sex at birth and gender identity with the LGBT youth group (EHRC, 2012). As a result the questions were altered to include ‘gender fluid’ and a yes/no/unsure response (see Table 2 below).

Table 1: Gender identity question amendments

Original item	Amended item
2A. What is your gender identity?	2A. What is your gender identity?
o Male	o Male
o Female	o Female
o Non-binary	o Non-binary

<input type="radio"/> Other- please specify.....	<input type="radio"/> Gender fluid <input type="radio"/> Other- please specify.....
2B. What was your sex at birth? <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Intersex <input type="radio"/> Other- please specify.....	2B. Do you identify with the sex assigned to you at birth? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unsure

Questionnaire design and pilot testing

Confidentiality, security and privacy were paramount to the questionnaire design and it was vital that the questionnaire was compatible with smart-phones and other hand-held devices. As such, each question's format was tested and adapted to ensure that it was visible and usable on small devices. The questionnaire was designed to take 15 minutes to complete. The questionnaire was piloted with the LGBT Youth Advisory Group (YAG) and a number of changes were made to questions.

2.4.2 Sampling

The target population were LGBT young people aged between 16 and 25 years old living in England who had experienced self-harm and/or suicidal feelings. A convenience sample was recruited using online networks and the questionnaire respondents were self-selected. The sample was recruited exclusively online via:

- i) LGBT organisations and networks e.g. Queer Youth Network, Imaan- LGBT Muslim organisation.
- ii) LGBT online social networks and other media e.g. twitter, Facebook, Tumblr, Reddit
- iii) Mental health organisations with a specific focus on LGBT youth e.g. PACE, MindOut

Online recruitment took place over four months. To ensure a diverse range of participants in terms of age, social class, ethnicity, sexual orientation, gender identity, the recruitment strategy targeted specific groups known to participate less in LGBT youth research e.g. those from a lower socio-economic status, ethnic minorities, and trans young people.

2.4.3 Data analysis

Results from both questionnaires (youth and mental health service staff questionnaire) were uploaded into SPSS statistical analysis software. The youth questionnaire data was analysed through three stages. The first stage was to 'clean' the data to ensure that all participants included were those that fulfilled eligibility criteria, the final sample size was 789 participants. The second stage examined the frequencies and responses for each of the questions in the questionnaire. The third stage of data analysis was statistical analysis. χ^2 tests were conducted to determine associations between variables. Probability criteria were set to $p < 0.05$ for inclusion. Throughout the remainder of this report, the significant outcomes of these tests are reported. Where possible, differences between groups are shown as odds ratios (OR) at 95% confidence intervals. Based on these associations, logistic regression was used to examine specific predictors for suicidality and help seeking among LGBT youth.

2.5 Stage 2: Mental health service staff questionnaire

2.5.1 Method

The mental health staff questionnaire had five sections: demographics, work status and roles, knowledge and attitudes, current practice and solutions. The questionnaire was designed to investigate:

- Mental health service staff understanding of young people's sexual orientation and gender identity in relation to suicide and self-harm;
- Mental health staff good practice when supporting LGBT young people that were self-harming or feeling suicidal; and
- The type of training, support or development mental health service staff required to support LGBT youth who were self-harming or feeling suicidal.

Those working in mental health services were likely to be time poor, and the questionnaire was designed to be short in duration and to address the research objectives concisely. The questionnaire was accessible via work or home computers and small devices (phones or tablets) to enable greater confidentiality and ease of access for staff. The survey was devised and distributed to a group of mental health nurses for the purposes of checking accessibility through NHS emails and work computers. In addition, feedback was sought on the content and acceptability of the survey. There were no issues in accessing the link whilst within the NHS organisation or on personal devices.

2.5.2 Sampling

The questionnaire was aimed at staff working in NHS mental health services that focused on younger people such as CAMHS, early intervention teams, and community mental health services. The sample was generated from three NHS Trusts:

- Camden and Islington NHS Foundation Trust;
- Leeds and York Partnership NHS Trust
- Manchester Health and Social Care Trust

2.5.3 Data analysis

Data analysis of the mental health service staff questionnaire addressed the research question using three stages of sequential analysis: Descriptive statistics, cross tabulations and Pearson's Chi-squared test (χ^2 test), and measures of effect size (odds ratio). Age, gender identity, sexual orientation and experiences/ reception of training were tested to establish whether there any statistically significant associations with the knowledge, attitudes and practice of participants.

2.6 Limitations

Although the intention was to recruit a diverse sample of young people, there were particular difficulties reaching those from black and minority ethnic (BME) populations and those from poorer and less educated backgrounds. The problem of generating representative and diverse samples for LGBT youth research has been identified by previous studies (McDermott et al., 2013). The recruitment strategy for the youth interviews and questionnaires was specifically designed to target those marginalised groups who are harder-to-reach. These included participants who were trans, disabled, homeless or living in poverty and/ or from BME groups. Sample diversity was monitored

throughout the data collection time period, which enabled the research team to identify population groups that were under-represented, and employ strategies to address the bias.

There were obstacles recruiting participants to the mental health service staff questionnaire (which is a common problem for NHS staff research). Ethical requirements prohibited direct approaches to potential participants by the research team, meaning that recruitment relied on self-selection of participants through notifications that were provided to them by NHS trusts. There was a very low response rate to the staff survey which limits how representative it is of staff views. However, from the demographics, it is clear that a range of ages, roles and professional backgrounds were represented. It is likely that people who identified as “other than heterosexual” are over-represented although it is difficult to know as there is no data on sexual orientation of the mental health workforce .

Overall, the sample is diverse in terms of age, disability, sexual orientation, gender identity and ethnic minority and socio-economic background. Nevertheless, there is an over-representation of White British and educated participants in the sample. This is a limitation of the study. However, it cannot be under-estimated how difficult it is to recruit marginalized populations groups who are stigmatized by their sexual orientation and gender identity to a study whose focus is suicide and self-harm which is sensitive, distressing and a further source of stigma.

2.7 Public and patient involvement

Young people’s involvement in this study was facilitated through establishing a ‘LGBT Youth Advisory Group’ (YAG). The YAG involvement was through both face-to-face meetings and a Facebook group. The YAG members involved throughout the study were consulted regarding the project website, recruitment materials, research content, questionnaire design, data collection methods, recruitment strategies, the reading of results and appropriate dissemination efforts. The research management group also included a service user consultant (Isaac Samuels) who attended the steering group meetings and contributed to the discussions related to the process of research throughout the study.

On completion of the stage 1 interviews with LGBT youth, two stakeholder meetings were conducted in London and Manchester. The purpose of these meetings was to feedback early findings of the interviews to those working in the education, welfare and health voluntary and statutory sectors that support distressed LGBT young people. At these events, professionals and volunteers were asked for their views and experiences of supporting LGBT young people who self-harm and feel suicidal. These perspectives provided a viewpoint that proved to be compatible with the young people that had been interviewed.

A ‘Queer Futures Expertise Exchange’ was held at the end of the research. The research findings were presented to an audience of LGBT youth and health, education and youth practitioners and policy-makers. Conference attendees were then asked to draw on their own ‘expertise’ to make recommendation to prevent and reduce LGBT youth suicide and self-harm (see section 7.3).

Section 3: Sample

This section presents characteristics of the participants in the two stages of the research study.

3.1 Stage 1: Qualitative semi-structured interviews

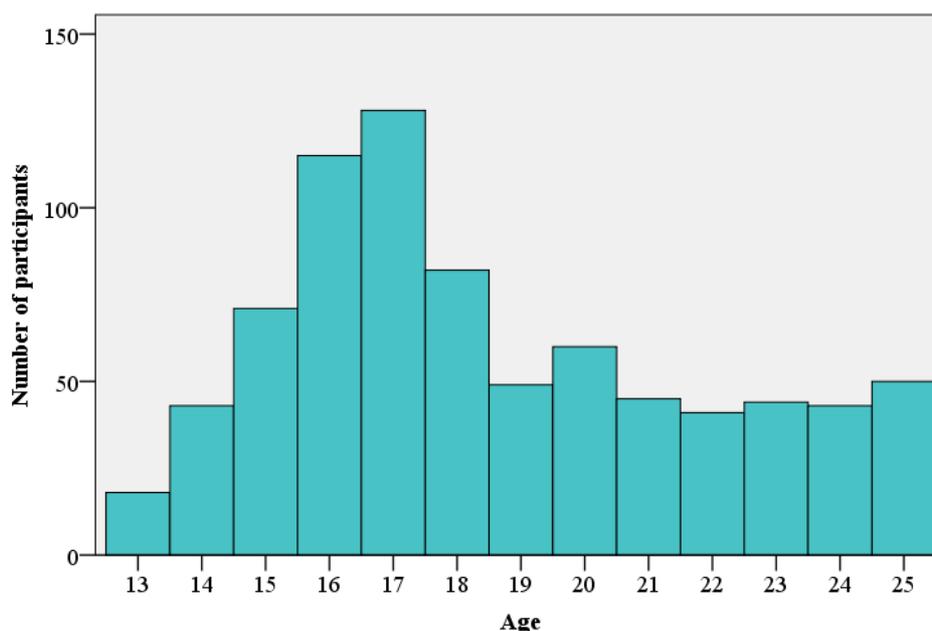
In total, 29 interviews with LGBT youth were completed. 15 of these were online, and 14 face to face. Participants were aged between 15 and 25, with every year group represented at least once. There were multiple gender identities; 12 participants had a gender diverse identity and 17 were cisgender. In regards to sexuality, 9 participants identified as gay, 6 as lesbian, 6 as pansexual, 4 as bisexual, 2 as straight, one as queer and one as unsure. 26 participants identified their ethnicity as white British, while the remaining 3 identified as British-Pakistani, Mixed, and British Asian. 6 of the participants indicated that they had a disability (see Appendix 6 for further sample details).

3.2 Stage 2: Youth questionnaire

3.2.1 Age

The final sample included 789 participants. Participants were aged from 13 to 25 years old with a mean age of 18.59. Figure 1 represents the age range of the sample.

Figure 1: Age of questionnaire participants



The largest single age group represented was 17 years old, making up 16.2% of the sample (n=128). This was followed by the 16 year (14.6%, n=115) and 18 year (10.4%, n=82) age groups.

3.2.2 Gender Identity

There was a range of gender identities represented in the sample. Re-categorisation of gender identity (see Section 2 for details), indicated that 43.5% (n=343) of the sample was trans or unsure about their gender identity, while 56.5% (n=446) were cisgender. The largest gender group in the sample was cisgender females (33.2%, n=262) followed by 'other (all)' (23.1%, n= 182), cisgender males (21.2%, n=167), trans males (13.2%, n=104) and trans females (9.4%, n=74).

39 participants chose to enter terms to define their gender identity. These terms included, among others, ‘gender queer’, ‘demigender’, ‘bigender’, ‘agender’, ‘non-binary male’, ‘questioning’, ‘transmasculine’ and ‘trigendered’.

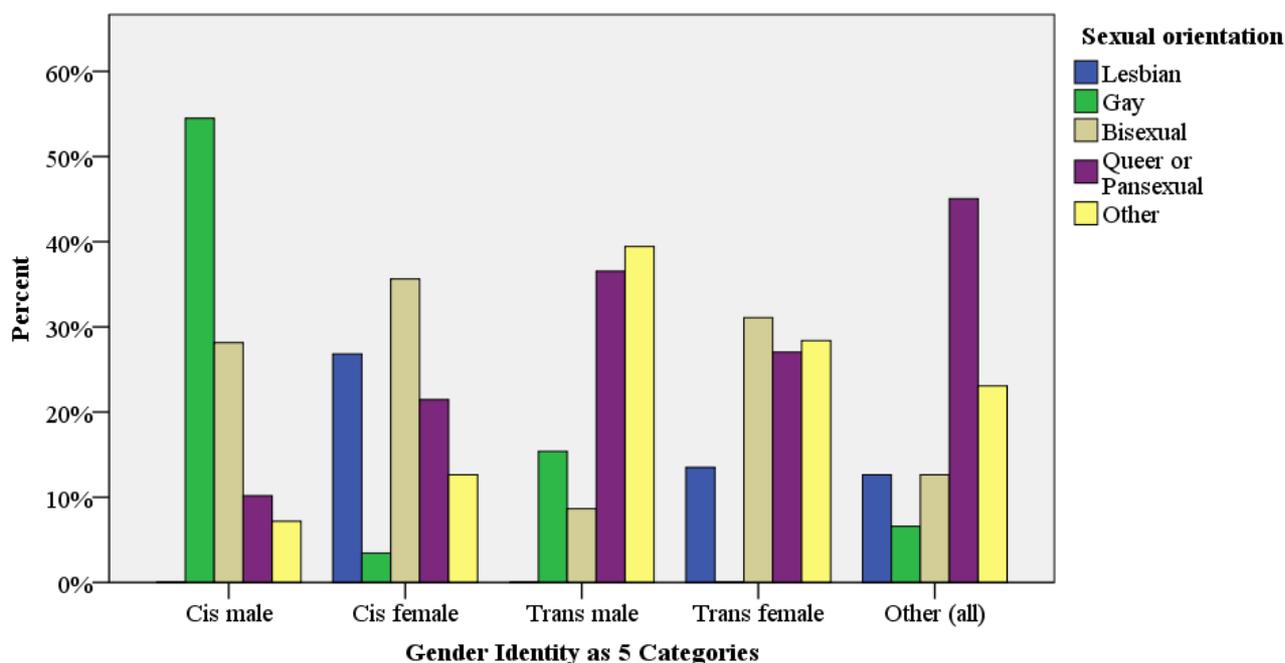
Gender identity and age

The trans/unsure participants were slightly older than the cisgender participants ($\chi^2=11.876$, $df=2$, $p < 0.01$). The mean age for cisgender participants was 18.25 years of age and the trans/unsure participants mean age was 19.02 years. While 70% ($n=309$) of the cisgender population were aged between 13 and 19 years old, only 57% ($n=197$) of the trans/unsure sample made up this age group. Almost 43% ($n=146$) of trans participants were aged 20-25 compared to 30% ($n=137$) of cisgender participants.

Gender identity and sexual orientation

There was a significant relationship between gender identity and sexual orientation ($\chi^2=400.335$, $df=16$, $p < 0.001$). This relationship can be seen in figure 2 below:

Figure 2: Participants’ gender identity (five categories) by sexual orientation



- Cisgender females were most likely to identify with a bisexual sexual identity (35.6%, $n=93$), followed by lesbian (26.8%, $n=70$), queer or pansexual (21.5%, $n=56$), ‘other’ (12.6%, $n=33$) and gay (3.4%, $n=9$).
- Cisgender males were most likely to identify with a gay sexual identity (54.5%, $n=91$), followed by bisexual (28.1%, $n=47$), queer or pansexual (10.2%, $n=17$) and ‘other’ (7.2%, $n=12$).
- Trans females were most likely to identify with a bisexual sexual identity (31.1%, $n=23$), followed by ‘other’ (28.4%, $n=21$), queer or pansexual (27%, $n=20$), and lesbian (13.5%, $n=10$).
- Trans males were most likely to identify with ‘other’ sexual identities (39.4%, $n=41$), followed by queer or pansexual (36.5%, $n=38$), gay (15.4%, $n=16$) and bisexual (8.7%, $n=9$).
- ‘Other’ gender identity participants were most likely to identify with queer or pansexual sexual identities (45.1%, $n=82$), followed by queer or pansexual (23.1%, $n=42$), lesbian (12.6%, $n=23$) and bisexual (12.6%, $n=23$), and gay (6.6%, $n=12$).

Table 4 below shows the frequency of the gender identities in each sexual identity grouping. It is important to note that the sexual orientation categories of lesbian, gay and bisexual are each dominated by mostly cisgender participants. Conversely, the categories queer, pansexual and ‘other’ have higher proportions of transgender participants.

Table 2: Sample characteristics: Sexual identity groupings according to gender identity

	%	(n)		%	(n)
Queer or Pansexual	27	(213)	Gay	16.2	(128)
"Other"	38.5	(82)	Cisgender males	71.1	(91)
Cisgender females	26.3	(56)	Trans males	12.5	(16)
Trans males	17.8	(38)	"Other"	9.4	(12)
Trans females	9.4	(20)	Cisgender females	7	(9)
Cisgender males	8	(17)			
Bisexual	24.7	(195)	Lesbian	13.1	(103)
Cisgender females	47.7	(93)	Cisgender females	68	(70)
Cisgender males	24.1	(47)	"Other"	22.3	(23)
Trans females	11.8	(23)	Trans females	9.7	(10)
"Other"	11.8	(23)			
Trans males	4.6	(9)			
"Other"	18.9	(149)			
"Other"	28.2	(42)			
Trans males	27.5	(41)			
Cisgender females	22.1	(33)			
Trans females	14.1	(21)			
Cisgender males	8.1	(12)			

3.2.3 Sexual Orientation

Participants identified with a range of sexual identities. The largest proportion of participants identified with Bisexual (24.7%, n=195), followed by Gay (16.2%, n=128), Pansexual (15%, n=118), Lesbian (13.1%, n=103), Queer (12.1%, n=95), Asexual (4.3%, n=34), Questioning (4.2%, n=33), Heterosexual (straight) (4.1%, n=32), Other (3.3%, n=26) and Unsure (3%, n=24). 59 participants selected to enter their sexuality in text format, and of these 34 were asexual. An ‘asexual’ category was created and included in analysis. The remaining terms included among others, ‘Aromantic’, ‘queer-romantic’, ‘omniromantic’, ‘heteroromantic’, ‘biromantic’, ‘demisexual’, ‘androsexual’, ‘gynecosexual’, ‘heteroflexible’, ‘panromantic’, ‘gynophilic’, ‘polysexual’ and ‘ace’. There were multiple combinations and configurations of these terms.

Sexual orientation and age

There was no significant difference in age of participants according to sexual orientation (Table 5). The mean age of participants across all sexual identities is within one year, with gay participants having the highest mean age (19.08) and lesbian participants the lowest (18.26).

Table 3: Mean age of sample participants by sexual identity

Sexual orientation (5 categories)	Mean	N	Std. Deviation
Lesbian	18.26	103	3.178
Gay	19.08	128	3.454
Bisexual	18.47	195	3.248
Queer or Pansexual	18.72	213	3.350
Other	18.37	149	3.197
Total	18.59	788	3.294

3.2.4 Ethnicity

The largest proportion of participants identified as White British (83%, n=655). Black or Minority Ethnic (BME) participants made up 9% of the sample (n=71), with every ethnicity category represented apart from Bangladeshi. The remaining 8% of sample consisted of White (other) individuals (n=63). Table 6 shows the distribution of ethnicity across the sample.

Table 4: Sample characteristics: Ethnicity

Ethnicity	Frequency (n)	Percent %
White- English/ Welsh/ Scottish/ Northern Irish/ British	655	83
White- Irish	15	1.9
White- Gypsy or Irish Traveller	1	0.1
Any other White background, please describe	47	6
White and Black Caribbean	10	1.3
White and Black African	3	0.4
White and Asian	10	1.3
Any other Mixed/ Multiple ethnic background, please describe	12	1.5
Indian	5	0.6
Pakistani	5	0.6
Bangladeshi	0	0
Chinese	3	0.4
Any other Asian background, please describe	9	1.1
African	5	0.6
Caribbean	3	0.4
Any other Black/ African/ Caribbean background, please describe	0	0
Arab	4	0.5
Any other ethnic group- please describe	2	0.3
Total	789	100

3.2.5 Religion

Most participants (72.2%, n=570) indicated that they were not religious. 19.3% (n=152) of participants were religious. The largest religious group were Christian (of any denomination) (11.8%, n=93), followed by those who were unsure/ undecided (8.5%, n=67). The remaining 7.5% were Buddhist, Hindu, Jewish and Muslim.

3.2.6 Social class

Social class was examined through measures of education, employment and income (free school meals). These were distributed across the sample as follows:

- **Free school meals:** 23.8% (n=188) of participants had received free school meals at some point, compared to 70.5% (n=556) of those who had not. The remainder (5.7%, n=45) did not know.
- **Highest qualification:** The majority of participants (83.9%, n=661) had completed some level of educational qualification including GCSEs (25.5%, n=201), A levels (20.7%, n=163), AS Levels (14.5%, n=114), first degrees (13.1%, n=103), HE diplomas (4.9%, n=39), higher

degrees (3.8%, n=30) and trade apprenticeships (1.4%, n=11). 16.1% (n=127) of the participants had not completed any educational qualifications.

- **Parent/ carer university degree:** There were almost equal proportions of participants whose parent/carer/s held a university degree (46.9%, n=370) and whose did not (45.1%, n=356). The remainder (8.0%, n=63) did not know whether their parent/s or carer/s held a university degree.
- **Employment status:** Most participants indicated that they were students (69.8%, n=550), however there were also some that were not employed (23.1%, n= 182), employed part time (19%, n= 150) and employed full time (11.8%, n=93).
- **University aspiration or attendance:** Most participants indicated that they did plan to go to university (43.9%, n=346), while 18.1% (n=143) were currently attending university, 17.5% (n=138) were uncertain about whether they would attend university, and 9.5% (n=75) indicated that they did not plan to go to university.

3.2.7 Disability

Over one quarter of the sample (25.2%, n=199) indicated that they had a disability, chronic illness or impairment. The most common disability, chronic illness or impairment chosen by participants was mental health conditions (77.9%, n=155). This makes up approximately 20% of the total sample. This was followed by those with a learning disability/ difficulty (10% of sample, n=79), those with a long standing illness or health condition (4.9% of sample, n=39), those that selected 'other' (2.8% of sample, n=22), those with a physical impairment (2.5% of sample, n=20), and those with a sensory impairment (1.4% of sample, n=11).

Those who had a chronic illness, impairment or disability tended to be older (mean 20.07) compared to those who did not (mean 18.09) ($\chi^2=57.688$, $df=2$, $p < 0.001$). In addition, participants who were trans or unsure were 2.23 times more likely to indicate that they had a disability/chronic illness/ impairment compared to cisgender participants (OR 2.23, 95% CI:1.61–3.09, $p < 0.001$).

Cisgender males (10.1% with a disability) were the gender identity grouping least likely to report having a disability, impairment or chronic illness, while the 'Other' gender identity group was most likely to report having a disability (39.6% with a disability), followed by trans males (32.7% with a disability), cis females (22.1% with a disability), trans females (20.3% with a disability) ($\chi^2=40.736$, $df=4$, $p < 0.001$).

3.2.8 Self-harm

88.8% (n=701) of participants had harmed themselves in some way. 40.4% (n=283) of those had harmed themselves within the last month, while 26.7% (n= 187) had harmed themselves between one and six months ago (Figure 3). The remaining 32.9% (n=230) had self-harmed over six months ago. Younger participants were more likely to have self-harmed within the last six months compared to 20-25 year olds ($\chi^2=20.907$, $df=4$, $p < 0.001$).

Figure 3: Sample characteristics: Recentness of self-harm



3.2.9 Suicidal Feelings

97.8% (n=772) of the sample had experienced suicidal thoughts or feelings, while only 2.2% (n=17) of the sample had not. Participants who had suicidal feelings were asked to qualify how ‘strong’ these feelings were. There were four options to choose from ‘Yes, it was a brief passing thought’ (10.9%, n=86), ‘I have wanted to stop existing, but did not want to kill myself’ (28.9%, n= 228), ‘I have made a plan to kill myself at least once’ (29%, n=229), and ‘I have attempted to kill myself’ (29%, n=229). Re-categorisation of this question (see Section 2 for further details) indicated that 58% of the sample (n=458) had planned or attempted suicide at some point, while 42% (n=331) had not.

3.3 Stage 2: Mental health staff questionnaire

NHS staff are difficult to recruit to studies and this was reflected in the sample size for the staff questionnaire. 113 participants answered question one (how old are you?), with a steady decline of participants up until the final question, which was answered by 83 participants. This equates to a 44% drop out rate.

3.3.1 Age

Participants were distributed evenly across all age groups in the mental health service staff questionnaire. 26.5% (n=30) of participants were 30 years old or under, 47.8% (n=54) were between 31 and 50, and 25.7% (n=29) were aged 51 and over.

3.3.2 Gender and Sexual Identity

96.5% (n=109) of the sample was cisgender, with only 3.5% (n=4) gender diverse. 41.7% (n=45) of the sample identified as a sexual identity other than heterosexual.

3.3.3 Ethnicity

96.3% (n=105) of the sample were from a white background, while almost 90% (89.9%, n=98) were from a White British ethnic background.

3.3.4 Occupation and training

Participants were employed in a variety of occupations. Over one quarter of participants were registered mental health nurses (27.6%, n=29), 15.2% (n=16) were healthcare/ nursing assistants, 11.4% (n=12) were clinical psychologists, and 8.6% (n=9) were occupational therapists. Other categories included 'Psychiatrists- Higher trainee' (1.9%, n=2) and Social Workers (1.9%, n=2). The largest single category of occupation selected was 'other' (29.2%, n=35).

There was also a diversity of work locations/ centres. The category selected the most was 'other' (45.2%, n=47), followed by those working in community mental health teams (23.1%, n=24), acute inpatient wards (9.6%, n=10), crisis assessment services (7.7%, n=8), early intervention teams (5.8%, n=6), CAMHS (2.9%, n=3), assertive outreach teams (1.9%, n=2), forensic inpatient units (1.9%, n=2), and home based treatment (1.9%, n=2).

While most of the sample had received training for self-harm (60%, n=60) or suicide prevention (59.4%, n=60), only one third (35.4%, n=35) had received training on LGBT awareness.

3.4 Sample summary

This section provided the sample characteristics of qualitative interviews and the youth and mental health service staff questionnaires. In the youth questionnaire, the 789 participants were diverse in age, gender identity, sexual orientation, disability, ethnicity and social class. There were a number of characteristics of the sample that were important to further analysis of the dataset. These were:

- Over a quarter of the sample indicated that they had a disability, chronic illness or impairment, and those who were older and/or trans/unsure were more likely to have a disability, chronic illness or impairment. Cisgender males were least likely to state they had such a condition.
- The sample was skewed toward more educated participants. Although over a fifth of the sample stated they had received Free School Meals, nearly half the sample indicated that their parents had a university degree and the majority of the sample stated they were either attending university or intended to enter higher education.
- The sample consisted solely of young people from sexual or gender minorities who had self-harmed or had suicidal feelings. Over half (58%) of the participants had planned or attempted suicide at some stage, while almost 90% (88.8%) of the sample had self-harmed.

The sample size in the mental health service staff questionnaire was small but the number was large enough to generate significant findings. Each question had between 83 and 113 respondents. This sample was again diverse in age, gender identity and sexual orientation. Participants were from a range of occupational backgrounds and demonstrated diversity in training experiences.

Section 4: Results: Understanding the elevated rates of LGBT youth suicide and self-harm

This section presents results from the interviews and the youth questionnaire which aim to develop understandings of why LGBT youth have elevated rates of suicide and self-harm (research questions 1 and 2). The results are reported in seven sections. Firstly, there is an examination of who was most likely to self-harm and experience suicidal feelings in the sample. In the subsequent sections, results concentrate on the five main areas which explain *why* there is higher risk of suicide and self-harm: i) homophobia, biphobia or transphobia; ii) sexual and/or gender norms; iii) managing sexual orientation and gender identity across multiple life domains; iv) being unable to talk; v) other life crisis. Finally, evidence relating to the complex relationship between self-harm and suicidal behaviour, and predicting suicidality are detailed.

4.1 Suicide and self-harm

In the youth questionnaire analysis, there were statistically significant associations between age, gender identity, disability and the likelihood of self-harming and suicidality (Table 7). Key findings included:

- Those who were in the older age groups were more likely to have planned or attempted suicide than those that were younger.
- Trans or unsure participants were 1.75 times more likely to have self-harmed, and 1.63 times more likely to have planned or attempted suicide than cisgender participants.
- Cisgender males were the gender identity grouping least likely to have self-harmed, and the group least likely to plan or attempt suicide.
- Participants with a disability were 2.88 times more likely to have self-harmed, and 2.38 times more likely to have planned or attempted suicide than those who did not have a disability.
- Those who had self-harmed were 10.03 times more likely to have planned or attempted suicide than those who had not harmed themselves.

The questionnaire results clearly demonstrate that age, gender identity and disability were associated with suicide and self-harm in this sample. This does not, however, provide any understanding about why LGBT young people may be at risk. The results from both the interview and questionnaire demonstrated that five interacting areas were crucial to explaining the elevated risk: homophobia, biphobia or transphobia; sexual and gender norms; managing sexual and gendered feelings across multiple life domains; being unable to talk; and other life crises. These are discussed in the following sections.

Table 5: Chi-square and odds (95% CI) ratio associations between suicidality and self-harm, age group, disability, gender identity and sexual orientation

	<i>Suicidality</i>				χ^2	OR	CI (95%)		<i>Self-harm</i>				χ^2	OR	CI (95%)	
	No plan or attempt		Plan or attempt				Lower	Upper	Did not self-harm		Did self-harm				Lower	Upper
	<i>n</i>	%	<i>n</i>	%					<i>n</i>	%	<i>n</i>	%				
<i>Age group</i>					6.312*								0.91			
16 and under	116	14.7	131	16.6				30	3.8	217	27.5					
17-19	112	14.2	147	18.6				25	3.2	234	29.7					
20-25	103	13.1	180	22.8				33	4.2	250	31.7					
<i>Disability, chronic illness or impairment</i>					23.99***	2.38	1.67	3.38					10.09***	2.88	1.46	5.68
Yes	54	6.8	145	18.4				10	1.3	189	24					
No	277	35.1	313	39.7				78	9.9	512	64.9					
<i>Gender identity (5 cat)</i>					28.01***								63.45***			
Cis male	99	12.5	68	8.6				45	5.7	122	15.5					
Cis female	103	13.1	159	20.2				14	1.8	248	31.4					
Trans male	33	4.2	71	9				4	0.5	100	12.7					
Trans female	29	3.7	45	5.7				13	1.6	61	7.7					
Other	67	8.5	115	14.6				12	1.5	170	21.5					
<i>Gender identity (2 cat)</i>					11.1***	1.63	1.22	2.18					5.48*	1.75	1.09	2.81
Cisgender	210	26.6	236	29.9				60	7.6	386	48.9					
Transgender	121	15.3	222	28.1				28	3.5	315	39.9					
<i>Sexual Orientation</i>					7.82								19.47***			
Lesbian	37	4.7	66	8.4				5	0.6	98	12.4					
Gay	65	8.2	63	8				27	3.4	101	12.8					
Bisexual	88	11.2	107	13.6				24	3	171	21.7					
Queer or Pansexual	82	10.4	131	16.6				17	2.2	196	24.9					
Other	59	7.5	90	11.4				15	1.9	134	17					
<i>Suicidality</i>													76.17***	10.03	5.46	18.43
Has not planned or attempted suicide									75	9.5	256	32.4				
Has planned or attempted suicide									13	1.6	445	56.4				
<i>Self-harm</i>					76.17***	10.03	5.46	18.4								
Has not self-harmed	75	9.5	13	1.6												
Has self-harmed	256	32.4	445	56.4												

Bold values indicate statistical significance. *p < 0.05; **p < 0.01; ***p < 0.001.

4.2 Homophobia, biphobia and transphobia

The majority (70.8%, n=527) of youth questionnaire participants had experienced some kind of abuse or negative interactions from others related to their sexual orientation/ gender identity while they were self-harming or having suicidal feelings. In the interviews, young people described the ways in which these experiences affected their self-harm and suicidal feelings. Anthony explains how homophobia at school led him to self-harm:

...there used to be this one boy who used to make fun of me because I've always come [to the LGBT youth group] for about a year, maybe two years now,[...] the comments that people make at school are the comments that stick to the back of your head and then when like I go to go to sleep and I start thinking about the day, they start coming over and over and over and I get really sad and I just want to hurt myself, sort of thing, like I'm ashamed to be me and... like that's why I would do it. So I would be like... Oh, I'm gross, and stuff like that, and I would end up self-harming... and I don't think I had another coping mechanism.
Anthony (16, gay, cis male, White British)

For Briana, school bullying on the basis of her sexual orientation made her feel her only option was suicide:

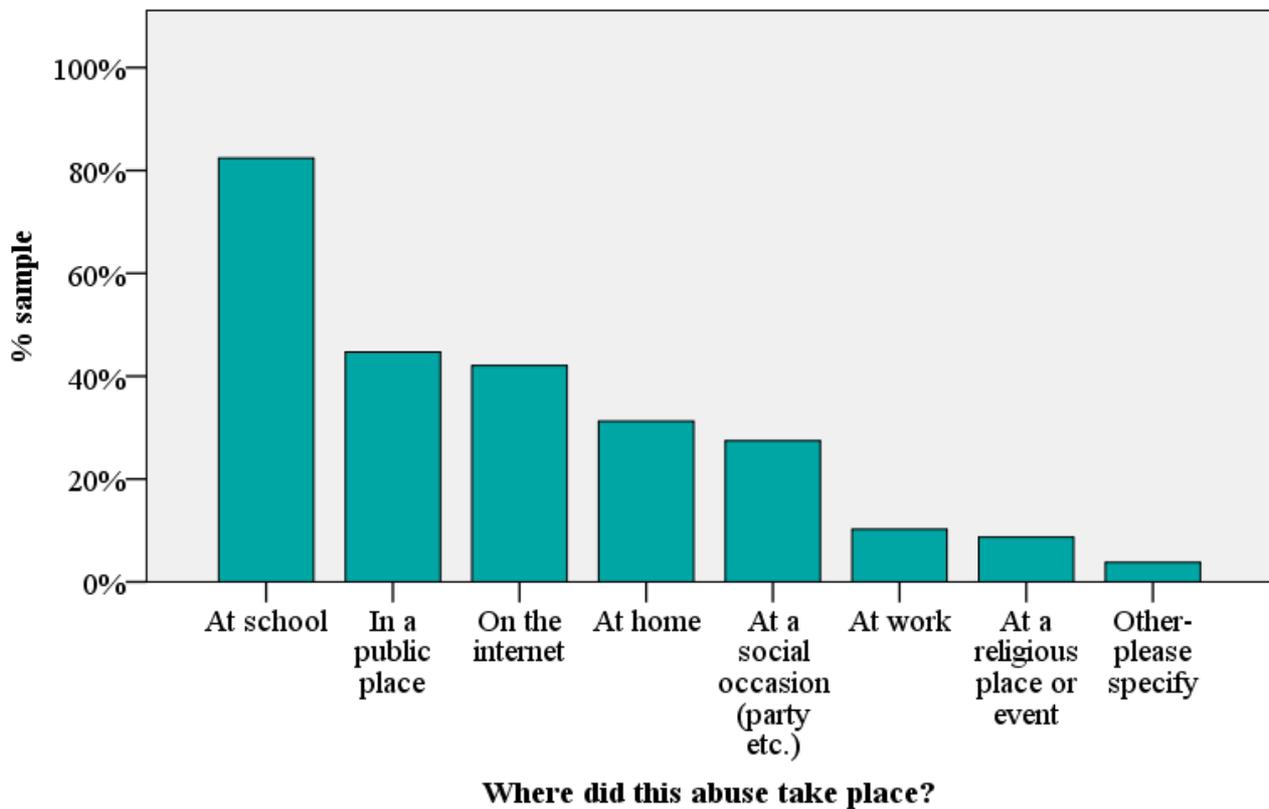
I remember just sitting there, wanting more than anything to just die, to end it all. I was so, so sick of them hurting me. I didn't want to feel like this anymore, and as I was constantly feeling like this, the majority of the time, I remember thinking that the only way to make it all stop was to die.
Briana (19, pansexual, female, White British)

Some participants also experienced homophobia, biphobia or transphobia from their families and in their homes. Ryan, the youngest interview participant, recounted how a family member's transphobia impacted on his self-harming:

... he was saying... trans people aren't real and that you can never truly be a man or a woman if you don't have the ability to either like to impregnate a woman or the reverse obviously to have a child [...] he was just so rude about it and I ended up just hanging up on him and crying a lot, and like I self-harmed then because, yeah, that was a horrible night. [...]But it just kind of felt really, really awful, like to kind of be betrayed by a family member who I was so sure who would accept me for that.
Ryan (15, gay, trans male, White British)

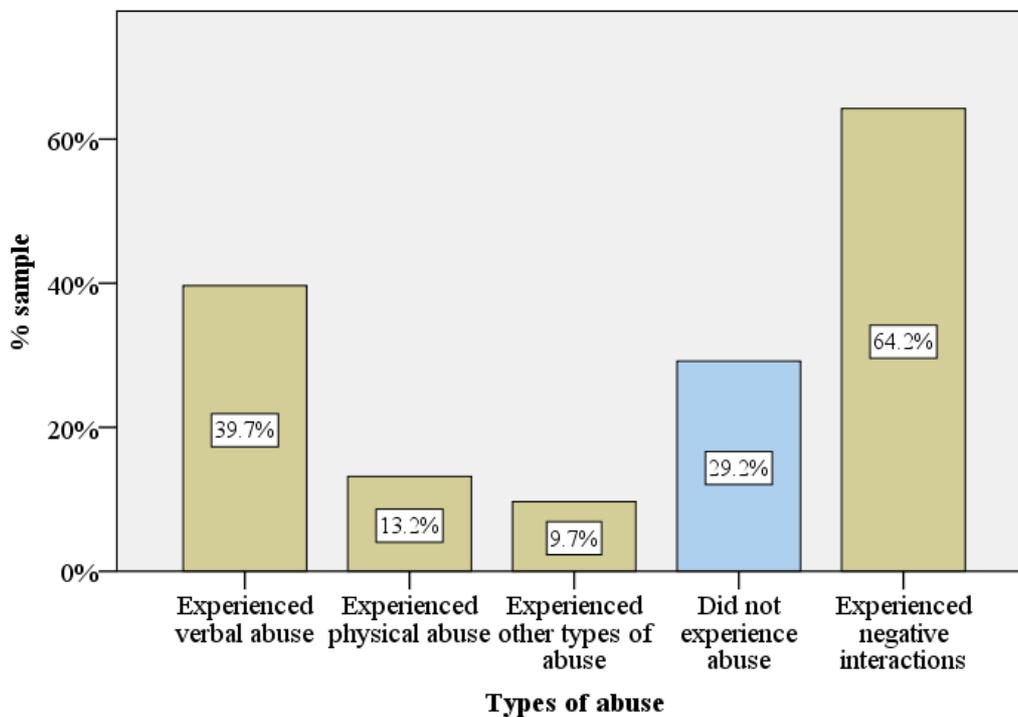
The majority (82.4%, n=435) of those that experienced abuse or negative interactions related to their gender identity or sexuality stated that it had occurred at school- almost double the proportion of any other location. This was followed by 'in a public place' (44.7%, n=236), 'on the internet' (42%, n=222), 'at home' (31.3%, n=165), 'at a social occasion' (27.5%, n=145), 'at work' (10.2%, n=54), 'at a religious place or event' (8.7%, n=46) and 'other' (3.8%, n=20) (see Figure 4).

Figure 4: Locations where participants experienced abuse



Participants were also asked about their experiences of different types of abuse related to sexual orientation and gender identity when they were self-harming or feeling suicidal (Figure 5). In total, almost 40% (39.7%, n=295) of all participants had experienced verbal abuse related to their sexual orientation/ gender identity, while 13.2% (n=98) had experienced physical abuse.

Figure 5: Experiences of types of abuse related to sexual orientation and gender identity



There were some differences between sexual orientation groupings and the types of abuse that participants encountered. Gay participants were the sexual identity group that reported the most

physical and verbal abuse that related to their sexual orientation/ gender identity. Over half (54.8%, n=68) of gay participants experienced verbal abuse related to their sexual orientation/ gender identity and 22.6% (n=28) had experienced physical abuse. Bisexual participants were the group with the lowest proportion of those that responded that they had experienced both verbal (31.2%, n=59) and physical violence (4.2%, n=8). Overall, some groups were more likely to experience abuse or negative interactions (in any form) than others (Table 8).

Table 6: Associations and odds (95%CI) ratios between abuse about sexual orientation/ gender identity and disability, gender identity, sexual orientation, suicidality and self-harm.

	<i>Experience of abuse</i>				χ^2	<i>p</i>	OR	CI (95%)	
	Did not experience abuse		Did experience abuse					Lower	Upper
	<i>n</i>	%*	<i>n</i>	%*					
<i>Disability, chronic illness or impairment</i>					16.81	<0.001	2.35	1.55	3.55
Yes	184	33.2	371	66.8					
No	33	17.5	156	82.5					
<i>Gender identity (5 cat)</i>					29.86	<0.001			
Cis male	49	30.6	111	69.4					
Cis female	94	37.6	156	62.4					
Trans male	15	14.9	86	85.1					
Trans female	26	40	39	60					
Other	33	19.6	39	80.4					
<i>Gender identity (2 cat)</i>					12.576	<0.001	1.81	1.3	2.53
Cisgender	146	34.3	280	65.7					
Transgender	71	22.3	247	77.7					
<i>Sexual Orientation</i>					14.15	0.007			
Lesbian	23	24.7	70	75.3					
Gay	25	20.2	99	79.8					
Bisexual	72	38.1	117	61.9					
Queer or Pansexual	52	26.4	145	73.6					
Other	44	31.4	96	68.6					
<i>Suicidality</i>					7.27	0.007	1.55	1.13	2.13
Has not planned or attempted suicide	106	34.5	201	65.5					
Has planned or attempted suicide	111	25.4	326	74.6					
<i>Self-harm</i>					3.65	0.56			
Has not self-harmed	32	38.1	52	61.9					
Has self-harmed	185	28	527	72					

* percentage values indicate the percentage of the sample that selected the response choice in question

Table 8 shows that participants who were trans/unsure (in particular, trans males) or disabled were significantly more likely to experience abuse related to their sexual orientation/ gender identity than those who were not. Trans/unsure participants were 1.81 times more likely to experience abuse than cisgender participants, while those with a disability were 2.35 times more likely. Bisexual participants were least likely to experience abuse, and gay participants most likely, of the sexual orientation groupings.

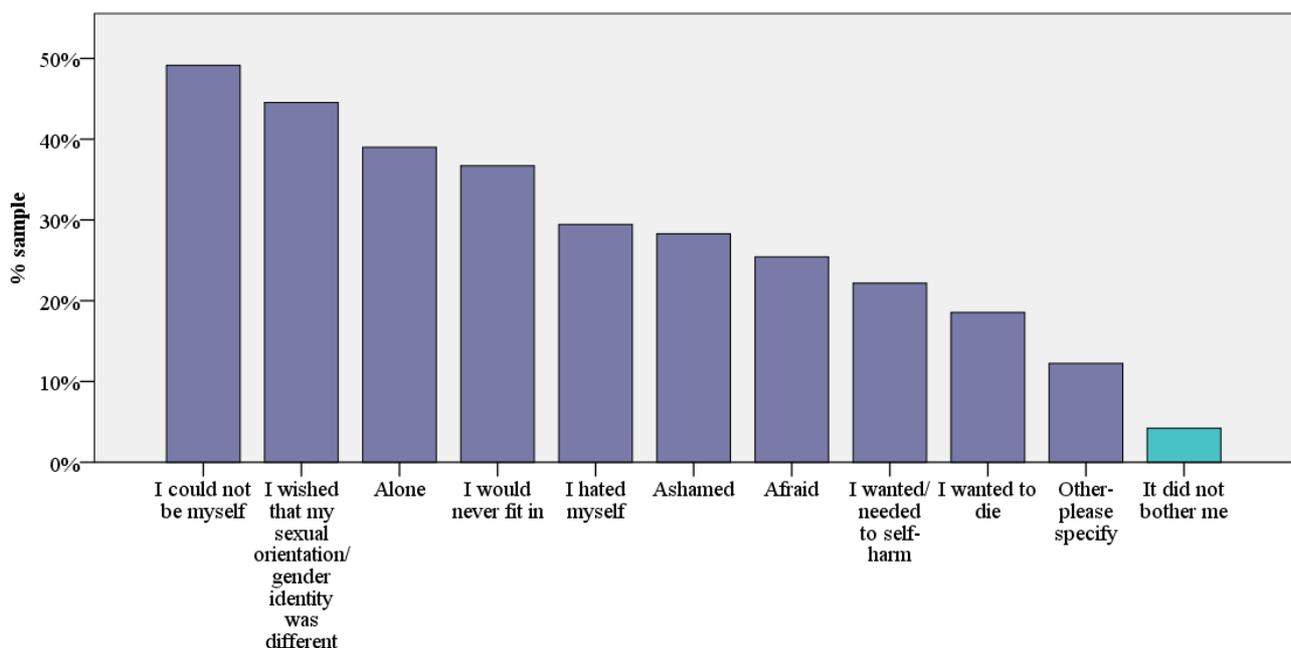
There was also a significant relationship between abuse about sexual orientation/ gender identity and suicidality. Those who experienced abuse or negative interactions related to their sexual

orientation/ gender identity were 1.55 times more likely to plan or attempt suicide than those who had not.

How abuse made participants feel

Figure 6 represents participant responses about how this abuse made them feel. Only 4.2% (n=22) of participants indicated that the negative interactions or abuse that they experienced ‘did not bother’ them. When explaining how abuse made participants feel, the most selected responses were: ‘I could not be myself’ (49.1%, n=257) and ‘I wished that my sexual orientation/ gender identity was different’ (44.6%, n=233). Responses of feeling ‘alone’ (39%, n=204) and that they would ‘never fit in’ (36.7%, n=192) indicated that young people felt excluded and isolated by abuse related to their sexual orientation/ gender identity. 22.2% (n=116) of participants felt that abuse about their sexual orientation/ gender identity made them want or need to self-harm, while 18.5% (n=97) responded that this abuse made them want to die.

Figure 6: Participants’ responses to ‘how did this abuse make you feel?’



Participants were then asked how much this abuse affected their self-harm and suicidal feelings. There were some differences between gender identity and sexual orientation and how much abuse relating to sexual orientation/ gender identity affected participants’ self-harm and suicidal feelings.

- Trans/unsure participants were significantly more likely to indicate that abuse due to their sexual orientation/ gender identity affected their self-harm and suicidal feelings ($\chi^2=19.415$, $df=4$, $p < 0.001$).
- Trans males were most likely to select that abuse about sexual orientation and gender identity strongly affected their self-harm and suicidal feelings, with 40.6% (n=39) of them selecting that it either ‘completely’ or ‘very much’ affected their self-harm and suicidal feelings. This was followed by ‘other’ gender identities (31.7%, n=52), cis males (26.5%, n=40), trans females (24.6%, n=15) and cisgender females (13.3%, n=32) ($\chi^2=37.651$, $df=8$, $p < 0.001$).

- Bisexual participants were significantly more likely to report that abuse about their sexual orientation/ gender identity did not affect their self-harm and suicidal feelings ($\chi^2=29.309$, $df=8$, $p < 0.001$).
- Participants who reported feeling affected by abuse related to their sexual orientation/ gender identity were 2.18 times more likely to plan or attempt suicide than those unaffected (OR 2.18, 95% CI: 1.61–2.95, $p < 0.001$).

4.3 Sexual and gender norms

While homophobia, biphobia or transphobia accounted for some of the emotional distress that participants experienced, some participants had not suffered abuse (29.2%) but had still self-harmed or felt suicidal. Results suggest that an additional influence on participants' mental health were the sexual and gender norms (that presume everyone is heterosexual and cisgender) that operated alongside homophobia, biphobia and transphobia. Data analysis of qualitative interviews indicated that participants were made to feel that something was wrong with them, without being told or abused directly. Many found the marginalisation and silence about their sexual orientation and gender identity upsetting and distressing and this contributed to their self-harming and/or suicidal feelings. For example, Matthew (below) reflected:

It's distressing when it [realization of sexuality/ gender identity] first starts happening because obviously you want to deny it because, no matter how much everyone says it's okay, part of you is always going to think: But it's a minority, therefore it's not as normal, and all this negative stuff could happen to me...
Matthew (17, unsure gender and sexuality, White British)

Both Farouk and Clem spoke about how they were aware that their sexuality was different from heterosexual norms, and that they felt this 'abnormality' was wrong, leading to feelings of isolation and self-harming.

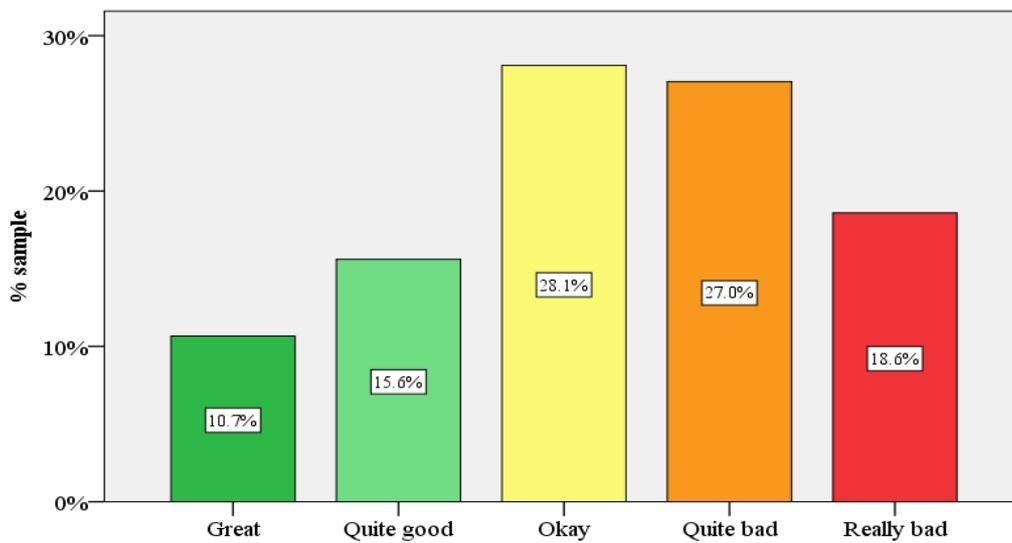
When I was at school...I had difficulty accepting my sexuality...I was seen as different...I felt very lonely, isolated, and I would lock myself inside the room, go home and start self-harming when I was young because I used to feel that...what I am is wrong and what am I doing in life. All of these feelings I have are putting guilt and pressure on top of me because my community and all my friends at the time because they were mainly Asians as well and they thought...choosing to be gay is completely wrong
Farouk (24, gay, cis male, British Asian)

I kind of used to self-harm all the time, like constantly. And I think part of that would be the fact that I was stressed about like realising I wasn't straight and not being able to talk to anyone about that and feeling kind of wrong about that, feeling wrong that I wasn't coming out because I feel like I should have been. And... but I think that was just a part of it and there was lots of stuff like tied up to kind of body image and self-esteem and just generally feeling like... like... I just basically felt like I was kind of a failure
Clem (18, bisexual, cis female, White British)

The youth questionnaire asked participants to rate their feelings about their sexual orientation/ gender identity during the times that they were self-harming or felt suicidal. The most selected response was 'okay' (28.1%, $n=216$) (Figure 7). Almost half (45.6%, $n=351$) of the participants felt negative ('quite bad' or 'really bad') about their sexual or gender identity, compared to a lower proportion (26.3%, $n=202$) that felt positive ('quite good' or 'great') about their sexual orientation/

gender identity. However, over half of the participants (54.4%, n=418) either felt ‘okay’ or positive about their sexual orientation/ gender identity.

Figure 7: Feelings about sexual orientation/ gender identity when self-harming or having suicidal feelings

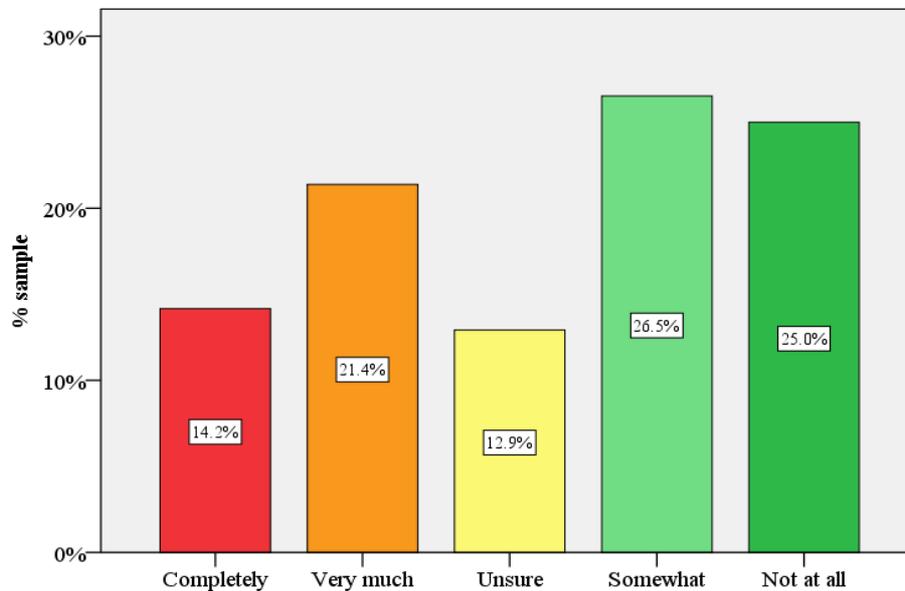


There were differences between how participants felt about their sexual orientation/ gender identity during the periods when they were self-harming or suicidal:

- Trans/ unsure participants were significantly more likely to feel negative about their sexual orientation/ gender identity than cisgender participants ($\chi^2=31.965$, $df=2$, $p <0.001$).
- Compared to other sexual identity groupings, bisexuals were significantly less likely ($\chi^2=48.112$, $df=8$, $p <0.001$) to feel negative about their sexual orientation/ gender identity.
- Participants who had planned or attempted suicide were more likely to feel negative about their sexual orientation/gender identity than those who had not ($\chi^2=8.272$, $df=2$, $p <0.05$).
- Those who experienced abuse were more likely to feel negative about their sexual orientation/ gender identity ($\chi^2=14.436$, $df=2$, $p <0.001$)

Participants were also asked directly about how their sexual orientation and gender identity affected their self-harm and suicide (Figure 8). Although sexual orientation and gender identity was selected by 35.6% (n=256) of participants as ‘completely’ or ‘very much’ influencing their self-harm and suicidal feelings, 25% (n=180) of participants responded that it did not affect their self-harm and suicidal feelings at all.

Figure 8: Effect of sexual orientation/ gender identity on self-harm and suicidal feelings



There were some significant differences in participant responses to this question:

- Compared to cisgender participants, trans/ unsure participants were significantly more likely to indicate that their sexual orientation /gender identity influenced their self-harm and suicidal feelings ($\chi^2=43.559$, $df=2$, $p <0.001$).
- Cisgender females were significantly less likely to indicate that their sexual orientation and gender identity ‘strongly’ affected their self-harm and suicidal feelings than other gender identity groupings ($\chi^2=99.601$, $df=8$, $p <0.001$).
- Bisexual participants were the least likely of all sexual orientation groupings to indicate that their self-harm and suicidal feelings were ‘strongly’ affected by sexual orientation or gender identity. They were also the most likely to say their self-harm/suicide was not affected at all by their sexual orientation and gender identity ($\chi^2=27.092$, $df=8$, $p <0.001$).
- Those that felt that their sexual orientation and gender identity ‘strongly’ affected their self-harm and suicidal feelings were significantly more likely to plan or attempt suicide than those who were unsure or were not affected by their sexual orientation and gender identity ($\chi^2=7.944$, $df=2$, $p <0.05$).

4.4 Managing sexual orientation and gender identity across multiple life domains

Those interviewed for the study gave complex accounts of the ways they ‘managed’ their sexual orientation and gender identity in different areas of their life. This often meant making decisions about whether to disguise or hide their sexual orientation or gender identity in different contexts, to a variety of people. Qualitative data analysis indicated that these strategies required significant emotional and cognitive work that could be distressing and anxiety provoking. George and Abdul each referred to this work:

I think I'd taken up a bit of a sort of challenge of trying to act normal all the time and obviously no-one can sort of, erm, choose to act completely different and act that way 100 per cent of the time, so it still sort of came through [...] and I think I wanted so hard, or tried so hard to sort of not do that, and that was quite distressing that I had to put so much effort in to fit in, I suppose.

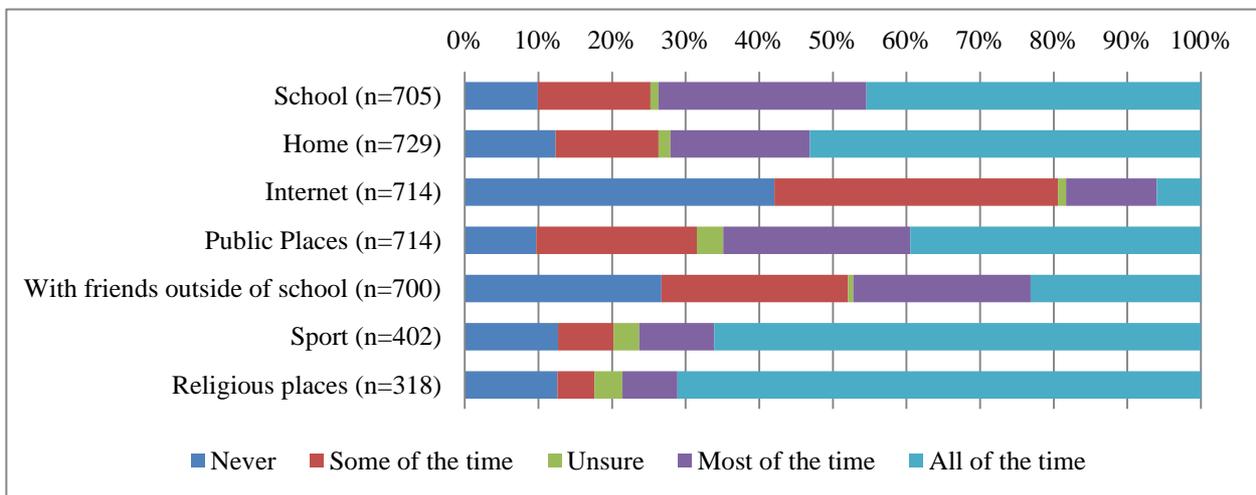
George (19, pansexual, cis male, White British)

When I was in first and second year of uni I used to wear a rainbow wristband and it always had to come off just before I got onto the train [...]; that became an unfortunate ritual of going back home.

Abdul (21, bisexual, cis male, British-Pakistani)

In the youth questionnaire participants were asked, “Thinking about times when you have self-harmed/ had suicidal feelings, how often did you hide your sexual orientation and gender identity from others in these places?” (see Figure 9 below). In total, ‘never’ was selected only 18.8% of the time. The remaining 81.2% of participants’ had hidden their sexual orientation/gender identity to some degree. The internet was the only place where the majority of participants (80.5%, n=575) responded that they ‘never’ or only ‘some of the time’ had to hide their sexual orientation/ gender identity. The only other place where participants were more likely to share their sexual orientation/ gender identity was with friends outside of school (52%, n=364), but even at this site, 47.2% (n=331) of participants responded that they had to hide their identity either most or all of the time.

Figure 9: Location and extent of participants' hiding their sexual orientation and/or gender identity



The places where the highest proportions of young people were hiding their sexual orientation/ gender identity most or all of the time were religious places (78.6% of 318 respondents, n=250); sport (76.4% of 402 respondents, n=307); school (73.6% of 705 respondents, n=519); home (72% of 729 respondents, n=525); and public places (64.9% of 714 respondents, n=463). 53.1% (n=387) of all participants never disclosed their sexual orientation/ gender identity in their home environments. Further analysis indicated that compared to trans/ unsure participants, cisgender participants were significantly more likely to hide their sexual orientation at home ‘all of the time’ ($\chi^2=49.609$, $df=4$, $p <0.001$). Trans or unsure participants were less likely than cisgender participants to ‘never’ hide their sexual orientation/ gender identity when at school ($\chi^2=9.561$, $df=4$, $p <0.05$).

Table 9 (below) shows that some groups of participants found hiding their gender identity or sexual orientation more distressing than others. While the majority (83.4%, n=600) of participants found hiding their sexual orientation/ gender identity distressing, trans/ unsure participants were 3.63 times more likely to feel distressed about hiding their sexual orientation/ gender identity than cisgender participants. In terms of sexual orientation, bisexual participants were less likely than all

other sexuality groups to find hiding their sexual orientation/ gender identity distressing. Those who were distressed by hiding their sexual orientation were 1.72 times more likely to self-harm.

Questionnaire participants were then asked to rate how much hiding their sexual orientation/ gender identity affected their self-harm and suicidal feelings (Table 9). Trans/unsure participants were more affected than cisgender participants. Trans females were most likely to indicate that keeping their sexual orientation/ gender identity a secret 'strongly' affected their self-harm and suicidal feelings, followed by trans males, 'other' gender identities, cisgender males and cisgender females. Compared to other sexual identity groupings, bisexual participants were most likely to feel that hiding their sexual orientation/ gender identity 'did not affect' their self-harm and suicidal feelings.

Participants who reported that keeping their sexual orientation/ gender identity a secret 'strongly' affected their self-harm and suicidal feelings were significantly more likely to attempt or plan suicide than those who were unaffected.

Table 7: Associations and odds (95%CI) ratios between distress caused by hiding sexual orientation/ gender identity and effect of keeping sexual orientation/ gender identity a secret with other variables.

	<i>Distress caused by hiding sexual orientation/ gender identity</i>				χ^2	OR	CI (95%)		<i>Effect of keeping sexual orientation/ gender identity a secret on self-harm/ suicidal feelings</i>						χ^2	
	Not distressing		Distressing				Lower	Upper	Strongly affected		Unsure or slightly affected		Did not affect			
	<i>n</i>	%	<i>n</i>	%					<i>n</i>	%	<i>n</i>	%	<i>n</i>	%		
<i>Disability, chronic illness or impairment</i>					0.69									3.63		
No	92	12.8	442	61.5					213	29.6	193	26.8	133	18.5		
Yes	27	3.8	158	22					78	10.8	70	9.7	32	4.5		
<i>Gender identity (5 cat)</i>					40.05***										81.54***	
Cis male	33	4.6	118	16.4					58	8.1	51	7.1	44	6.1		
Cis female	59	8.2	182	25.3					59	8.2	108	15	74	10.3		
Trans male	0	0	96	13.4					59	8.2	29	4	9	1.3		
Trans female	3	0.4	60	8.3					47	6.5	9	1.3	6	0.8		
Other	24	3.3	144	20					68	9.5	66	9.2	32	4.5		
<i>Gender identity (2 cat)</i>					30.97***	3.63	2.26	5.84								42.31***
Cisgender	95	13.2	313	43.5					125	17.4	165	22.9	119	16.6		
Transgender	24	3.3	287	39.9					166	23.1	98	13.6	46	6.4		
<i>Sexual Orientation</i>					18.91***										18.71*	
Lesbian	9	1.3	82	11.4					42	5.8	34	4.7	13	1.8		
Gay	16	1.8	104	14.5					55	7.7	44	6.1	18	2.5		
Bisexual	48	6.7	134	18.6					61	8.5	66	9.2	58	8.1		
Queer or Pansexual	30	4.2	164	22.8					71	9.9	71	9.9	48	6.7		
Other	19	2.6	116	16.1					62	8.6	48	6.7	27	3.8		
<i>Suicidality</i>					1.76										10.92**	
Has not planned or attempted suicide	56	7.8	243	33.8					100	13.9	122	17	78	10.8		
Has planned or attempted suicide	63	8.8	357	49.7					191	26.6	141	19.6	87	12.1		
<i>Self-harm</i>					3.87*	1.72	0.99	2.98								4.85
Has not self-harmed	20	2.8	63	8.8					26	3.6	30	4.2	26	3.6		
Has self-harmed	99	13.8	537	74.7					265	36.9	233	32.4	165	19.3		

Bold values indicate statistical significance. *p < 0.05; **p < 0.01; ***p < 0.001.

4.5 Being unable to talk

The interviewees in the study frequently described the difficulties they had talking about their distress, emotions, self-harming, suicidal feelings, sexual orientation and/or gender. In the quotations below, Luce and Leigh articulate clearly the impact of not being able to talk about their emotions:

I did not talk to anyone [about] it nor did I try to get help. I did not want to feel like I was weak by talking because to everyone else I was appearing so strong and independent and together, however I was actually feeling the complete opposite.

Luce (24, gay, cis female, White British)

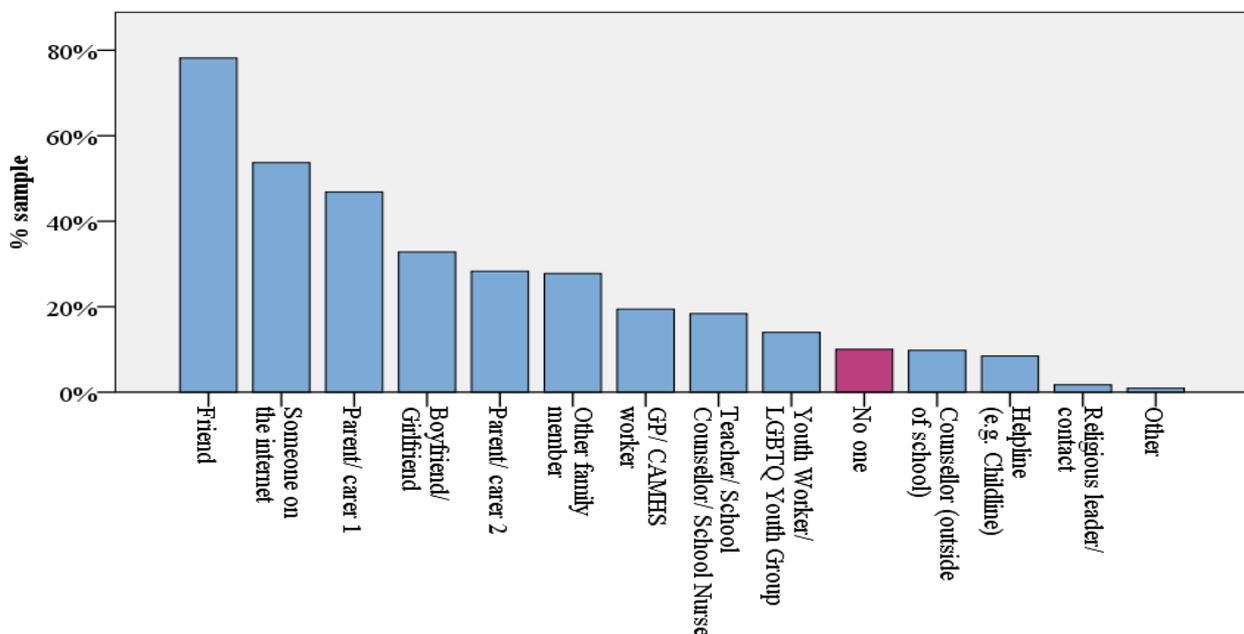
...no one knew about it and I didn't want anybody to find out, I was cutting on my thighs so no one could find out. I felt completely isolated from everyone during this time in my life, I thought that if they found out how I was feeling, and how I was coping they would start to treat me differently and not want to be involved at all.

Leigh (17, pansexual, trans male, White British)

The interview analysis suggested that young people found it particularly problematic to talk about their sexuality and gender to others, and this was distressing to them. In the questionnaire, 10.1% (n=76) of the sample indicated that they had not told anyone about their sexual orientation/ gender identity when they were self-harming and/or feeling suicidal (Figure 10). The most common place/person to tell about sexual orientation and gender identity was ‘friend’ (78.2%, n=591), followed by ‘someone on the internet’ (53.7%, n=406), ‘parent/carer 1’ (46.8%, n=354), boyfriend/ girlfriend (32.8%, 248), parent/carer 2 (28.3%, n=214) and other family member (27.8%, n=210).

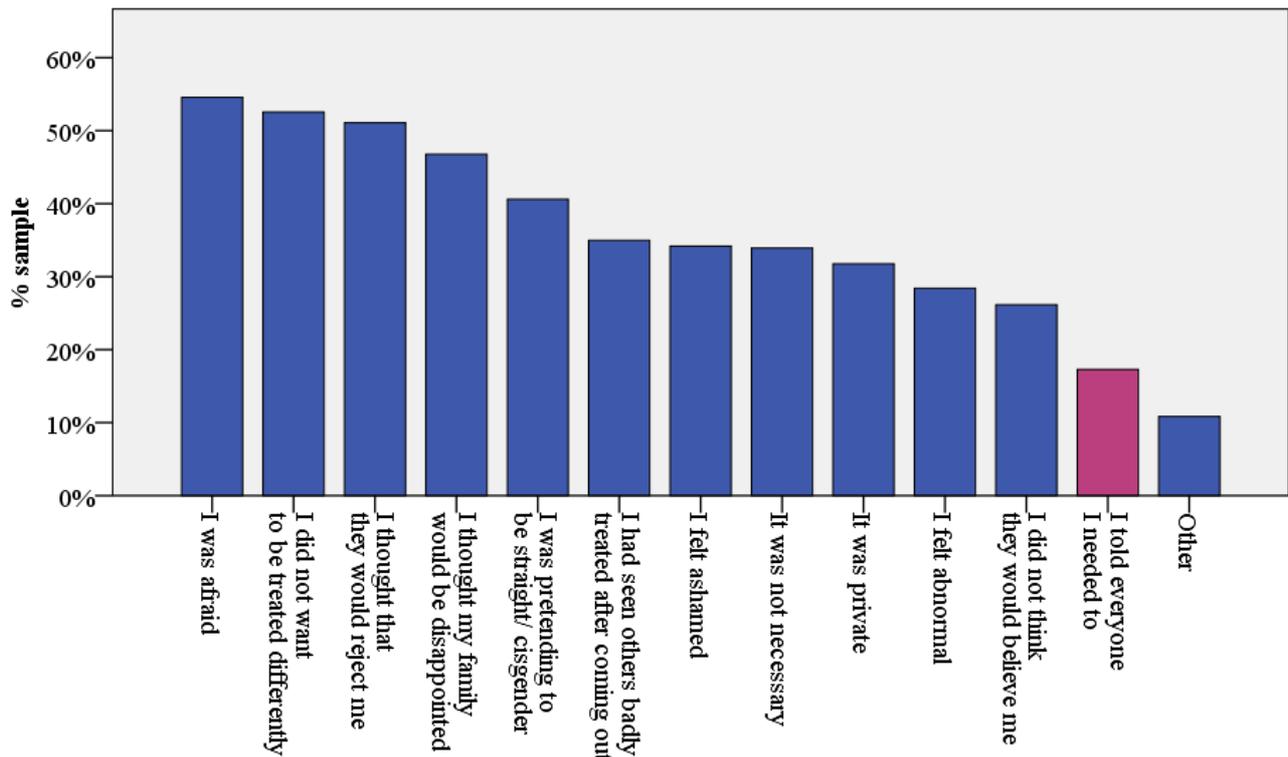
The most frequent ‘formal’ person/ place that participants told about their sexual orientation and gender identity was GP/ CAMHS worker (19.4%, n=147). This was followed by teacher/ school counsellor/ school nurse (18.4%, n=139), youth worker/ LGBT youth group (14.0%, n=106), counsellor (outside of school) (9.8%, n=74) and helpline (8.5%, n=64). Very few participants had told religious contacts (1.7%, n=13) or ‘other’ people (0.9%, n=7).

Figure 10: 'Who did you tell about your sexual orientation/ gender identity?'



Participants were then asked why they did not tell some people about their sexual orientation/ gender identity. Only 17.3% (n=129) of participants responded that they told everyone that they needed to about their sexuality and gender, suggesting that 82.3% (n=617) of participants had a reason to conceal their sexual orientation/ gender identity at some point (Figure 11). ‘Being afraid’, ‘expecting rejection’ or ‘different treatment’ due to disclosing sexual orientation/ gender identity were the top three reasons that participants chose for not disclosing their sexual orientation/ gender identity. Over half of the participants chose each of these options. Importantly, 40.6% (n=303) of respondents reported that when they were self-harming or having suicidal feelings they were pretending to be straight/cisgender, which prevented them from telling some people about their sexual orientation/ gender identity (Figure 11).

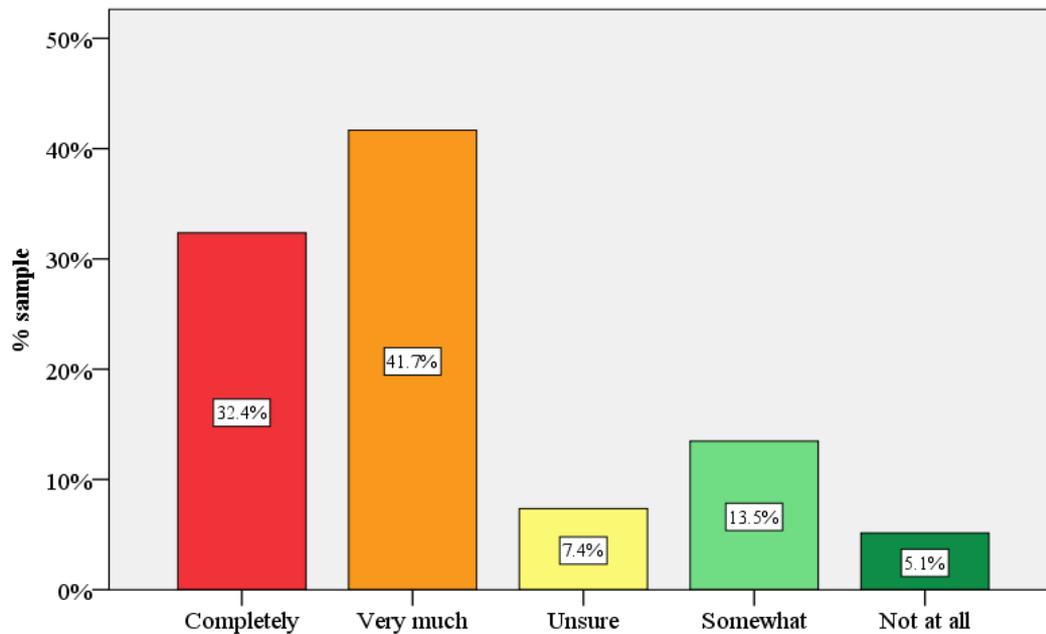
Figure 11: 'Why did you not tell some people about your sexual orientation/ gender identity?'



Participants were asked how much ‘Not being about to talk about my feelings and emotions’ influenced their self-harm and suicidal feelings. Figure 12 below demonstrates that almost three quarters (74.1%, n=533) of participants indicated that not being able to talk about their feelings and emotions influenced their self-harm and suicidal feelings either ‘completely’ or ‘very much’.

Participants who felt more affected by not being able to talk about their feelings and emotions had significantly higher rates of self-harm than those participants who felt less affected ($\chi^2=20.047$, $df=2$, $p < 0.001$). Additionally, those who planned or attempted suicide were more likely to indicate that their self-harm and suicidal feelings were strongly affected by not being able to talk about feelings or emotions ($\chi^2=12.798$, $df=2$, $p < 0.01$).

Figure 12: 'How much did not being able to talk about your feelings and emotions affect your self-harm and suicidal feelings?'



4.6 Other life crises

Analysis of qualitative data indicated that there was a range of factors unrelated to sexual orientation and gender identity that impacted on participants' emotional distress, self-harm and suicidal feelings. These included financial demands, bereavement, academic pressures, friendship or relationship problems, physical or mental health problems and experiences of violence/abuse including previous physical and sexual assaults. These incidents and environments complicated the young people's management of their sexual orientation and gender identity, creating additional strain. For example, Evie describes below the complications of having mental health problems, the death of her mother and financial constraints:

I hallucinate in the house when I get in states, I hear things, I can't go out, I've always got to rely on my dad for things. And like... there's money problems at home where, when my mam died, all the money went. When I left school, we lost the child benefit and the tax credit, so it's just my dad's pension we live off, and by the time he does the rent, the gas, the light, the essentials, that's £200 a fortnight, £400 a month, there's hardly enough money to even get food. [...] I can't do public transport, he can't afford the payments, and if that car goes I can't see any way of getting out and I feel like a prisoner in that house.
Evie (17, straight, trans female, White British)

Claire experienced trauma and distress in her home environment due to an abusive parent, causing her to have to leave the family home.

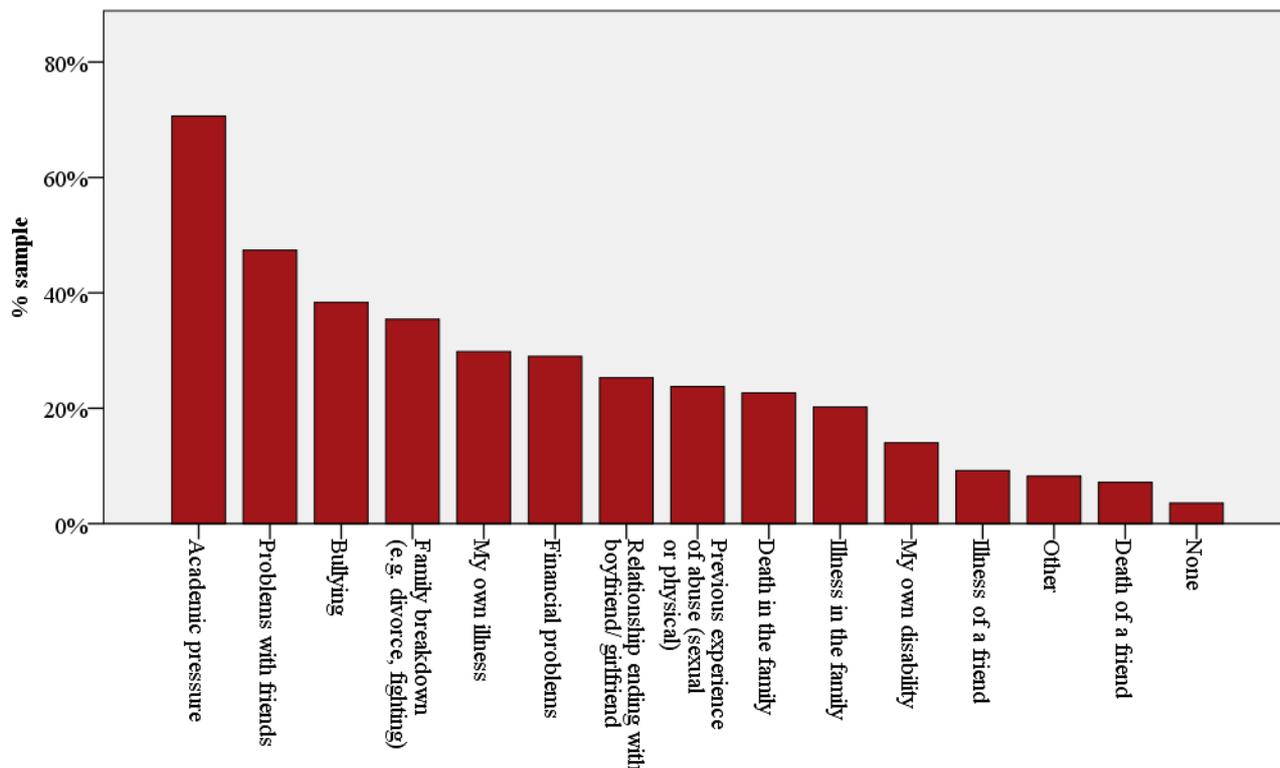
Claire: I had quite an abusive childhood so... from my father's point of view... erm... he was like every kind of -ist you can think of... racist, prejudiced... all those kind of things, so I left home when I was 16, erm, to escape that situation. [...] I think most of... things that I struggle with probably stem from that situation.
I: Mm.
Claire: And being in a relationship with a woman's just, you know, an added bonus for my easy life. (laughs)
I: How did it come to the point where you left?

Claire: Erm... well, there was a situation where I felt like my life was threatened and I just left in the middle of the night, so I just kind of waited till everyone was asleep and disappeared.

Claire (20, pansexual, cis female, White British)

In the youth questionnaire participants were asked about the other factors that contributed to their distress when they were self-harming and/or had suicidal feelings.

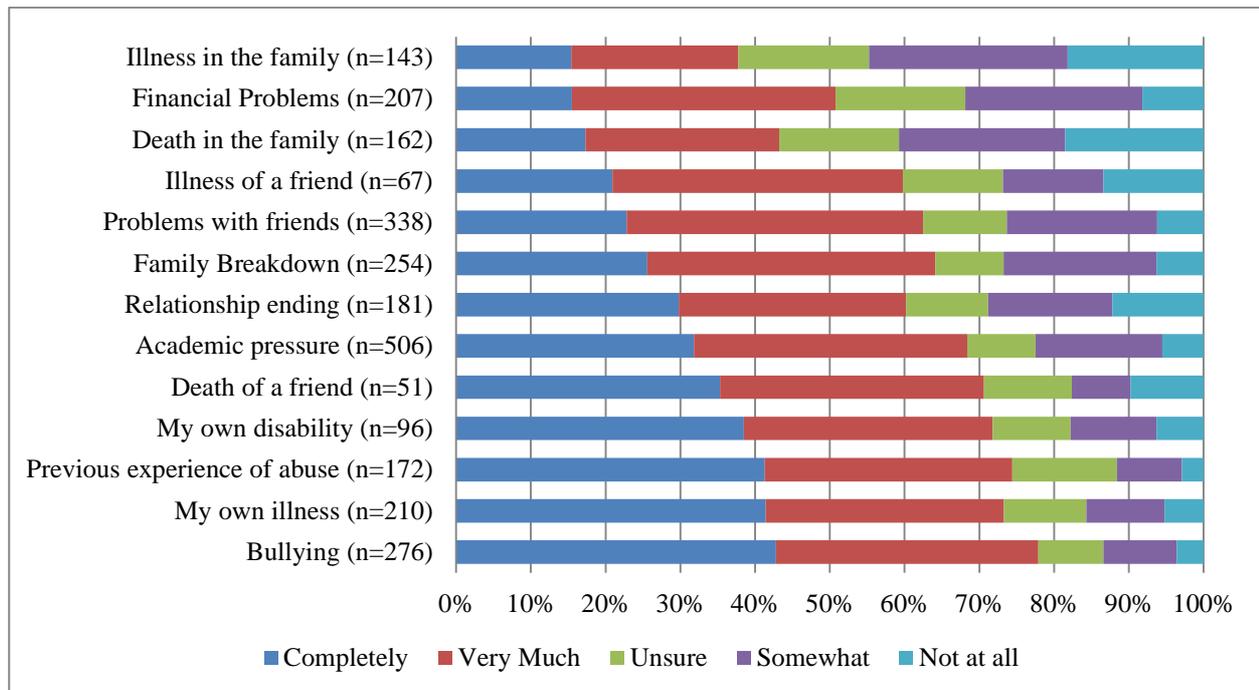
Figure 13: Other reasons for distress



There was an average of 3.85 additional reasons for distress indicated by each participant. The most common was academic pressure, selected by 70.6% (n=514) of respondents. This was followed by problems with friends (47.4%, n=345), bullying (38.3%, n=279), family breakdown (35.4%, n=258), participant illness (29.8%, n=217), financial problems (29%, n=211) and romantic relationships ending (25.3%, n=184). Previous experiences of abuse were experienced by almost a quarter of participants (23.8%, n=173). Only 26 participants (3.6%) ticked the ‘none’ option.

These findings suggest that emotional distress for most LGBT young people in the sample is multi-faceted. Participants were asked to rate how much the additional reasons for distress influenced their self-harm and suicidal feelings (Figure 14). The factors that had the highest proportion of participants indicating that their self-harm and suicidal feelings were completely or very much influenced by them were ‘bullying’ (77.9%, n=215) ‘previous experience of abuse’ (74.4%, n=128), ‘my own illness’ (73.3%, n=154), ‘my own disability’ (71.8%, n=69) and ‘death of a friend’ (70.6%, n=36).

Figure 14: Other reasons for distress: Level of influence on participants' self-harm and suicidal feelings



4.7 The relationship between self-harm and suicidality

Previous research has demonstrated that self-harm is a risk factor for youth suicide, but there is also evidence that self-harm is a coping mechanism for young people (Hawton et al., 2006). The interviews with LGBT youth confirmed that the relationship between suicide and self-harm is complex and not straightforward. Some participants believed that these two outcomes were linked, others did not, and others were uncertain, or believed that the relationship was dynamic- sometimes linked or unlinked. For example, both Anthony and Leigh described how self-harming could be a way of coping with intense emotions and believed that self-harm prevented suicide:

it really did help me and I'm not ashamed to say it. It was my coping mechanism through these difficult times, it allowed me to free myself; if temporarily, from the pain and emotions that was running through my head. I think without the ability to express this through the form of cutting I would be dead right now, if I'm to be fully honest.

Leigh (17, pansexual, trans male, White British)

*I think the self-harming stopped the suicidal thoughts for me because it was getting rid of the negative thoughts by the end of it, and I think that it was almost a way of **cop**ing without... I reckon if I **hadn't** self-harmed, it probably would have got worse...*

Anthony (16, gay, cis male, White British)

Other participants indicated that there was an emotional difference between when they self-harmed and when they felt suicidal.

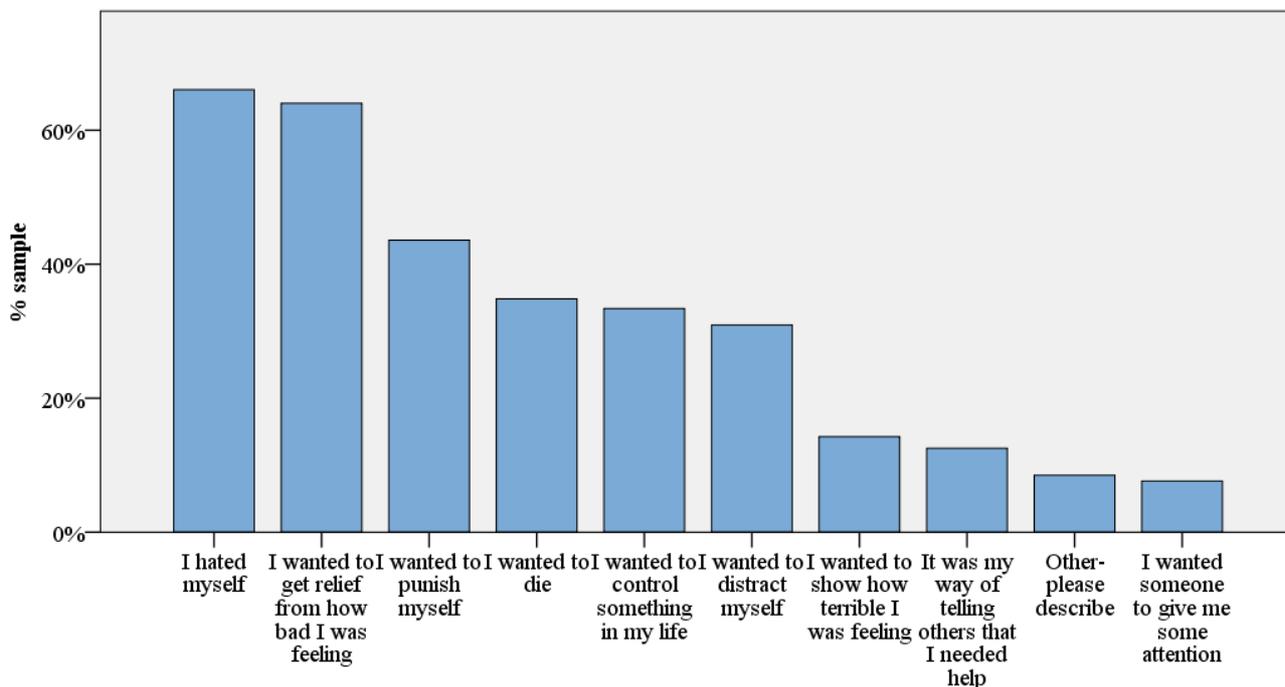
... when I was younger when I self-harmed was like anger, erm, towards myself, towards other people... whereas, when I had the thoughts of suicide, I didn't really feel like that. I think the feelings were just completely different. I think for me the suicide stuff was just... I felt I had nothing... I wanted to give up like... I had a succession (laughs) of shit things happen... Erm... and that was like well, why... what's the point anymore? Why bother? Whereas the self-harm... there was always something to look forward to...

Jeremy (24, gay, trans male, White British)

In order to explore this relationship further, participants in the questionnaire were asked about their own reasons for self-harming, and their own reasons for feeling suicidal, and then for their views on the link between self-harm and suicide.

When asked about the reasons for their own self-harm, participants were able to choose up to four options. Respondents to this question (n=695) chose a mean of 3.16 reasons for their self-harm. The most selected responses were ‘I hated myself’ (66%, n=459) and ‘I wanted to get relief from how bad I was feeling’ (64%, n=445). These were followed by ‘I wanted to punish myself’ (43.6%, n=303) and ‘I wanted to die’ (34.8%, n=242) (see Figure 15 below). One third of participants reflected that they wanted to ‘control something’ in their life, and a similar number wanted to distract themselves. The least selected response was ‘I wanted someone to give me some attention’ (7.6% of participants, n=53).

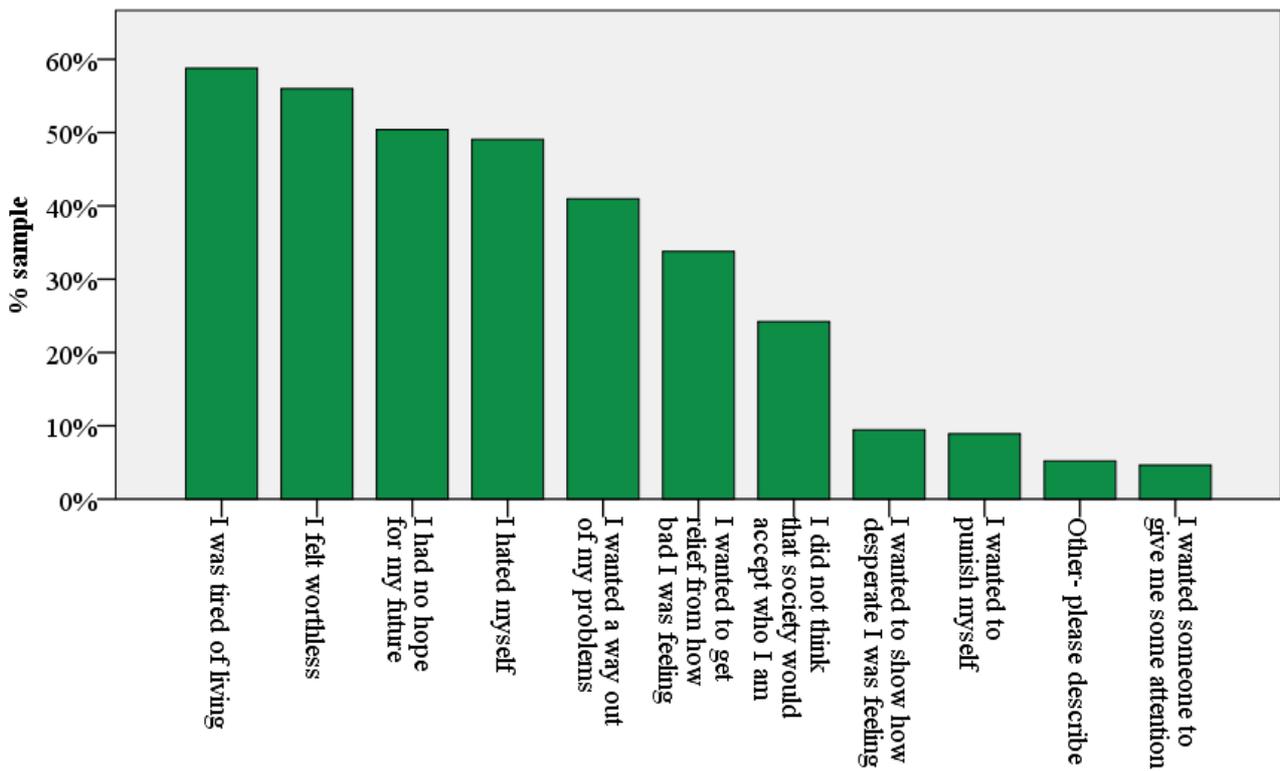
Figure 15: Reasons for self-harm



Only one third of those that had self-harmed (34.8%, n=242) indicated that they self-harmed because they ‘wanted to die’. Most respondents (65.2%, n= 453) did not associate their self-harm with wanting to end their life. Instead, responses suggest that there are multiple motivations and intentions behind self-harm.

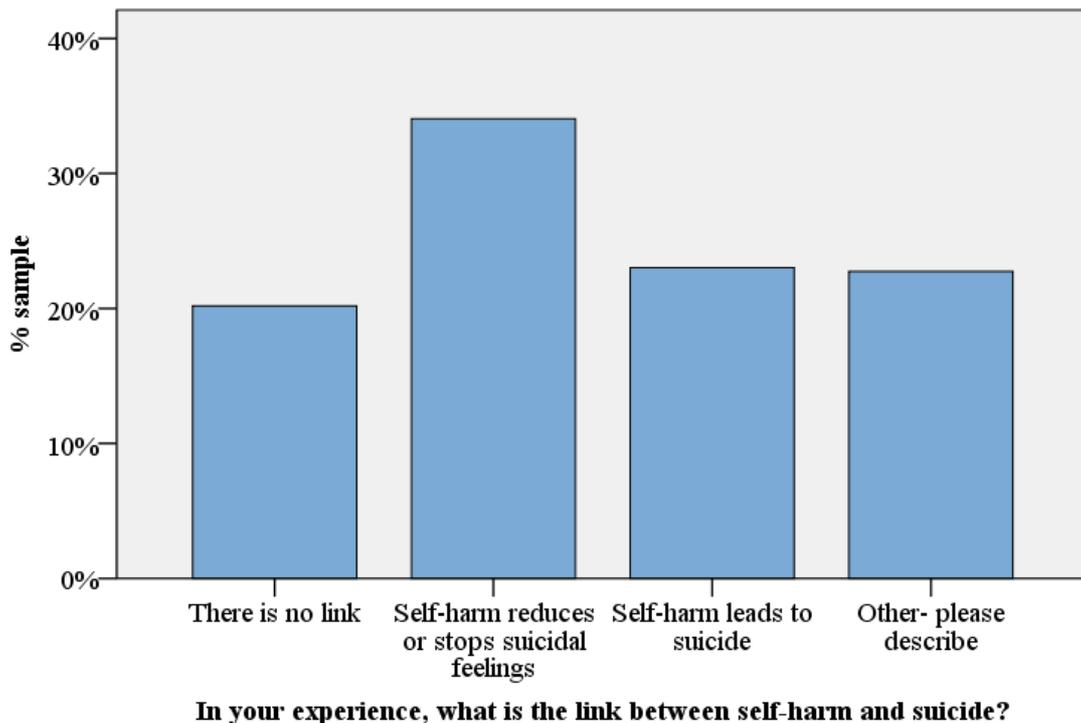
When asked about the reasons for suicidal feelings or attempts, participants were again able to choose up to four options. These responses are represented in Figure 16. Over half the respondents to this question (n=752) chose the top three options, ‘I was tired of living’ (58.8%, n=442), ‘I felt worthless’ (56%, n=421) and ‘I had no hope for my future’ (50.4%, n= 379). Almost half also chose ‘I hated myself’ (49.1%, n=369). The least selected option was ‘I wanted someone to give me some attention’ (4.7%, n=35).

Figure 16: Reasons for suicidal thoughts, plans or attempts



Responses to the direct question about the link between suicide and self-harm were fairly evenly distributed across all four response options (Figure 17). The most frequently chosen option was ‘self-harm reduces or stops suicidal feelings’, selected by just over one third of respondents (34.1%, n=253). The least chosen response was ‘there is no link’ (n=150, 20.2%). 23% (n=171) of participants chose ‘self-harm leads to suicide’ (n=171, 23%) and 22.7% (n=169) chose ‘other-please describe’.

Figure 17: Link/s between self-harm and suicide: Participant perspectives



The majority of participants provided written responses alongside their selections, these have been characterised into 4 themes in Table 10 below.

Table 8: Content analysis of participants' written responses on the link between suicide and self-harm

Theme	Description	Data
There is no link (n=45)	Respondents that chose this option gave varied open text responses that either rejected a connection between self-harm and suicide, or positioned the relationship as dynamic, unique and complex	<p><i>“Self harm was normally when I was frustrated or upset and suicidal feelings are more when I feel I have no future or all of life seems too much”</i></p> <p><i>“people can kill themselves with no previous history of self harm and people can self harm without wanting to kill themselves”.</i></p>
Self-harm reduces or stops suicidal feelings (n=100)	Text responses in this category largely described self-harm and suicide as being driven by distinctly different feelings and emotions. Self-harm was often described as a coping strategy for distressing situations or feelings, with the intention of continuing to live. Conversely, suicide was described as an ending action, to exit the world completely when things were irreparable or without hope	<p><i>“it's just a release once I've done it. I feel better. it's a coping mechanism a rubbish one but sometime the only one I have”</i></p> <p><i>“I have self-harmed in the past to try and exorcise suicidal feelings. I am not sure if it actually reduces or stops these feelings, but that was my thinking at the time ‘i can't kill myself but i have to do something”</i></p>
Self-harm leads to suicide (n=70)	Written responses within this category indicated that significant emotions, events or circumstances led to both self-harm and suicide. Self-harm was described as being a strategy that could only produce a certain amount of relief, and suicide may be the next possible option.	<p><i>“The more I self harmed the less it helped so another way to stop my pain was suicide”</i></p> <p><i>“I feel like the problems that lead to someone self-harming can lead to something more serious if those problems aren't dealt with initially.”</i></p>
Other (n=167)	The written responses for the ‘other’ category often described the difficulty of responding to the question and described how self-harm and suicidal feelings were experienced by different people in different ways.	<p><i>“The same root feelings can lead to both”</i></p> <p><i>“The link depends on the person, this is not the same for everyone”</i></p> <p><i>“Self-harm can be a release to get rid of suicidal feelings, but it can also get worse and worse until eventually the self-harmer takes it to the next level and tries to end their life. Every case is unique and different, and it very much depends on the circumstances.”</i></p>

4.7.1 Predicting suicidality

Further analysis aimed to explore the relationship between self-harm and suicide. Logistic regression was performed to assess the impact of self-harm and other significant variables on the likelihood that respondents would report that they had planned or attempted suicide. Eight variables were included in the model. Table 11 shows that five of the eight independent variables made a

unique statistically significant contribution to the model (self-harm, disability, gender identity, effect of abuse and effect of not talking). The strongest predictor of a suicide plan or attempt was self-harm, recording an odds ratio of 7.45. This indicated that respondents that had self-harmed were over seven times more likely to report that they had planned or attempted suicide than those who had not self-harmed, controlling for all other factors in the model.

Table 9: Logistic regression: Suicidality

	B	S.E.	Wald χ^2	<i>p</i>	Odds Ratio	95% C.I. for Odds Ratio	
						Lower	Upper
Self-harm	2.008	0.323	38.553	0.000	7.447	3.951	14.035
Disability	0.800	0.210	14.540	0.000	2.225	1.475	3.355
Gender Identity	0.403	0.176	5.231	0.022	1.497	1.059	2.115
Experience of abuse	-0.222	0.219	1.027	0.311	0.801	0.521	1.230
Effect of keeping sexual orientation/ gender identity secret on self-harm and suicidal feelings	-0.213	0.261	0.666	0.414	0.808	0.485	1.347
Effect of hiding sexual orientation/ gender identity on self-harm and suicidal feelings	-0.155	0.275	0.316	0.574	0.857	0.500	1.769
Effect of abuse about sexual orientation/ gender identity on self- harm and suicidal feelings	0.758	0.208	13.249	0.000	2.135	1.149	3.212
Effect of not talking about feelings and emotions on self-harm and suicidal feelings	0.887	0.440	4.062	0.044	2.428	1.025	5.752
Constant	-2.608	0.514	25.743	0.000	0.074		

Those participants who indicated they were effected by being unable to talk about emotions were nearly 2.5 times more likely to report they had attempted or planned suicide. Similarly, those who reported they were effected by homophobic, biphobic or transphobic abuse had double the odds of planning or attempting suicide. Those who were disabled were more than twice as likely to have planned or attempted suicide, and those who were trans/unsure were one and a half times more likely than cisgender participants to attempt or plan suicide.

The full model containing all predictors was statistically significant ($\chi^2=111.007$, $df=8$, $p<.001$), indicating that the model was able to distinguish between respondents who reported a suicide plan/attempt and those who did not. However, it is important to note that the independent variables used in this model offered a poor explanation of variability in suicide plans or attempts. The model as a whole explained between 14.9% (Cox and Snell R Square) and 20% (Nagelkerke R Square) of the variance in suicidality.

4.9 Key findings

Similar to other studies on youth suicide, self-harm increased the likelihood of planned or attempted suicide by sevenfold. Those having a disability, chronic illness or impairment were twice as likely to have planned or attempted suicide and almost three times as likely to self-harm. Gender identity was also a risk factor for self-harm and suicide. Those who were gender diverse (trans/unsure) were nearly twice as likely to have self-harmed and one and a half times more likely to have planned or attempted suicide than cisgender participants. Cisgender males were the least likely to plan or attempt suicide, or self-harm compared to other gender identities.

The results of the study suggest that explaining the relationship between sexual orientation and gender identity and youth self-harm and suicide is not straightforward. The study results found five interconnecting areas were crucial to explaining the elevated risk: homophobia, biphobia or transphobia; sexual and gender norms; managing sexual and gendered feelings across multiple life domains; being unable to talk; and other life crises.

- **Homophobia/biphobia/transphobia**

The majority (70.8%, n=527) of the sample had experienced direct abuse or negative interactions about their sexual or gender identity when they were self-harming or feeling suicidal. A great number of these incidents had occurred in schools but the participants experienced this hostility to sexual orientation and gender identity across a multitude of life domains (in public, the internet, leisure spaces, work, religious places). Those who experienced abuse were one and a half times more likely to plan or attempt suicide.

Gender diverse participants (trans/unsure) or those who were disabled were twice as likely to experience abuse related to their sexual orientation/ gender identity than those who were not. They were also more likely to indicate that the abuse influenced their self-harm and suicidal feelings. Bisexual participants were least likely to experience abuse compared to other sexual orientation groupings, and most likely to report that the experience of abuse did not affect their self-harm and suicidal feelings.

Those who reported they were affected by homophobic, biphobic or transphobic abuse had double the odds of planning or attempting suicide.

- **Sexual and gender norms**

While homophobia, biphobia or transphobia accounted for some of the emotional distress that the participants experienced, a further influence were sexual and gender norms that made many participants feel that something was wrong with them, without being told or abused directly.

Almost half the questionnaire participants felt negative about their sexual or gender identity during the time they were self-harming or felt suicidal; a far lower proportion felt positive about their sexual orientation or gender identity. Gender diverse participants were most likely to feel negative, and bisexual young people least likely to feel negative, about their sexual orientation and gender identity. Those who felt negative about their sexual and/or gender identity were more likely to have planned or attempted suicide.

Those who felt their sexual orientation and gender identity strongly impacted their self-harm and suicidal feelings were more likely to plan or attempt suicide. Again, gender diverse young people were most likely and bisexual participants least likely to indicate that their sexual orientation and gender identity influenced their self-harm and suicidal feelings.

- **Managing sexuality and gender identity across multiple life domains**

The study results suggest that having to make decisions about whether to disguise or hide their sexual orientation or gender identity in different contexts, to a variety of people, could impact negatively on young people's mental health. The majority of young people found hiding their sexuality and gender identity distressing. The places where they were hiding their identities least were the internet and with friends outside of school. The places with the highest proportions of

young people hiding their sexual orientation/gender identity were religious institutions, sport environments, school, home and public places.

Gender diverse participants were over three and a half times more likely to feel distressed about hiding their sexual orientation/gender identity compared to cisgender young people. Bisexual participants were significantly less distressed than other sexual identity groupings. Those who found hiding their sexual orientation and gender identity distressing were nearly two times more likely to self-harm.

Young people who reported that keeping their sexual orientation/ gender identity a secret strongly affected their self-harm and suicidal feelings were significantly more likely to attempt or plan suicide.

- **Being unable to talk**

The consequences of homophobia, biphobia and transphobia, being made to feel abnormal, and having to disguise their sexual and gender identities were that many participants felt isolated and unable to talk about their feelings and emotions, and this proved to be a significant influence on participants' self-harm and suicidal feelings.

Ten percent of the young people indicated they had not told anyone about their sexual orientation or gender identity, and only 17.1% had told everyone they needed to about their sexuality and gender. The people most often told were friends, family members and romantic partners. Participants most frequent reasons for concealing their identities were because they were afraid of being treated differently, rejection, and disappointing their family. Two fifths of respondents were pretending to be straight/cisgender, which prevented them from telling some people about their sexual orientation and/ or gender identity.

Almost three quarters of participants (74.1%, n=533) indicated that not being able to talk about their feelings and emotions (in relations to their mental health, sexuality and gender identity) strongly influenced their self-harm and suicidal feelings. Those young people who felt more affected by not being able to talk about their feelings and emotions had significantly higher rates of self-harm and were nearly two and a half times more likely to report they had attempted or planned suicide.

- **Other life crises**

Sexual orientation and gender identity was not necessarily always at the heart of LGBT youth self-harm and suicidality. One quarter of participants indicated that their self-harm and suicidal feelings were 'not at all' influenced by sexual orientation/ gender identity.

Participants experienced a range of other 'additional' reasons for distress that were unrelated to sexual orientation/ gender identity. The most common were academic pressure, problems with friends, bullying, family breakdown, participant illness, financial problems, romantic relationships ending, and previous experiences of abuse.

From these additional factors, participants indicated most often that bullying, previous experience of abuse, their own illness and disability, and death of a friend strongly influenced their self-harm and suicidal feelings.

- **The relationship between suicide and self-harm**

Self-harm was a clear risk factor for youth suicide in this study. However, young people's views on the relationship between their self-harm and suicidal feelings were multiple and complex. Just over one third of participants believed 'self-harm reduces or stops suicidal feelings' and fifth stated that 'there is no link' and 'self-harm leads to suicide'. There were also a significant proportion of participants who believed that different people experienced self-harm and suicidal feelings in different ways.

There were similarities and difference in responses to questions about the reasons for self-harm and the reasons for suicidal feelings and behaviours. The four most frequent reason for self-harm were 'I hated myself', 'I wanted to get relief from how bad I was feeling', 'I wanted to punish myself' and also 'I wanted to die'. The most frequent reason for suicidality were 'I was tired of living', 'I felt worthless', 'I had no hope for my future' but almost half also chose, similar to reasons for self-harm, 'I hated myself'. In both cases 'I wanted someone to give me some attention' was the least selected option.

Section 5: Results: LGBT youth help-seeking

This section details findings from both the qualitative interviews and the youth questionnaire to provide evidence on LGBT youth help-seeking for suicidal feelings and self-harm. This section addresses the research questions 3-5 and 7 and focuses on: i) motivations for help-seeking; ii) who and where LGBT youth seek help; iii) internet use; iv) experiences of help and support; v) preferred sources and mode of support.

5.1 Asking for help

In the interviews, participants spoke without exception about the difficulties they had asking for help. The often wanted assistance with their sexuality, gender and/or mental health, and these topics were inextricably linked. The analysis of the interview data suggested that part of the reason the participants found it problematic to access support, advice and assistance was due to three inter-related factors. Firstly, they were required to negotiate sexual orientation and gender norms that excluded and marginalised their own sexuality and gender identity. For example, in the quotations below Farouk explains how his parents' homophobia was a barrier to getting support, and Claire describes how fear of her parents' reactions to her disclosure as LGBT stopped her seeking help:

I think what caused me to speak to the doctor was, do you know, because my parents were always on about the fact that, do you know, being gay is wrong. That's how they saw it, that it was an illness or it was a disease, and I thought that treatment is available out there for it and I never thought that but it was almost like they were playing with my mind-set that I had no other option. And my parents, my dad was like: 'Yeah, speak to the doctor and he'll give you some medication and you'll get better.'

Farouk (24, gay, cis male, British Asian)

Claire: I think I saw a poster when I was kind of at high school but there's no like... for posters for LGBT groups, there's no address, you have to ring someone, so that put me off because I just didn't have the confidence to ring that number. So...

I: What stopped you?

*Claire: Erm, I don't know. I think it was just... I think it was just fear of the unknown kind of thing and... and obviously my parents wouldn't have approved of it so... I think it's difficult when you live at home to go to groups, LGBT groups, because you either have to **lie** if they don't know you're LGBT, erm, or... yeah, you either have to lie or come out, (laughing) one or the other.*

Claire (20, pansexual, cis female, White British)

The second reason the participants had problems accessing support and care was due to the stigma of having a mental health problem. Anthony and Jeremy recount their experiences:

I don't think I've wanted to do a formal thing because I've never wanted to be labelled. Like because I had such a big thing about being labelled as gay, I didn't want to be labelled as (laughing) the gay, depressed person.

Anthony (16, gay, cis male, White British)

*...it [self-harm] was never really talked about when I was at school that I can remember... and it was always frowned upon. And I was at school when the kind of emo-phase was around...so **that** was the link: if you were self-harming you were emo, and if you were emo you weren't a good person to get on with and you would be bullied. So I just... I... yeah, I just didn't talk to anyone.*

Jeremy (24, gay, trans male, White British)

The third factor accounting for the interviewees' reluctance to seek help was that they felt adults and wider society demeaned their emotions and did not take them seriously. They believe that their emotional distress was often characterised as attention seeking and adults blamed their problems on, for example, 'teen hormones'. In the quotations below Sean and Harry both suggest that they did not think their problems would be taken seriously:

Erm... I think I kind of felt like they might think that my problems weren't like valid enough to get help. Sounds kind of ridiculous now but like I think that's how I felt at the time.

Harry (17, trans male, pansexual, White British)

Like I don't want to be judged because my problems might not seem a big...and because it will just make me feel bad because I feel like I'm just doing it because of the smallest things, but it's not. And then the fact that they'd know that... what I was sad about, and they'd know the things I'd done, like they'd judge me just for doing it.

Sean (17, male-genderfluid, gay, White British)

Self-reliance, autonomy and being in control were also important reasons for not seeking help. Some interviewees did not ask for help because they felt that they were coping, that is, their self-harming was controlled, done safely and with minimum risk to their life. Others felt their low moods or even suicidal feelings happened infrequently or that they could cope alone, and if their feelings became unmanageable they would probably seek help. These findings resonate with Biddle et al.'s (2007) research that suggested young people looked for mental health support when they are at crisis point and they are no longer able to cope with their distress. Leigh and Luce explain in the following quotations the point at which they decided to ask for help:

I suppose the turning point for me is the realisation that I would die if I didn't decide to get better. I decided I didn't want to feel like this for the rest of my life and wanted to achieve something in life.

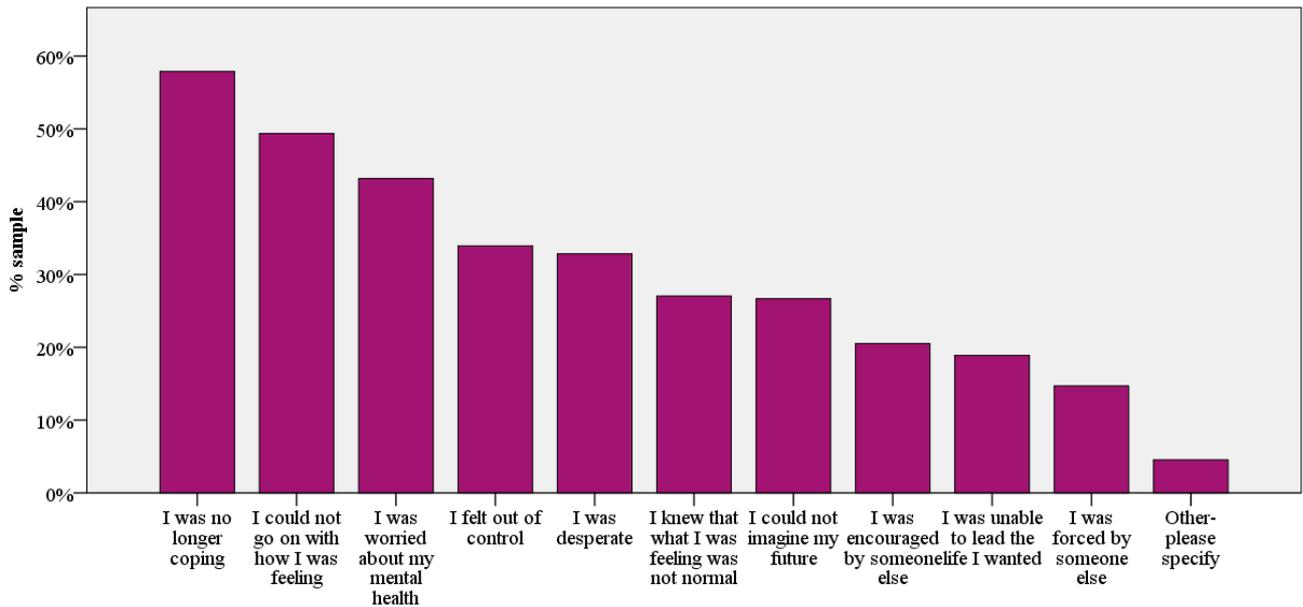
Leigh (17, trans male, pansexual, White British)

Last year I ended up going to hospital for a self inflicted head injury (I claimed that I had hit my head on a loft beam) and ended up with concussion. I knew that I needed to find a better way to deal with my emotions.

Luce (24, gay, cis female, White British)

In the questionnaire, 77.1% of participants (n=552) had asked for help from at least one source and 22.9% had not asked for help (n=164). When asked *why* they asked for help, participants chose on average, from a multiple response question (maximum of four), 3.3 reasons for seeking help. Figure 18 illustrates that 'I was no longer coping' (57.9%, n=319) was selected by over half the participants. This was followed by 'I could not go on with how I was feeling' (49.4%, n=272), and 'I was worried about my mental health' (43.2%, n=238). The least selected response was 'other' (4.5%, n=25). 'I was forced by someone else' (14.7%, n=81) was the next least selected response, and 'I was encouraged by someone else' was also only selected by 20.5% (n=113) of participants. Feeling 'out of control' (33.9%, n=187) and 'desperate' (32.8%, n=181) were selected by close to one third of participants as reasons for seeking help, showing again the centrality of emotions. Finally, over a quarter (26.7%, n=147) of participants indicated that not being able to imagine their future was a reason for seeking help. There were no significant relationships between why participants asked for help and gender identity, sexual orientation, disability, self-harm and suicidality.

Figure 18: Reasons for help-seeking



Participants were then asked why they had not sought help from others (see Figure 19). 705 participants responded to this question, with a mean of 3.51 selections per person. This suggests that young people often have a number of interconnected reasons for not seeking help.

Figure 19: Reasons for not seeking help

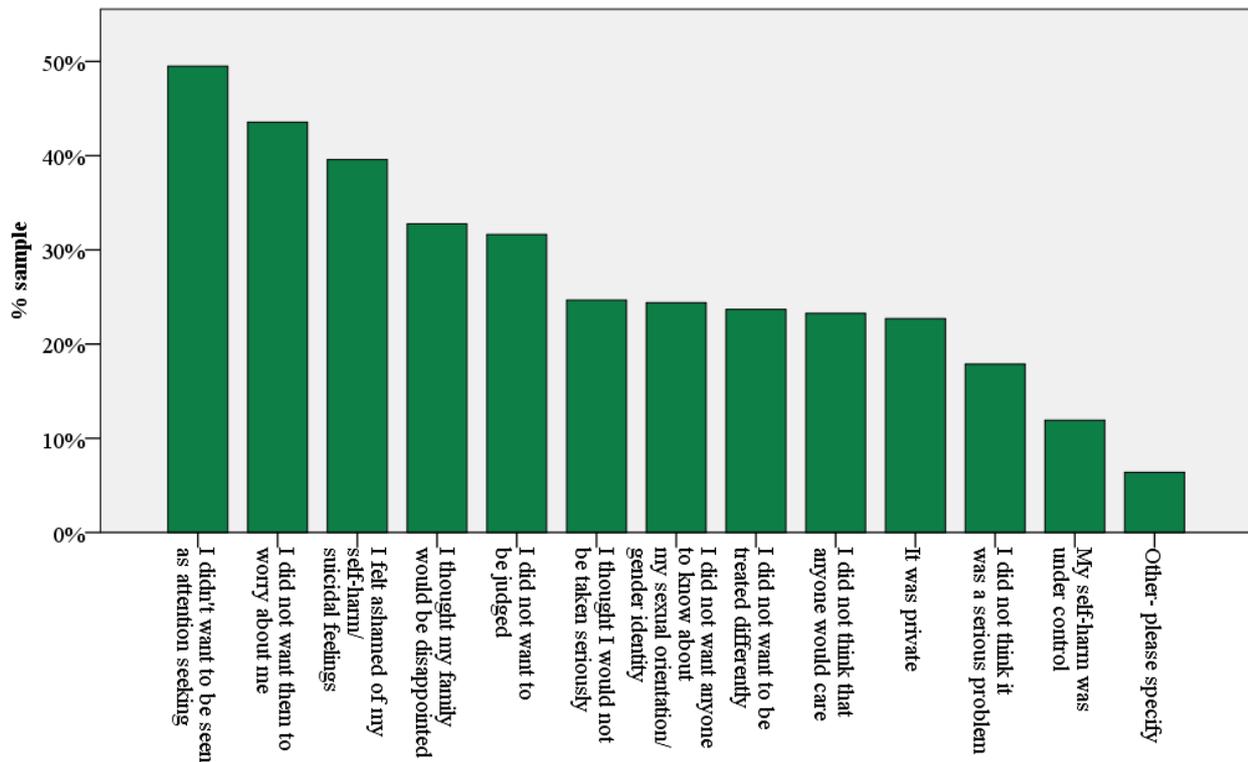


Figure 19 shows that the most selected response, chosen by almost half (49.5%, n=349) of respondents, was 'I didn't want to be seen as attention seeking', followed by 'I did not want them to worry about me' (43.5%, n=307). The next most common responses were 'I felt ashamed of my self-harm/ suicidal feelings' (39.6%, n=279), 'I thought my family would be disappointed' (32.8%, n=231), 'I did not want to be judged' (31.6%, n=223), 'I thought I would not be taken seriously'

(24.7%, n=174) and ‘I did not want anyone to know about my sexual orientation/ gender identity’, which was selected by just under one quarter of participants (24.4%, n=172). Apart from ‘other’, the two least chosen responses were ‘I did not think it was a serious problem’ (17.9%, n=126), ‘My self-harm was under control’ (11.9%, n=84). Only 6.4% (n=45) of participants selected ‘other’.

Further analysis found statistically significant relationships between help seeking and disability, gender identity, suicidality and self-harm (see Table 12 below).

Table 10: Associations and odds (95%CI) ratios between asking for help, disability, gender identity, sexual orientation, suicidality and self-harm

	Did not ask for help		Did ask for help		χ^2	OR	CI (95%)	
	n	%	n	%			Lower	Upper
<i>Disability, chronic illness or impairment</i>					7.13**	1.83	1.17	2.86
No	136	19	401	56				
Yes	28	3.9	151	21.1				
<i>Gender identity (5 cat)</i>					6.253	n/a		
Cis male	44	6.1	108	15.1				
Cis female	58	8.1	181	25.3				
Trans male	17	2.4	79	11				
Trans female	12	1.7	51	7.1				
Other	33	4.6	133	18.6				
<i>Gender identity (2 cat)</i>					5.45*	1.54	1.07	2.2
Cisgender	106	14.8	300	41.9				
Transgender	58	8.1	252	35.2				
<i>Sexual Orientation</i>					2.369	n/a		
Lesbian	23	3.2	66	9.2				
Gay	31	4.3	85	11.9				
Bisexual	43	6	142	19.9				
Queer or Pansexual	39	5.5	151	21.1				
Other	28	3.9	107	15				
<i>Suicidality</i>					16.84***	2.08	1.46	2.96
Has not planned or attempted suicide	91	12.7	207	28.9				
Has planned or attempted suicide	73	10.2	345	48.2				
<i>Self-harm</i>					32.96***	3.79	2.35	6.11
Has not self-harmed	39	5.4	42	5.9				
Has self-harmed	125	17.5	510	71.2				

Bold values indicate statistical significance. *p < 0.05; **p < 0.01; ***p < 0.001.

These results show that those with a disability, chronic illness or impairment were 1.83 times more likely to seek help than those without a disability. Trans/ unsure participants were one and a half times more likely to ask for help than cisgender participants. Participants that had planned or attempted suicide were over two times more likely to ask for help than those that had not. Similarly, those that had self-harmed were almost four times more likely those that had not self-harmed to seek help.

5.1.1 Predicting help-seeking

Logistic regression was performed to assess the impact of a number of factors on the likelihood that participants would report that they had asked for help. Five variables were included in the model;

table 13 demonstrates that three of these (self-harm, suicide plan or attempt and experience of abuse related to sexual orientation/ gender identity) made a unique statistically significant contribution to the model. The strongest predictor of asking for help was whether the participant had self-harmed, recording an odds ratio of 2.82. This indicated that participants that had self-harmed were almost three times more likely to report asking for help than those who had not, controlling for all other factors in the model.

Table 11: Logistic regression: Help-seeking

	B	S.E.	Wald χ^2	<i>p</i>	Odds Ratio	95% C.I. for Odds Ratio	
						Lower	Upper
Gender identity	0.212	0.195	1.174	0.279	1.236	0.843	1.813
Disability	0.270	0.241	1.251	0.263	1.31	0.816	2.103
Self-harm	1.038	0.263	15.533	0.000	2.823	1.685	4.729
Suicide plan or attempt	0.393	0.198	3.936	0.047	1.482	1.005	2.186
Experience of abuse related to sexual orientation/ gender identity	0.590	0.195	9.178	0.002	1.804	1.232	2.643
Constant	-0.418	0.261	2.566	0.109	0.109		

The full model containing all of these predictors was statistically significant ($\chi^2=47.19$, $df=5$, $p<0.001$), indicating that the model was able to distinguish between respondents who reported asking for help and those that did not. The independent variables used in this model, however, offered a very poor explanation of variability in help-seeking. The model as a whole only explained between 6.4% (Cox and Snell R Square) and 9.8% (Nagelkerke R Square) of the variance in help seeking. Only 9.3% ($n=15$) of those who did not ask for help were correctly classified, while 98% of those who did ask for help were correctly classified ($n=538$). Overall, this led to the correct classification of 77.8% of cases, only a 0.2% improvement from the constant. As such, this model has limited value in predicting whether young people would ask for help.

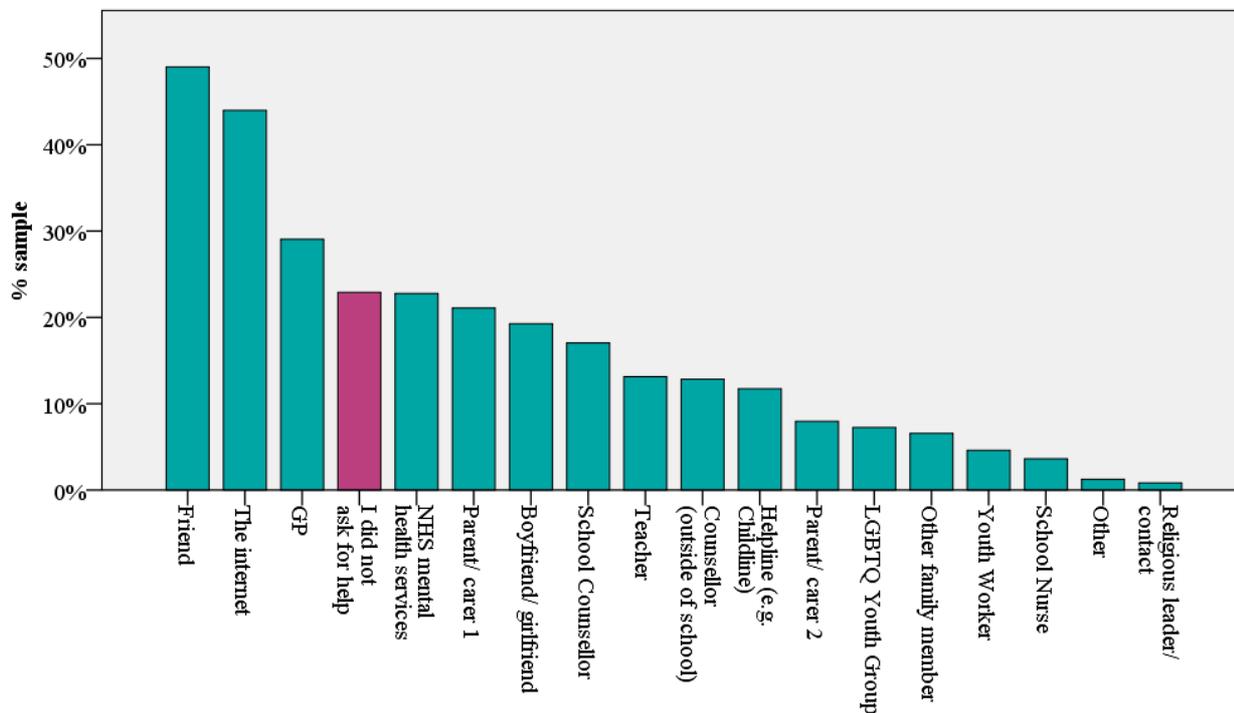
5.2 From who and where do LGBT youth seek help?

Analysis of the interview data suggested participants found it easier to access ‘informal’ sources of help such as the internet, family and friends rather than NHS or school-based mental health services. This was because interviewees felt most safe with these sources of help in terms of their sexual orientation, gender identity and mental health. The youth questionnaire included a multi-response option question about whom and where participants sought help for their self-harm and suicidal feelings. 77.1% of participants ($n=552$) had asked for help from at least one source. Over one fifth of the sample indicated ‘I did not ask for help’ (22.9%, $n=164$) when they were either self-harming or feeling suicidal.

Participants who had sought help approached a mean of 2.72 sites (i.e. people, places). Figure 20 shows that the most utilised source of help was seeking help from a friend (49%, $n=351$) followed by the internet (44%, $n=315$). While almost half of the participants sought help from ‘friends’ and ‘the internet’, the next most utilised was ‘GP’ (29.1%, $n=208$), followed by ‘NHS mental health services’ (22.8%, $n=163$). These NHS services had higher access rates than parents, or boyfriend/girlfriend. There were low numbers of participants who had approached school-based

sources of help. 17% (n=122) of participants had accessed school counsellors, 13.1% (n=94) had asked for help from a teacher and only 3.6% (n=26) from a school nurse. In addition, only 11.7% (n=84) sample participants had used helplines such as Childline.

Figure 20: Participants' sources of help when self-harming or suicidal

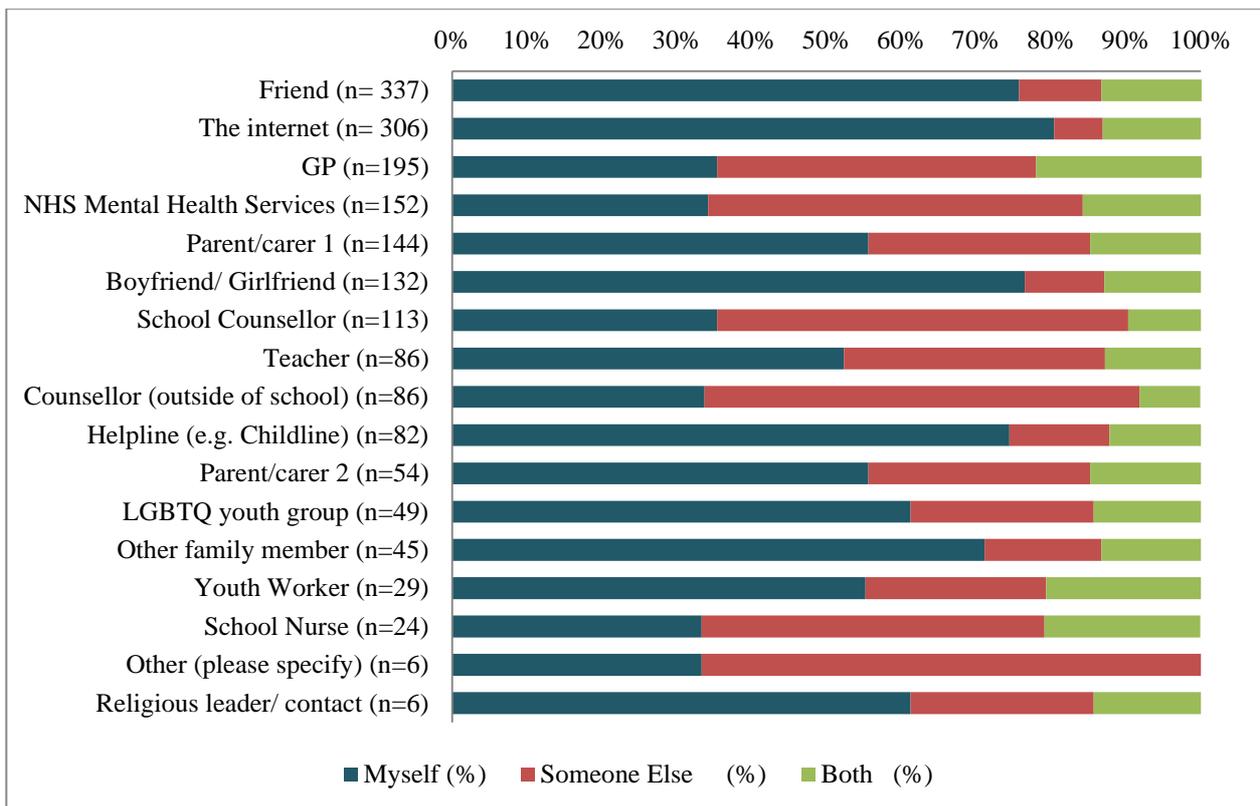


The findings from the qualitative data analysis suggested that experiences of help-seeking had a relationship with whether young people were self-motivated to access help, or were encouraged by others. In the questionnaire participants were asked who had motivated them to seek help from each source. Figure 21 below compares the different sources of help and the different ways that participants were motivated to utilise them.

The two most utilised forms of help, ‘friend’ and ‘the internet’, were overwhelmingly self-motivated sources of help. Only ‘boyfriend/girlfriend’ was indicated as being self-motivated more than ‘friend’. The internet was a self-motivated choice for accessing help by over 80% of the participant sample. Over three quarters (75.7%, n=255) of the respondents were self-motivated to ask for help from their friend/s and their boyfriend/girlfriend (76.5%, n=101) and helplines (74.4%, n=61).

In comparison, GPs (35.4%, n=69) and NHS mental health services (34.2%, n=52) had less than half of participants indicating that they were solely self-motivated to access them. It was more common for those asking for help from these services to have been encouraged by someone else. 42.6% (n=83) of those accessing GPs and 50% (n=76) of those accessing NHS mental health services indicated that someone else had motivated them to do so.

Figure 21: Sources of help: Whether help sought was self-motivated, encouraged by someone else, or both



There was only one significant relationship between motivation to ask for help from different sources and suicidality, sexual orientation, and gender identity. Trans/ unsure participants were more self-motivated to seek help from the internet than cisgender participants ($\chi^2=6.446$, $df=2$, $p < 0.05$). There were no statistically significant relationships between who motivated participants to ask for help and helpfulness of support (see section 5.4.2.)

5.3 Internet use and suicide

The majority of interviewees and questionnaire participants used the internet when they were self-harming or having suicidal feelings. Data analysis suggested that their experiences of going online were a mixture of positive and negative. For many the internet was a safe environment to address their feelings of isolation, shame, uncertainty or fear about both their sexual orientation/gender identity and mental health. In the interviews for example, Farouk and Briana spoke about how the internet helped them explore their sexual and gender identity:

I've used the internet more often to search on about sexuality issues. So I first used the internet when I was beginning to find out about this whole gay element and then I started to read up information about sexuality. I used various measures like tools, like the Channel 4 'gayometer' whatever, it came on, and I started to use that to find out, yeah, am I really gay, or whatever. And, yeah, but it's been a very useful resourceful tool.

Farouk (24, gay, cis male, British Asian)

I use the internet to reach out to others, and to find a community. I have some friends online (mostly all lgbt) who I talk to regularly. They have always been really great if I've been in a bad place and needed to talk or support. We tend to be there for each other. This was really great because none of my friends or family are lgbt, so finding people online definitely helped me feel less alone and isolated.

Briana (19, pansexual, cis female, White British)

Some participants, like Evie below, described accessing support and information about their mental health, self-harm and suicidal feelings:

I've self-medicated loads, that sort of thing, and researched loads of drugs and gone to doctor's, 'How about this? How about that? I think I've got this, can I be on that?' [...] But I don't just talk openly with people I don't know about my life on Facebook or anything. It's more the NHS's website or Yahoo and stuff.
Evie (17, straight, trans female, White British)

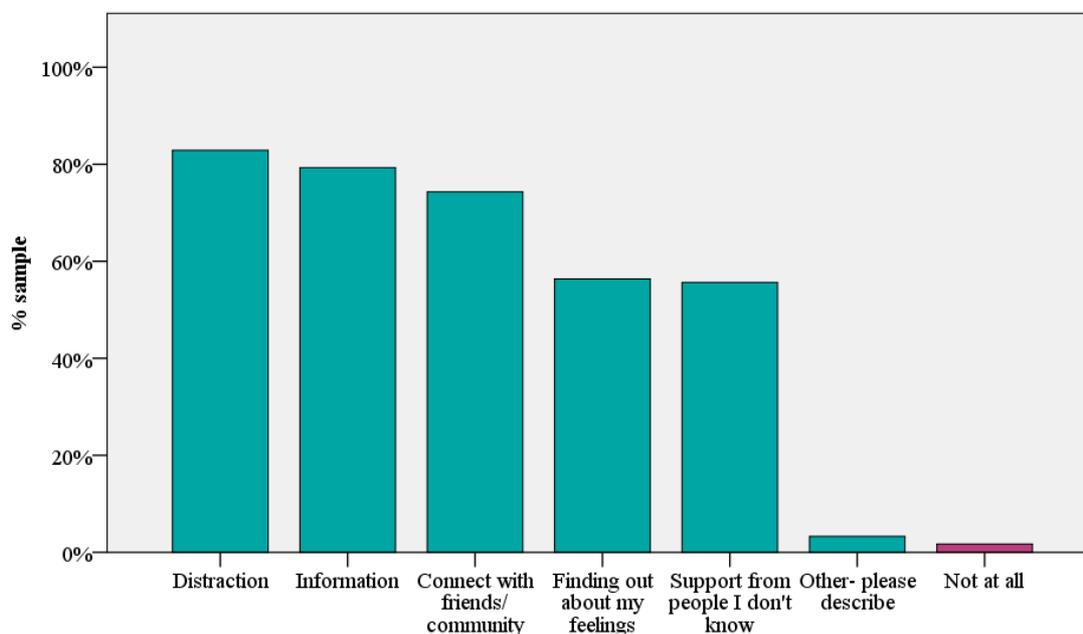
Interviewees indicated that the benefits of going online were anonymity, that they did not need to verbalise their confused and conflicting emotions and that they could withdraw (log off/ close window) at any point. However, the internet was also described as a harmful environment at times:

... it did work as a negative thing as well because there are some very militant people who are policing everything you say, [...]. And there's also some really dodgy stuff on there: there's a lot of triggering things, people self-harming, homophobic shit and ... so it was great but there's always a downside...
Jeremy (24, gay, trans male, White British)

i used to use the internet in a very negative way- using sites like tumblr to network with other ill people- looking at pictures of peoples scars and bones and posting pictures of my own. and i used to watch loads of youtube videos which would trigger me [...]. but now i don't use it for anything related to self harm, EDs or depression. Probably what i use it for most is LGBT related things.
Jess (24, lesbian, cis female, White British)

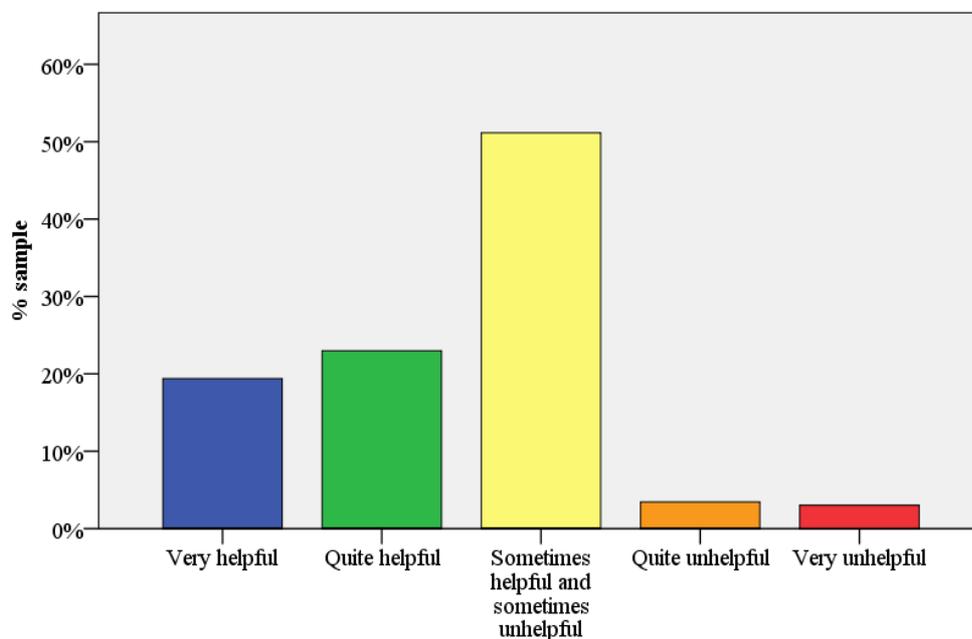
The youth questionnaire asked participants why they used the internet when they were self-harming or feeling suicidal (Figure 22). Only 12 participants (0.5%) responded that they did not use the internet at all. Participants indicated that they used the internet for multiple reasons, the most common reason, selected by more than four participants out of five, was 'distraction' (82.9%, n=581). This was closely followed by 'information' (79.3%, n=556), and 'connect with friends/ community' (74.3%, n=521). More than half of the participants utilised the internet to find out about their feelings (56.3%, n=395), and gain support from people they didn't know (55.6%, n=390).

Figure 22: Participant reasons for using the internet when self-harming or feeling suicidal



Participants were also asked how helpful they found the internet when they were self-harming or feeling suicidal (Figure 23). Only 6.5% (n=45) of participants indicated that the internet was unhelpful. 51.1% (n=356) indicated that it was sometimes helpful and sometimes unhelpful. 42.4% (n=295) of participants indicated that the internet had been helpful when they wanted to self-harm or had suicidal feelings. There were no significant differences between participant perspectives of helpfulness of the internet and sexual orientation, gender identity, disability or suicidality.

Figure 23: Participant assessment of the helpfulness of the internet when self-harming or having suicidal feelings



Many participants (n=203) provided text responses to the open-ended question on internet use for self-harming and suicidality. Table 14 shows examples of positive, negative and mixed (positive and negative) views on the internet.

Table 12: Participant written responses about the internet

Positive	Negative	Both positive and negative
<p>“I don't think it harms as much as people think it does. The Internet saved my life.”</p> <p>“I found a video on YouTube summarising depression and about getting help. It was this video that encouraged me to seek help from my parents.”</p> <p>“Helped me find an amazing LGBT youth group”</p> <p>“It allowed me to take comfort in (and experiment with) presenting female, even before I admitted to myself that I'm transgender”</p> <p>“It helps as a distraction from my thoughts. It also makes me feel</p>	<p>“Gay internet contest [content] is highly sexualised and dominated by adults, wich alienates younger youth struggling with self acceptance, at times making it worst for various reasons”</p> <p>“A lot of websites can be more triggering rather than helpful.”</p> <p>“Communities that support you with depression and suicidal feelings are often filled with so much sadness and hopelessness that it makes you feel worse.”</p>	<p>“I used to search out people and websites that posted abuse and read it purposefully. I was also doxxed once. But the internet was the one place I was recognised as male. It's complicated.”</p> <p>“It can provide great distraction but it is also a platform for loud hateful people”</p> <p>“Sometimes massively helpful, often abusive lonely and hurtful”</p>

like I'm a part of the LGBT community”

These written responses combined with the questionnaire and interview data indicate that the internet is not experienced by young people as simply good or bad. It is perhaps more accurate to think about the internet in relation to young people's mental health as an arena where, like the offline world, there are contexts when online support, information and advice can be helpful but there can also be virtual contexts that can be damaging. Importantly, young people in the sample were aware of the contradictory possibilities of going online.

5.4 Experiences of support and help

5.4.1 Informal support

The qualitative data analysis suggested that LGBT youth groups, friends and the internet were the sources of help which young people found most supportive. For example, Lex explains how attending a LGBT specific youth groups promoted self-esteem and eroded feelings of abnormality:

Really took away the feeling of isolation and enabled me to get a core group of friends who understood me. It also meant I was able to access other LGBT services as speakers and sexual health groups etc all got involved. It also meant we were able to grow in confidence both in terms of feeling accepted and in accepting ourselves[...] The best thing I did at that original group was to make a banner with our own logos on and walk in the [...] pride parade. One of the proudest moments ever when my mum was shouting my name in the crowd - the name I adopted and not the one I was given. It was so loud but in that moment I only heard and saw her waving yelling "that's my Lex". Amazing for my confidence.

Lex (25, lesbian, genderqueer, White British)

The previous section (5.3) showed that the internet was a widely used source of information by participants and it often produced a high level of satisfaction amongst young people. Friends were also an important source of trusted support where young people could talk about sexual orientation and gender identity, gain advice and discuss self-harm and suicidal feelings without feeling judged. Claire highlighted the importance of one friend:

*[...]she'd had experiences of, erm, struggling with her mental health so she was really understanding and she basically spent a year trying to tell me that it wasn't my fault and that I was a good person and all the things that I'd been through weren't... I didn't deserve them and they weren't, erm, okay. So with that **one** person trying to undo all this kind of 16 years of hell, erm... she was kind of that person that I could rely on and... and trust her with anything,*

Claire (20, pansexual, cis female, White British)

In this study, the young people interviewed described parents as a 'risky' place to seek help. There were intense emotions bound up in disclosing their sexual orientation, gender identity and emotional distress. This included fear of rejection, hope of acceptance and fear of loss of resources (for example being kicked out of home, not being supported financially). Jeremy described his parents' reaction when he wrote a letter to explain that he was trans:

I spent all week writing this letter. It was eight pages front and back and, erm... a really like heartfelt, lengthy, hand-written - I didn't even do it on the computer - letter.[...]. And, erm... they just... (sighs) I can't even begin to explain their reaction: it was... they completely cut me off. So they were paying my phone bills

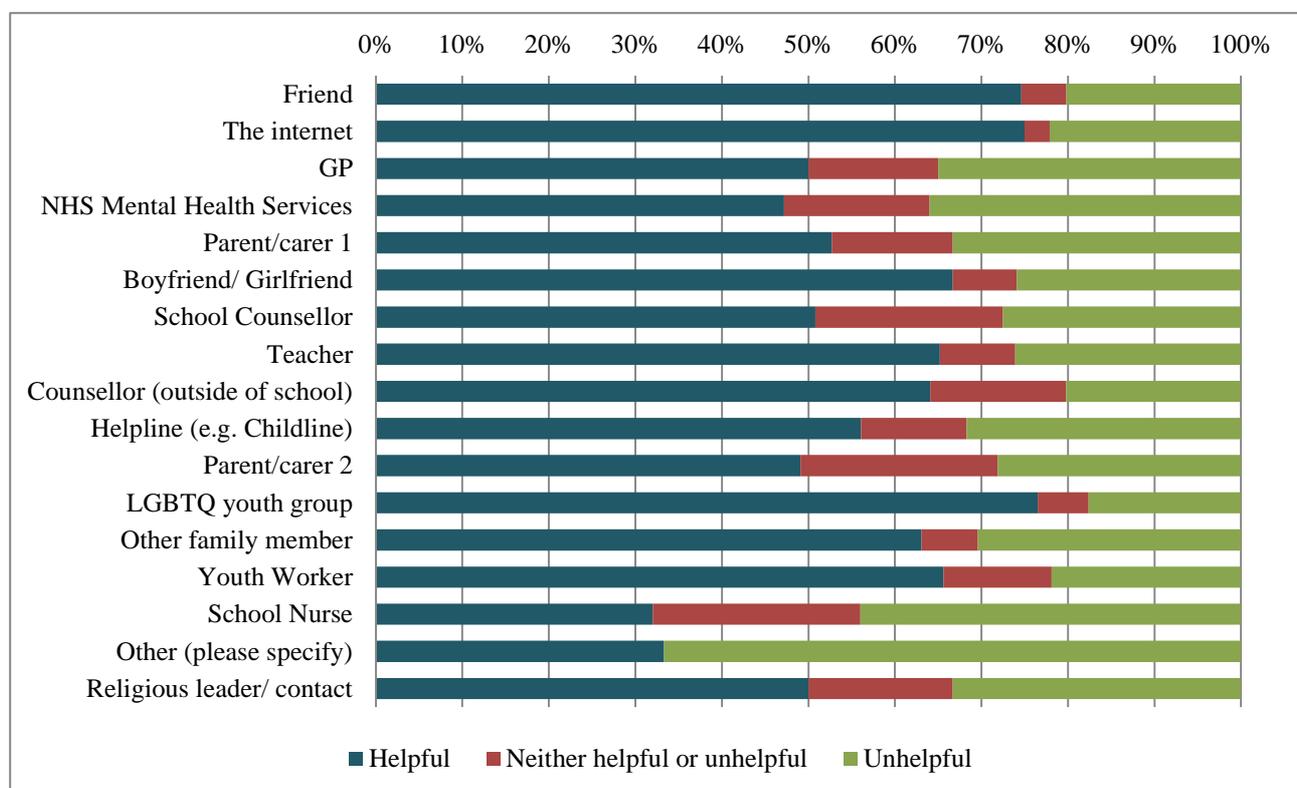
so I had to get a new phone bill. I needed that job because they didn't pay my rent.[...] I didn't speak to them for about two, two and a half, three years.

Jeremy (24, gay, trans male, White British)

In the youth questionnaire, participants were asked to rate the level of helpfulness of the support they received. Figure 24 compares the different sources of help and participants' ratings of 'helpfulness'. It illustrates that participants had overwhelmingly positive experiences when asking for help from friends or seeking help online. Three quarters of participants that utilised these indicated that they had been helpful. The only other source that was as high as this was 'LGBT youth group' (76.5% of participant experiences were positive). While the other two sources are the most utilised, LGBT youth groups were only used by 7.3% (n=52) of the sample. Youth workers were also used by few participants (4.6%, n=33), but were seen as helpful by 65.6% of those that interacted with them. Those from 'other' gender identities were the least likely to find friends helpful (70%, n=56), followed by cisgender females (71.3%, n=87). Trans females were most likely to find friends helpful (90.9%, n=30) ($\chi^2=18.393$, $df=8$, $p < 0.05$).

In terms of family, participant responses painted a mixed picture. Parent/ carer 1 was seen as a helpful source of help just over half the time (52.7%, n=79) while they were unhelpful one third of the time (33.3%, n=50). Parent/ carer 2 was less often utilised as a source of help, and had a slightly lower proportion of participants indicating that they were helpful (49.1%, n=28). Other family members were only approached for help by 6.6% of the sample, but 63% of these participants (n=29) found them helpful. Those who had planned or attempted suicide were significantly less likely to indicate that the help received from parent/carer 1 was 'helpful' than those who had not planned or attempted suicide. They were also far more likely to report that the support was 'unhelpful' ($\chi^2=7.433$, $df=2$, $p < 0.05$).

Figure 24: 'Helpfulness' of different sources of help



5.4.2 Health services

General practitioners (GPs)

In the questionnaire the third most utilised source of help was ‘GPs’ but this category of help had less favourable ratings in terms of helpfulness compared to the ‘internet’ and ‘friends’ (see Figure 24 above). Only half of those who accessed a GP (n=103) indicated that they had found the experience helpful, while 35% (n=75) indicated that it had been unhelpful. Analysis of the interview data pointed to the mixed experiences of young people seeking help from their GP. In the quotation below, Farouk describes the homophobia he encountered from his GP:

Farouk: [...] And then my doctor was even worse so then my doctor said... what did he say, he came out with a comment about – I changed my doctor now – but he came out with the comment that gay people, they’re bigots, they’re not normal people.

Farouk (24, gay, cis male, British Asian)

However, interview participants also gave accounts of positive experiences where GP’s had listened to young people, affirmed their identities, and encouraged them to talk about those aspects of life that were troubling. Heather and Sam both recounted helpful experiences with their GPs:

My GP is amazing. [...] Last time I saw her I felt able to talk a bit about self-harm, and when she asked about that, my sexuality came up. I wasn’t sure how she’d react but she was really supportive...

Heather (23, lesbian, cis female, White British)

My GP was actually pretty good, he gave me a lot of choice and generally just followed standard procedures with a few multiple choice questionnaires every now and then and referring me to mental health services when I needed it. He very much let it be a patient lead treatment and I liked that.

Sam (19, bisexual, trans male, White British)

Mental health services

In the questionnaire, only 47.2% (n=76) found NHS mental health services helpful, while 36% (n=58) found them unhelpful. Cisgender participants were more likely to indicate that NHS Mental health services were ‘helpful’ when compared to participants who were trans or unsure. Just over one third (36%, n=31) of trans/ unsure participants felt that the NHS mental health services that they had accessed had been helpful, while almost two thirds (60%, n=45) of cisgender participants felt that they were helpful ($\chi^2=10.555$, $df=2$, $p < 0.01$). Trans females were least likely to find NHS mental health services helpful compared to all the other gender identity groups ($\chi^2=27.936$, $df=8$, $p < 0.001$).

CAMHS was a common service for the young people interviewed to be referred to by their GPs. No qualitative interview participants indicated that their experiences with CAMHS were positive. Data analysis suggested that the negative experiences that young people experienced were related to not ‘connecting’ with practitioners and their limited knowledge and understanding of LGBT issues. This led to young people being less forthcoming with comprehensive details about their experiences, emotions and behaviours. Difficulties in communication were sometimes due to a focus on the mental health or symptoms of the young person rather than the underlying causes of their distress or grief. This could be interpreted by young people as the practitioners ‘missing the point’ or being disinterested. Sam and Cat described their experiences with CAMHS:

As I say, when I saw CAMHS I really hated my therapist. I don't know if it's because she worked with children and adolescents or maybe because she was just a little bit limited in her intellectual ability, but she was very patronising and didn't seem to understand things well. [...]I think the experience would have been a whole load better if she had focused less on my self-harming and more about how I was feeling in the first place.

Sam (19, bisexual, trans male, White British)

[...]I was sent to CAMHS. I was put on pro-zac right away, and had to take CBT. I did two courses of CBT but I didn't particularly feel that they were helpful because the only thing that I needed to hear was that it was okay and normal and natural to be gay, and that god loved me regardless. I felt that the only person who would understand me was someone who was gay AND Christian, and my therapist was neither, so not particularly useful.

Cat (20, lesbian, cis female, White British)

The interviewees' accounts of their CAMHS use suggested that their disconnect with mental health practitioners was exacerbated by the young people feeling as if they lost their agency when engaging with service providers. Treatment plans that were not negotiated with the young people, and therefore lacking a negotiated understanding of their needs, were a particular point of concern. This sometimes meant that the mental health worker was positioned as expert and the young person was 'told' how to 'fix' their problems rather than a more facilitative and person-centred approach. Molly told the interviewer:

I didn't argue with her [the CAMHS counsellor] but we didn't really see eye to eye because her views on things were basically just: Oh, well, I'm a trained professional, I know what's best... so I'd be trying to say, 'Well, listen, I can't... I like, you know, I can't go to...' like for example like, say if like I had an appointment on a school day and then I was like really not well and I was distressed and she would go, 'Just go back to school and you'll be fine.' [...] And for her it was just like 'Act like... act like a normal person and you'll be normal' like, you know, 'Go to school, do sports, eat healthily,' and like it's really not that simple.

Molly (18, lesbian, cis female, White British)

Gender identity clinics

Some of the trans young people interviewed had accessed gender identity clinics or specialist trans consultants. These services were often accessed at critical moments, and young people wanted personal and responsive services to make them feel as if they were addressing their needs. Some of the participants complained about waiting times, which often meant they sought alternative avenues of support through private health care, the internet and/ or overseas health care. Steffi sought help at when she was feeling suicidal. She described how her experience with the NHS Trans Service led her, with the financial assistance of her parents, to utilise private health care instead of waiting for long periods to access a NHS clinic:

Yeah, it took a month... it took a month for the... for the referral to sort of like be processed by them and then their response was, 'We can't see you for six months,' which obviously, you know, started making me feel about the same again from before [suicidal], but my parents sort of stepped in at that point and they sent me to [South East City] to a doctor there, which was only 10 days. So... I don't... if I hadn't seen him, I probably wouldn't be here today.

Steffi (25, gay, trans female, White British)

Time delay was not the only issue faced by young trans people. They also found it a strain to repeatedly justify their trans status in order to access the treatment. Jeremy reflected on these moments:

I've been assessed several times at Gender Identity Clinics as well, which is always an experience... I have to tell the same story over and over again: I am trans, I'm not lying, I promise.

Jeremy (24, gay, trans male, White British)

Being tested and having to 'pass' as trans placed an additional amount of stress on young trans individuals, and some young trans people gave accounts of difficulties fitting their gender identity within the NHS gender identity assessments, Mallqu, who identified as non-binary, explains:

*[I feel] powerless, erm... just powerless to go through the NHS in order to get the help that I need, which I wanted... not just for myself but also, erm, so the NHS has some kind of non-binary presence, because at the moment you'll... if you go through NHS, erm... documents that the NHS created regarding transition, it talks about trans men and trans women, no-one else... **absolutely** no-one else.*

Mallqu (22, pansexual, genderqueer, mixed ethnicity)

5.4.3 Schools

Schools had mixed results in terms of helpfulness. While participants who approached school counsellors found them helpful only 50.8% (n=61) of the time, those who approached teachers found them helpful 65.2% (n=60) of the time. School Nurses were found to be the least helpful of all sources of help, with only 32% (n=8) finding them helpful, and 44% (n=11) finding them unhelpful. For many of the young people interviewed, school was a problematic environment to seek support and help. Dylan experiences with a school counsellor exemplified the problem:

I was in school where my friends were and I didn't want them to see me crying so I didn't... I stopped myself from crying, and she was like: I can see that you're getting upset but you're not crying – why is that? And I was like: Because I'm going to walk out of this room in about 10 minutes. All my friends are going to know why I'm... where I've been, because on the door it says 'School Counsellor'. The room that the meetings are in is on the corridor where all of the [...] lockers are so they're all going to be there, there's no escape, like there's no way to get out of that room without them seeing you walking out.

Dylan (17, straight, transmale, White British)

5.5 Preferred sources and modes of help

The questionnaire included items that examined participants preferred sources of help. Table 15 shows that participants indicated that the three sources of help that would be most likely to be chosen by participants were LGBT individuals or youth groups, 53.3% (n=369) of participants indicated that they would be likely or very likely to seek help in this way. This was followed by mental health professionals (47.2%, n=325) and peers (46.2%, n=319). The place that participants were least likely to ask for help was at school or from teachers. 71% (n= 483) of participants said that they were unlikely or very unlikely to ask for help from school or teachers. This was followed by family (63.8%, n=439) and youth groups (57%, n=385). It may be also be important to recognise that there was uncertainty about seeking help from some places. Almost one quarter (24.3%, n=167) were unsure whether they would seek help from mental health professionals, with over one quarter (27.1%, n=183) unsure about youth groups.

Table 13: Participants preferred sources of help

	Who would you be most likely to ask for help?					
	Likely		Unsure		Unlikely	
	%	(n)	%	(n)	%	(n)
LGBT individuals or groups	53.3	(369)	21.7	(150)	25	(173)
Mental health professionals	47.2	(325)	24.3	(167)	28.5	(196)
Peers	46.2	(319)	19	(131)	34.9	(241)
Family	19	(131)	17.2	(118)	63.8	(439)
Youth Group	15.9	(107)	27.1	(183)	57	(385)
Schools/ teachers	12.2	(83)	16.8	(114)	71	(483)

During the interviews, participants made explicit distinctions between the modes (face-to-face, online, phone or SMS/text) of help they would prefer to use to access support. Esther and Dylan had quite strong preferences:

At the point of acute distress I would not go online to search for anything. It seems a very long and unhelpful process. The best thing is probably a face-to-face contact with someone. Once I see the other person, they may influence me to change my emotions. Writing, emailing or searching the web would not help in this case. However, if there is no other option I would text someone. But if the other person who im texting (and who in most cases has no idea what im going through) suddenly does not reply or decides that he/she is buzy with something else and stops texting me it makes it even worse. So its not a reliable help technique I think.

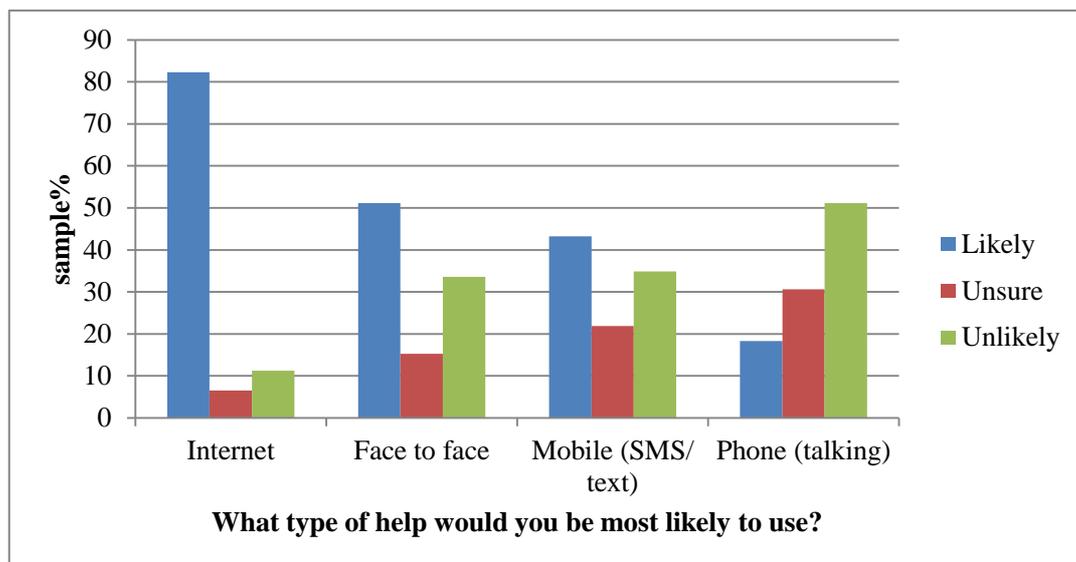
Esther (21, bisexual, cis female, White British)

I don't do talking face to face with people that I've never met before. My GP like, even when I was ill, I used to just sit there and my mum would tell them what was wrong. [...]And I can't do the talking to them kind of thing. So if I had to go in and tell them how I was feeling, it'd be like not something I could do. Whereas, if it was on... like where I could type it.....I'd be able to type it. Because you can't see them, you can't see their... the facial... like their expressions. Because I found from the counsellor, it was very patronising.

Dylan (17, Transmale, straight, White British)

The youth questionnaire asked participants about mode of help they would be likely to use. Figure 25 demonstrates that the greatest proportion of participants indicated that the type of help they would most likely use was the internet. 82.3% (n=572) of participants indicated that they would be 'likely' or 'very likely' to choose help in this form. Only 11.2% (n=78) of participants responded that they would be unlikely or very unlikely to use help via the internet. Face to face help was the next most likely form of help to be selected by participants, with just over half (51.1%, n=355) indicating that they would likely or very likely use this type of help. This was followed by Mobile (SMS/text) support (43.2%, n=297). The least chosen form of help was talking over the phone. Over half (51.1%, n=351) of participants indicated that they would not choose to use help in this form. However, this was also the type of help that most people were unsure about using (30.6%, n=210).

Figure 25: Participants' preferences for modes of help



There were a number of significant differences between groups of participants and the type of help they would be most likely to use:

- Trans/unsure participants were more likely to respond that they would 'likely' or 'very likely' use the internet to ask for/ receive help when compared to cisgender participants ($\chi^2=6.973$, $df=2$, $p <0.05$). Trans/unsure participants were also more likely to indicate that they would be 'unlikely' or 'very unlikely' to seek or utilise face-to-face support when compared to cisgender participants ($\chi^2=7.167$, $df=2$, $p <0.05$).
- Lesbian and gay participants were most likely to indicate that they would choose face-to-face help, while 'other' participants were the least likely. Bisexual participants were most likely to select 'unsure' ($\chi^2=18.688$, $df=8$, $p <0.05$).
- Those in the oldest age category (20-25 years old) were less likely to want to use mobiles (SMS/text) to seek and receive help when compared to the other age groups. Those aged 16 and under were more likely to choose this form of help-seeking ($\chi^2=15.653$, $df=4$, $p <0.01$). In addition, those in oldest age category were more likely to want to seek or receive face-to-face help compared to those under 20 years of age ($\chi^2=40.702$, $df=4$, $p <0.001$).
- Participants who had planned or attempted suicide were more likely to indicate that they were 'unlikely' or 'very unlikely' to choose phone (talking) as a method of support compared to those who had not planned or attempted suicide ($\chi^2=6.431$, $df=2$, $p <0.05$).

5.6 Key findings

• Asking for help

Over three quarters of participants (n=552) had asked for help for their self-harm and suicidal feelings from at least one source, but nearly a quarter had not asked for help (n=164). Results indicated that LGBT young people looked for support when they were at crisis point. When asked why they asked for help, over half of the questionnaire participants selected 'I was no longer coping' followed by 'I could not go on with how I was feeling'. When asked why they did not ask for help the response chosen by almost half of respondents was 'I didn't want to be seen as attention seeking', followed by 'I did not want them to worry about me', and 'I felt ashamed of my self-

harm/ suicidal feelings'. Just under one quarter of participants selected 'I did not want anyone to know about my sexual orientation/ gender identity'.

Results showed that participants who had planned or attempted suicide; had self-harmed; had experience of abuse related to sexual orientation/ gender identity were significant predictors of help-seeking. The strongest predictor of asking for help was whether the participant had self-harmed.

- **From who and where do LGBT youth seek help?**

Help was sought most frequently from friends and the internet. Only just under a third of participants had accessed their GP, and a fifth had sought help from NHS mental health services. NHS mental health services had higher rates of access than other 'informal' sources like parents or boyfriend/girlfriend.

The results show that participants accessed different sources of help in divergent ways. Accessing friends, the internet, boyfriend/girlfriend and helplines were almost always self-motivated. GPs, mental health services, counsellors, school counsellors and school nurses were more often motivated by someone else.

- **Internet use and suicide**

When the participants were asked how they utilised the internet for help and support when they were self-harming or having suicidal feelings, the responses suggest that experiences were a mixture of both positive and negative. Importantly, this study shows that young people understood both the benefits and shortcomings of the internet. All of the questionnaire participants indicated that they used the internet when they were self-harming or experiencing suicidal feelings, showing its ubiquity in their lives. The participants used it for a range of reasons including distraction, information, connecting with friends and community, to find out about their feelings and to get support. Only 6.5% of participants responded that the internet was unhelpful when they had suicidal feelings or wanted to self-harm. Instead, most participants indicated that the internet was sometimes helpful and sometimes unhelpful

- **Experience of support and help**

The study found that generally most participants had positive experiences when asking for help online, from friends or from LGBT youth groups. Parents were seen as helpful approximately half the time, as were school counsellors. Teachers and youth workers had slightly higher ratings.

GPs and NHS mental health services had lower ratings of helpfulness. Only half (50%) of those who accessed a GP indicated that they had found the experience helpful, while over a third (35%) indicated that it had been unhelpful. This compares similarly with NHS mental health services, of which just under a half (47.2%) found helpful, while again just over a third (36%) found them unhelpful. Cisgender participants were more likely to indicate that NHS Mental health services were 'helpful' when compared to participants who were trans or unsure. Interview participants recounted poor experiences with CAMHS. Their accounts included feeling that they did not 'connect' with practitioners, that the staff had limited knowledge and understanding of LGBT issues, and feeling excluded from the decisions made about their care.

Some of the trans young people had utilised gender identity clinics or specialist trans consultants. In the interviews participants complained about the length of waiting times, which meant they

sometimes sought alternative avenues of support through private health care, the internet and overseas health care. In addition, repeatedly having to justify their trans status in order to access treatment placed extra stress on young trans individuals.

- **Preferred sources and modes of help**

Questionnaire results indicated that young people would be most likely to ask for help from LGBT individuals or youth groups (53.3%), followed by mental health professionals (47.2%) and peers (46.2%). Participants were least likely to ask for help from school/ teachers (71%), family (63.8%) and youth groups (57%). There was also uncertainty about seeking help from some sources. Almost one quarter of questionnaire participants were unsure whether they would seek help from mental health professionals, with over one quarter unsure about youth groups.

Findings also indicated that the largest proportion of participants would prefer to access help through the internet, followed by face-to-face and mobile (sms/texting) forms of support. Talking on the phone was the least preferred option of the sample.

Gender diverse participants were more likely to indicate that they would use the internet than cisgender participants. Older participants were less likely to want to use mobile or texting and more likely to prefer face-to-face methods, while younger participants were more likely to prefer mobile as a mode of help. Those that had planned or attempted suicide were less likely to prefer talking on the phone than those that had not.

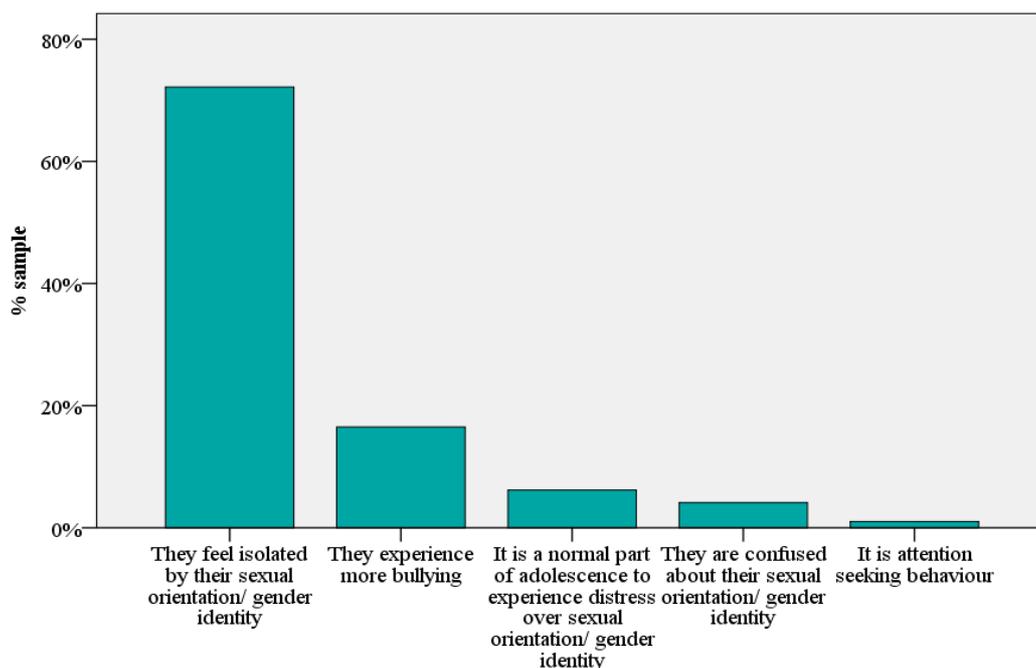
Section 6: Results: Mental health service staff knowledge, attitudes and practice

This section details the results of the mental health service staff questionnaire and addresses research question 6. The section focuses on: i) staff knowledge and attitudes; ii) mental health service practice and; iii) engaging LGBT youth in mental health services.

6.1 Staff knowledge and attitudes

Participants were asked about their knowledge and attitudes relating to the distress experienced by LGBT youth. Figure 26 below shows that the majority of participants (72.2%, n=70) responded that LGBT youth experienced more distress than their heterosexual cisgender counterparts because they ‘feel isolated by their sexual orientation/ gender identity’. This was followed by 16.5% of participants who indicated that the increased distress was due to them ‘experiencing more bullying’, and 6.2% (n=6) who thought it was a ‘normal part of adolescence to experience distress over sexual orientation/ gender identity’, and that they are ‘confused about sexual orientation/ gender identity’ (4.1%, n=4). Only one participant (1%) indicated that they believed these young people experience increased emotional distress because ‘it is attention seeking behaviour’.

Figure 26: Mental health service staff views on why LGBT youth experience more emotional distress

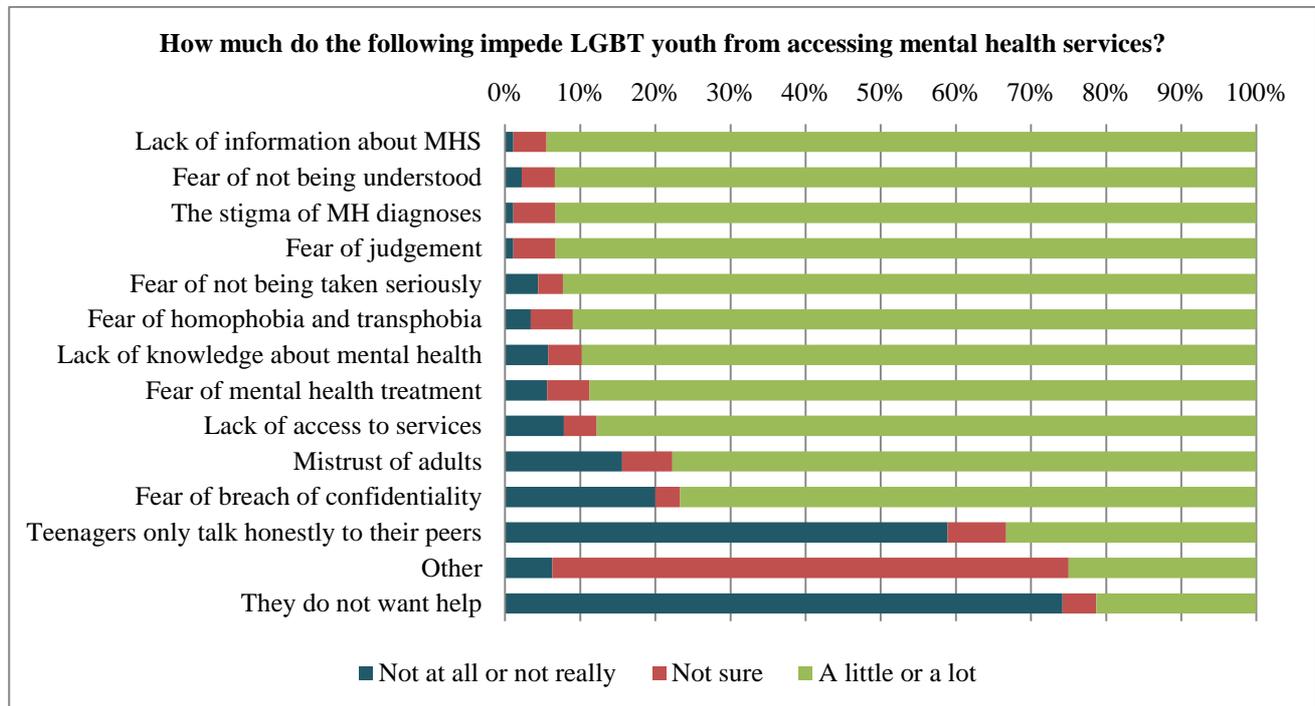


Participants were also asked about what they believed to be the main cause of young people self-harming. 92.8% (n=90) of participants responded that the main reason was ‘it is a way of coping with difficult feelings’. 6.2% (n=6) said that it was a stress reliever, while only one participant (1%) indicated that ‘it is a way of attention seeking’. No participants chose the other two options- ‘It is a sign of a personality disorder’ and ‘It is because they feel suicidal’.

Participants indicated that there were many impediments to LGBT youth asking for help from mental health services. Figure 27 below shows that the most selected barrier to asking for help was ‘Lack of information about mental health services’ by 94.4% (n=85) of participants. Fear of not being understood, the stigma of mental health diagnoses, and fear of judgement were each selected

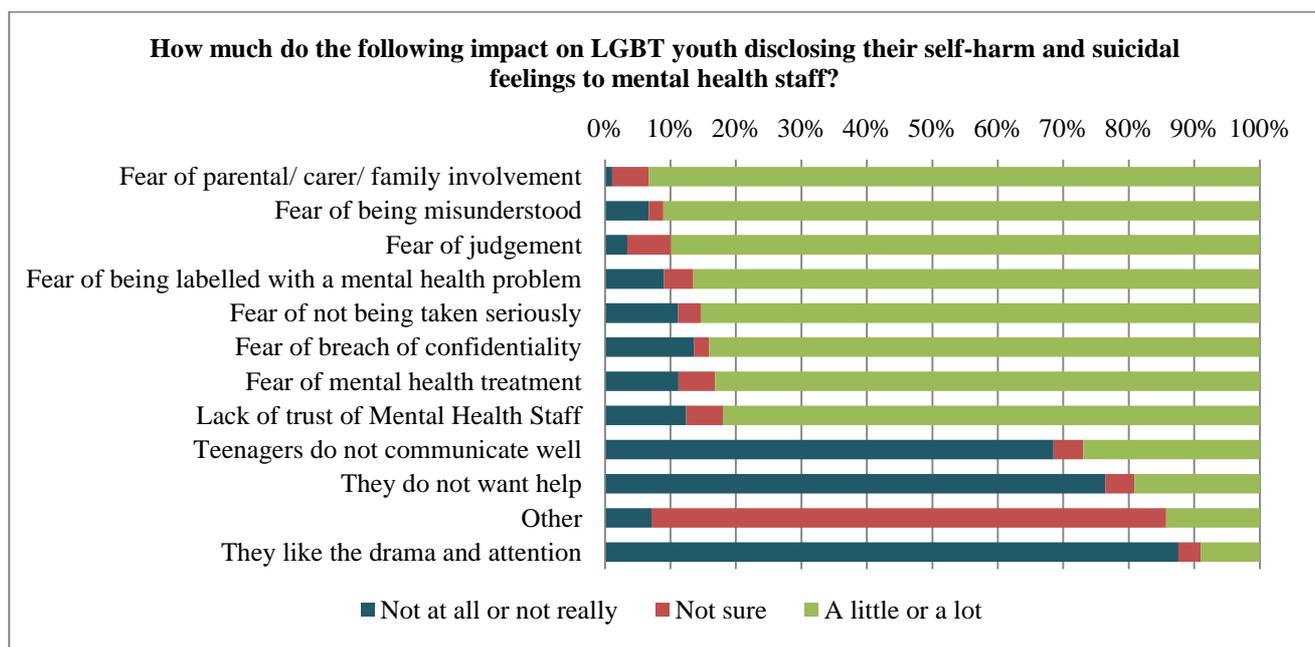
by 93.3% (n=84) of participants as being an obstruction to seeking help. Fear of not being taken seriously (92.2%, n=83) and fear of transphobia/ homophobia (91%, n=81) followed. There were no significant differences found between these understandings and participants' sexual orientation, age, or reception of training (self-harm, suicide prevention, and LGBT awareness).

Figure 27: Participant views on barriers to LGBT youth asking for help from mental health services



Participants were asked about barriers that prevent LGBT young people from disclosing their self-harm and suicidal feelings to mental health staff (see Figure 28 below). Fear of parental/ carer/ family involvement was most selected (93.3%, n=83), while fear of being misunderstood was also selected by over 90% (90.1%, n=81) of participants. There was no significant difference in terms of sexual orientation, age and training in terms of participants' responses this item.

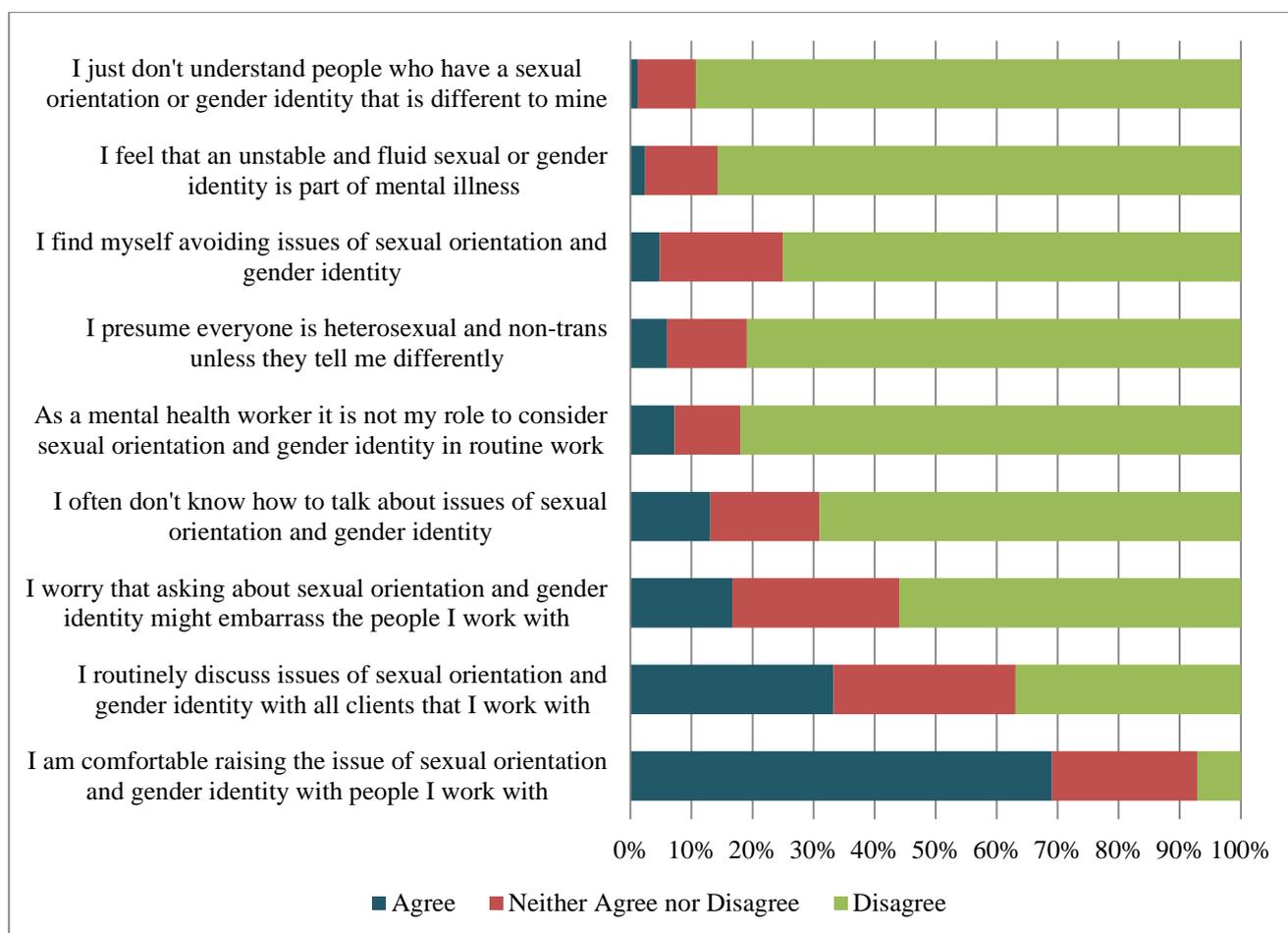
Figure 28: Participant views on barriers to youth disclosure of self-harm and suicidal feelings to mental health service staff



6.2 Staff practice and training

Participants were asked to rate their confidence in discussing sexual orientation and gender identity in their work (figure 29). The option that was most divisive was ‘I routinely discuss issues of sexual orientation and gender identity with all clients that I work with’. 33.3% of participants agreed with this statement, 36.9% disagreed, and 29.8% neither agreed nor disagreed. Other comments that had lower proportions of people disagreeing included ‘I often don’t know how to talk about issues of sexual orientation and gender identity’ (69% disagreed), ‘I worry that asking about sexual orientation and gender identity might embarrass the people I work with’ (56% disagreed), ‘I am comfortable raising the issue of sexual orientation and gender identity with people I work with’ (69% agreed), and ‘I find myself avoiding issues of sexual orientation and gender identity’ (75% disagreed).

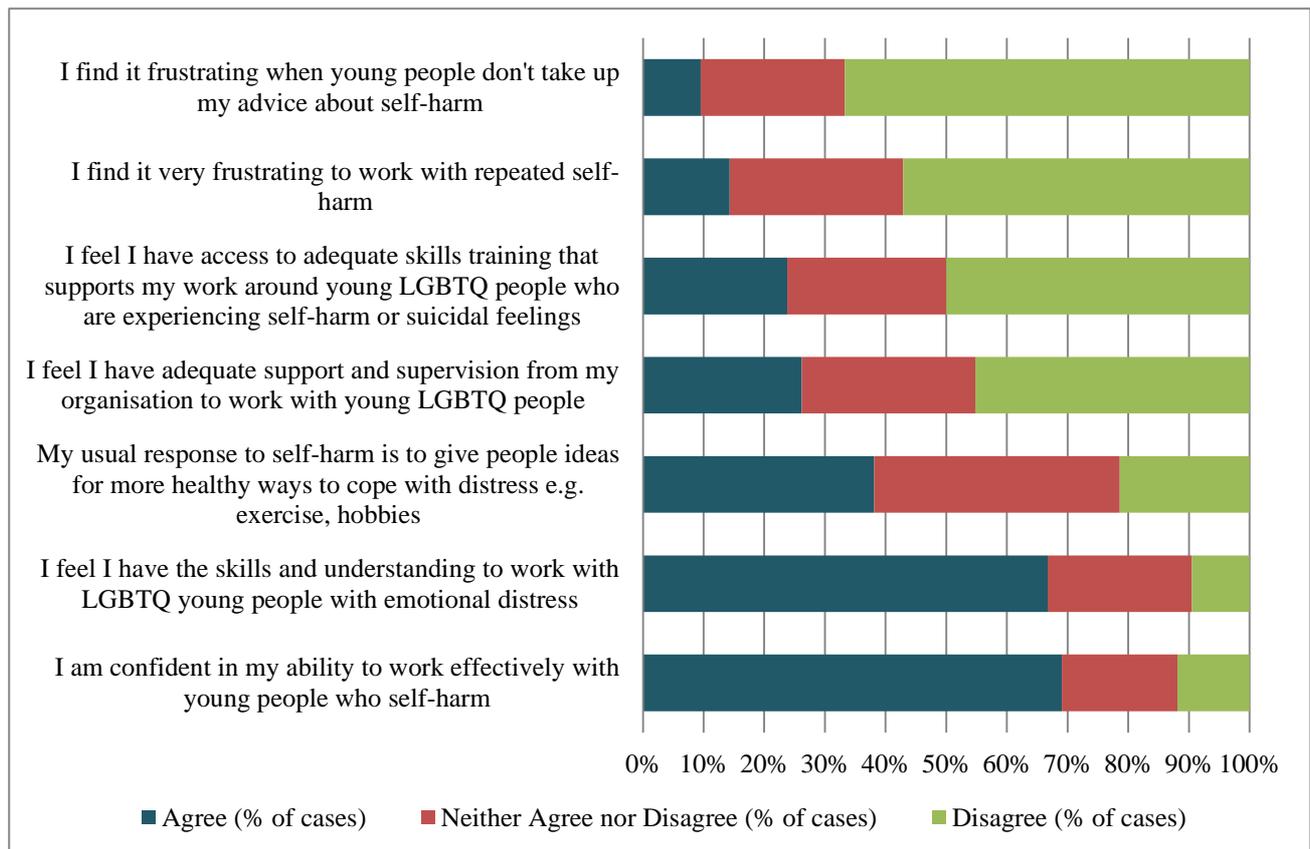
Figure 29: Mental health staff views on discussing sexual orientation and gender identity at work



Further analysis indicated that those who had received training with a focus on LGBT awareness were significantly more likely to state that they routinely discussed issues of sexual orientation/ gender identity with all clients that they worked with. Those who had not had training in LGBT awareness were more likely to state that they did not routinely discuss sexual orientation/ gender identity with all clients that they worked with ($\chi^2=8.782$, $df=2$, $p <0.05$). In addition, although most (68.3%, $n=56$) participants disagreed with the statement ‘I often don’t know how to talk about issues of sexual orientation and gender identity’, those who had training in LGBT awareness were more likely to disagree with it. Those who had not received training were more likely to select ‘neither agree nor disagree’ ($\chi^2=9.028$, $df=2$, $p <0.05$).

Figure 30 presents the attitudes to working with young people who are LGBT, self-harming or suicidal. The statement that provided the greatest consensus of agreement was ‘I am confident in my ability to work effectively with young people who self-harm’ (69%, n=58), followed by ‘I feel I have the skills and understanding to work with LGBT young people with emotional distress’ (66.7%, n=56) and ‘I find it frustrating when young people don’t take up my advice about self-harm’ (66.7%, n=56). 50% (n=42) of participants did not believe that they had access to adequate skills training that supported their work with LGBT youth who are self-harming or having suicidal feelings. 45.2% (n=38) did not feel that they had adequate support and supervision from their organisation to work with LGBT youth.

Figure 30: Participant views on working with young people who are LGBT, self-harming or having suicidal feelings



There were significant differences between responses that related to participants’ ability to support young people and participants’ training experiences (there were no significant differences for age or sexual orientation):

- Those who had received self-harm training were significantly more likely to agree that they felt confident in their ability to work effectively with young people who self-harm ($\chi^2=6.059$, $df=2$, $p <0.05$).
- Those participants that had self-harm training were significantly less likely to find it frustrating when young people did not take their advice about self-harm ($\chi^2=7.295$, $df=2$, $p <0.05$).
- Those that had received LGBT awareness training were significantly more likely to feel that their organisation was supporting them to work with LGBT youth, while those that had not received this training were less likely to feel supported ($\chi^2=14.401$, $df=2$, $p <0.001$).
- Those who had received LGBT awareness training were significantly more likely to report that they had access to adequate skills training that supported their work with self-harming

or suicidal LGBT youth than those who had not received training ($\chi^2=21.911$, $df=2$, $p < 0.001$).

6.3 Engaging LGBT youth in mental health services

When asked about the best way to engage LGBT youth in mental health services, almost one third (31.3%, $n=26$) of participants selected ‘mandatory awareness training for staff’ (see Figure 31 below). The next was ‘more proactive discussions facilitated by staff about sexual orientation and gender identity and mental health’ (18.1%, $n=15$), followed by ‘guidelines for practice with LGBT youth who self-harm or feel suicidal’ (15.7%, $n=13$), ‘outreach work targeting LGBT youth groups’ (13.3%, $n=11$), ‘having information about LGBT issues and support groups displayed’ (10.8%, $n=9$) and ‘an online support service targeted to LGBT young people’ (10.8%, $n=9$). There were no significant differences in participant understandings of how to engage LGBT youth.

Figure 31: Mental health service staff views on the best ways to engage LGBT youth in their services

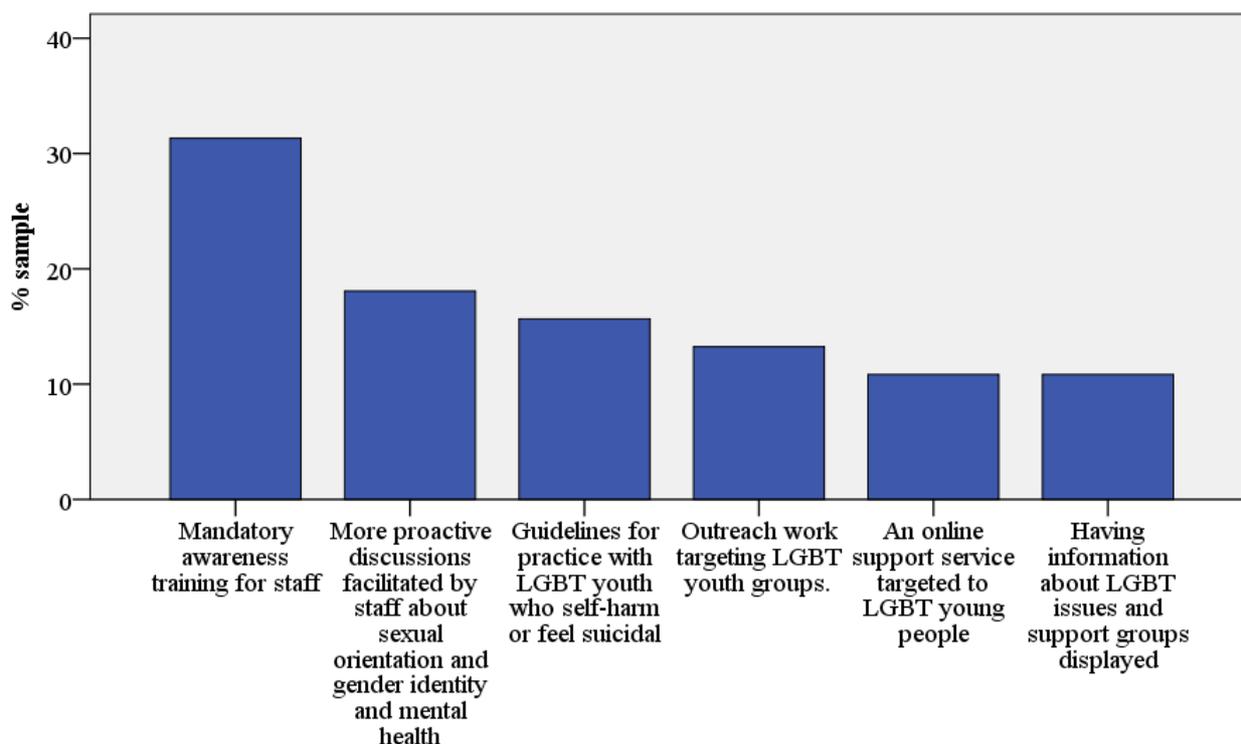


Table 16 shows participants additional comments about how to help LGBT young people who self-harm or feel suicidal ($n=22$). These have been coded into 5 categories.

Table 14: Mental health service staff additional comments on helping LGBT youth who self-harm or feel suicidal

Category	Questionnaire data
Personal experiences of homophobia:	<i>My fear is that if a colleague is refusing to shake my hand because of my sexuality, how will he treat an LGBT service user? Will this lead to neglect?</i>
The stigma of self-harm:	<i>"Attention-seeking" = stigmatising if viewed negatively, but substituting 'attention' for care-seeking or affection/closeness-seeking and I think that can be part of what underpins self harm for some, so I encourage a re-framing and there is always destigmatising work to be done in teams around this</i>

Issues around waiting lists/ accessing services:	<i>Improved access to Gender Identity services and support is essential, 3 year waiting lists (as I have been informed by [name of city] GI service is the case [name of city]) will undoubtedly exacerbate mental distress and potential for thoughts of self-harm and/ or suicide</i>
Staff training:	<p><i>I think health staff need to be educated to understand why self harm and suicide in this group is a significant risk indicator, and then what practitioners can do to best support/treat this group more effectively</i></p> <p><i>Often staff (and people in general) are not aware of the specific issues an individual can experience relating to LGBTQ. Where there is a lack of understanding, the support cannot be tailored effectively and the young people can feel invalidated by staff ignorance. Often staff wish to help young people but are simply not aware of, or able to empathise with their experience. Open discussions both personally and professionally, training and a shift in the perception of the LGBTQ society could contribute towards the inclusion and meaningful support of LGBTQ young people.</i></p>
Specialised resources:	<p><i>would be beneficial if each team would have specific LGBT rep/advocate the team could access when needed and who could provide advice/consultation issues relating to LGBT people.</i></p> <p><i>These people have specific needs AND NEED A SERVICE TO SUPPORT THEM</i></p>

6.4 Key findings

- **Staff knowledge and attitudes**

The mental health service staff that participated in the questionnaire had a good level of knowledge about LGBT youth and self-harm and suicide. For example, the majority believed that LGBT youth experienced more emotional distress because they felt isolated by their sexual orientation/ gender identity. In addition, most recognised that it is a way of coping with difficult feelings

They recognised that there were many impediments for LGBT youth to overcome to access their services. The most frequently selected barriers to asking for help was ‘lack of information about mental health services’, ‘fear of not being understood’, ‘the stigma of mental health diagnoses’, and ‘fear of judgement’

The participants were also aware of a number of reasons that prevent LGBT young people from disclosing their self-harm and suicidal feelings to mental health staff. Most agreed with the statement that ‘Fear of parental/ carer/ family involvement’ and ‘fear of being misunderstood’ may prevent young people disclosing. Participants largely disagreed that young people do not disclose their self-harm and suicidal feelings because ‘they do not communicate well’, ‘they like drama and attention’, or ‘they do not want help’.

- **Mental health staff practice**

Participants were asked to rate their confidence in relation to discussing and raising sexual orientation and gender identity in their work. In response to 'I routinely discuss issues of sexual orientation and gender identity with all clients that I work with'. 33.3% of participants agreed with this statement, 36.9% disagreed, and 29.8% neither agreed nor disagreed. Those who had received training with a focus on LGBT awareness were more likely to state that they routinely discussed issues of sexual orientation/ gender identity with all clients that they worked with. Those who had not had training in LGBT awareness were more likely to state that they did not routinely discuss sexual orientation/ gender identity with all clients that they worked with.

There were significant differences between responses that related to participants' ability to support young people who self-harm or feel suicidal and participants' training experiences. Those who had received training with a focus on self-harm and suicide were significantly more likely to agree that they felt confident in their ability to work effectively with young people and less likely to find it frustrating when young people did not take their advice about self-harm.

Those that had received training with a focus on LGBT awareness were significantly more likely to feel that their organisation was supporting them, and that they had access to adequate skills training that supported their work with self-harming or suicidal LGBT youth, than those who had not received training.

Half of participants did not believe that they had access to adequate skills training that supported their work with LGBT youth who are self-harming or having suicidal feelings. Almost half did not feel that they had adequate support and supervision from their organisation to work with LGBT youth.

- **Engaging LGBT youth in mental health services**

When asked about the best way to engage LGBT youth in the services, most chose 'mandatory awareness training for staff'. The importance of the potential of specific training in terms of increasing confidence, and changing practice was re-affirmed by other results regarding impact of training. Training about self-harm and LGBT awareness had significant impacts on the (self-reported) routine discussion of sexual orientation/ gender identity, confidence of working with young people who self-harm, less likely to feel frustration regarding self-harming young people, and feelings of employer support to work with LGBT youth who are self-harming or suicidal.

Section 7: Conclusions and policy recommendations

The aim of this study was to provide, for the first time, evidence on why young LGBT people may be at a higher risk of suicide and self-harm than their heterosexual and cisgender counterparts. It is by understanding the underpinning reasons for these elevated rates that effective suicide prevention policy and practice can be developed.

The Preventing Suicide in England Strategy (2012) identifies tailoring approaches to improve mental health in specific groups including both children and young people, and LGBT population groups, as key to reducing suicide. The results of this study have shown that the higher prevalence of suicide and self-harm among LGBT youth populations can be attributed to a number of specific complex interlinked factors which combine together to make LGBT youth feel like they are abnormal, marginalised, isolated, disconnected and these stresses contribute to poor mental health. A key recommendation of this report is that as a priority the NIHR commission research to provide evidence on what works in preventing suicide within this high risk group.

The Preventing Suicide in England Strategy (2012) also identifies that staff across the health and care services need to be aware of the increased risk of mental distress, self-harm and suicidal feeling in LGBT populations. The results from this study demonstrate quite unambiguously that LGBT youth are reluctant to seek help from health, education and care services, and when they do access them, they do not always find them helpful. NHS services should be inclusive and welcoming to all people irrespective of their sexuality, gender identity, ethnicity, age, and/or disability. A key recommendation is that there is mandatory LGBT awareness training for all mental health service staff. We found from the staff survey that there was a relationship between those who had received LGBT training and routinely discussing these issues in practice. This should be happening as part of Equality and Diversity training. In addition, work should be undertaken to ensure that health providers adhere to their responsibilities to Equality and Diversity.

In the following sections, the policy implications of the study results are discussed in relation to: i) preventing LGBT youth suicide and self-harm and; ii) improving the provision of mental health support and services.

7.1 Preventing LGBT youth suicide and self-harm

The experience of homophobic, biphobic or transphobic abuse doubled the odds of planning or attempting suicide for participants. The majority of the sample had experience of abuse related to their sexual orientation or gender identity and this occurred most often in the school environment, followed by public places, the internet and at home. Tackling this abuse and discrimination in schools, colleges and education institutions is essential to preventing suicidality and self-harm in this group of young people.

Most of the participants lived with the presumption that everyone is heterosexual and cisgender (i.e. sexual and gender norms), this combined with the threat or reality of homophobia, biphobia and transphobia caused many participants to feel negative about their sexual and/or gender identity and increased their risk of a planned or attempted suicide. Participants were also made to feel that they could not be open about their sexual orientation/ gender identity in a variety of environments (e.g. school, home, internet, public). Young people had to continually make decisions about when and where it was safe to disclose their identities and as a result, the majority of participants hid their

sexual orientation/ gender identity to some degree. This secrecy led to feelings of distress, shame, stigma, fear and failure and increased the likelihood of self-harm and suicide.

The consequences of homophobia, biphobia and transphobia, being made to feel abnormal because there were not heterosexual or cisgender, having to disguise their sexual and gender identities, and perhaps other life crises (e.g. previous experience of abuse, their own illness/ disability, death of a friend) were that many participants felt isolated and unable to talk about their feelings and emotions, and this increased the likelihood of self-harm and attempted or planned suicide.

The conclusion of this study is that in order to develop effective public health policy to prevent suicide in LGBT young people, the social factors that heighten risk need to be addressed. As a priority this would entail:

- Tackling homophobic, biphobic or transphobic abuse in schools
- Addressing and challenging the continuing sexual and gender norms which marginalise those who are not heterosexual and cisgender
- Providing support and space for LGBT youth to talk about their emotional lives in a safe and non-judgemental environment.

Key policy areas to focus upon are:

- Schools and education
- The role of the online forums and social media
- LGBT youth provision

These are discussed in the following sections.

7.1.2 Schools and education

National policies that aim to tackle homophobic, biphobic and transphobic bullying in schools, colleges and education institutions are crucial to reducing a significant contributor to mental distress in LGBT youth. All educational institutions should have policies to prohibit discrimination and victimisation on the basis of sexual orientation and gender identity (thus complying with the 2010 Equality Act and Public Sector Duty).

Immediate work needs to be undertaken to ensure that schools, colleges and higher education institutions are safe and supportive for gender and sexuality diverse young people. Part of this work may include, for example, ensuring sexuality and gender diversity are compulsory curriculum components. Evidence from the US and Canada demonstrates that education institutions which have in place anti-discrimination policies and supportive measures for LGBT young people have lower rates of self-harm and suicidality compared to education institutions without such policies (Hatzenbuehler et al., 2014, Saewyc et al., 2014). There are international examples of school-based initiatives e.g. Gay Straight Alliance in the US (<https://gsanetwork.org>) and Safe-schools Coalition in Australia (<http://www.safeschoolscoalition.org.au>) which have successfully developed safe and inclusive learning environments for all young people regardless of their sexual orientation or gender identity.

A further recommendation is the development of school-based suicide and self-harm awareness programmes which are embedded in mental health education as part of the curriculum. This study has replicated previous findings that friends are most often turned to when young people want help

with their distress (Hawton et al., 2006). School-based suicide and self-harm awareness programmes would enable young people to know what to do if someone is feeling suicidal or self-harming. Systematic reviews of school-based suicide prevention strategies consistently suggest that these programmes are effective at increasing pupils (and staff) knowledge, attitudes and help-seeking behaviours (Robinson et al., 2013, Cusimano and Sameem, 2011, Katz et al., 2013).

7.2.2 The role of online support and social media

LGBT young people in the study were most likely to use, and want to use, the internet for support and help with their self-harm and suicidal distress. Online interaction was very important to LGBT youth because it provided a safe environment where uncertainty and confusion could be worked out, where difficult emotions could be expressed, and advice and information about mental health could be sought in an anonymous and non-judgemental environment.

Social media and online interaction also provided a means of connecting to others with similar experiences. It was a place where young people could safely disclose their sexual orientation and gender identities and create communities where they felt they belonged. This reduced isolation and facilitated self-esteem, self-acceptance and hope for the future as a LGBT person.

While it must be acknowledged that the internet can also be a negative environment (e.g. cyber bullying), the internet has the potential to be a gateway to more formal sources of help. It is recommended that further research is required on how online platforms can be utilized for suicide prevention and self-harm reduction. There is very little international research that has evaluated online suicide prevention interventions for young people.

7.2.3 LGBT youth provision

LGBT youth groups (online and face-to-face) were rated as the most helpful sources of support. The participants found them to be safe and understanding environments that allowed them to build self-esteem, self-confidence and robust identities. In addition, LGBT youth groups helped to reduce isolation and provided connections with others, which decreased mental distress. This is especially important because, in this study, the family and school proven to be risky environments for young people with diverse sexualities and genders. They can be places where LGBT youth feel unsafe and suffer bullying, abuse and rejection. The provision of support which is neither school or family-based provides a crucial safety net for young people in mental distress.

There is currently a dearth of research on suicide prevention interventions which target LGBT young people. It is recommended that research is undertaken to investigate youth group-based community suicide prevention interventions which specifically target LGBT youth.

7.2 Improving mental health support and services

In this study over three quarters of participants had asked for help for their self-harm and suicidal feelings, most often from the internet or friends. This meant that nearly a quarter of participants had not asked for any type of help at all. It is also concerning that LGBT young people looked for support most commonly when they had reached crisis point because they were no longer coping. Ideally, young people should feel comfortable to look for help prior to this point.

Given that being unable to talk about emotions and feelings (connected to self-harm, suicide, sexuality and gender) increased the risk of self-harm and planning or attempting suicide in the

sample, it is crucial that there is an understanding of the reasons *why* young people do not ask for help. The results suggest that there were three major interconnecting reasons that explained why participants found it problematic to access support. Firstly, they were fearful of hostility to their sexual and gender identity. Secondly, they feared the stigma of having a mental health problem. The third factor accounting for the reluctance to seek help was that the participants felt adults and wider society demeaned their emotions and did not take them seriously.

Perhaps it is therefore unsurprising that only just less than a third of participants had accessed their GP, and a fifth had sought help from NHS mental health services. Furthermore, the overall experience of GPs, mental health services such as CAMHS, gender identity clinics and school-based support was poor. From the perspective of mental health service staff, there were significant barriers to LGBT youth accessing NHS services. These included lack of information about mental health services, fear of judgment and not being understood, and the stigma of mental health diagnoses. Mental health staff identified mandatory LGBT awareness training as one of the best ways to engage LGBT youth in mental health services. The study results indicate that those staff with experience of receiving training on LGBT awareness and self-harm/suicide were more likely to be confident working with LGBT young people who self-harm. However, this may be due to a self-selection bias and more formal research should assess the impact of LGBT training on health care practice as well as people who use the services.

In stark contrast to formal health services, participants rated the internet, friends and LGBT youth groups as very helpful when they were self-harming or feeling suicidal. Young people stated they would be most likely to ask for help from LGBT individuals or youth groups, peers, and mental health professionals. Their preferred mode of access for help was online, followed by face-to-face and mobile (SMS/texting) forms of support. Talking on the phone was the least preferred option.

The conclusion of this study is that in order to support LGBT young people who self-harm and/or feel suicidal there must be recognition that only approximately one fifth of those needing help have contact with formal mental health services. Overwhelmingly participants used informal sources of help (the internet and friends) most frequently. As a priority mental health support and services for this vulnerable group need to be improved, this would entail:

- Mental health support and services provided *outside* the clinical environment.
- NHS mental health services developed so they are more appropriate for this at-risk population group.
- Gender identity services developed so they are more appropriate for this at-risk population group.

Key policy areas to focus upon:

- Online mental health support
- LGBT specific mental health support
- Mental health and gender identity (NHS) services

These are discussed in the following sections.

7.2.1 Online mental health support

The development of online mental health support is a priority. LGBT young people favoured this form of help-seeking and used the internet successfully for support and help. The participants had

positive experiences online and identified features such as ease of access, anonymity, control and lack of judgement as important. Increasingly, in recognition of young people's preferences, mental health support and crisis intervention are being provided online, for example Childline have an online chat facility.

It is recommended that further research should be conducted on how the internet can be utilised for supporting young LGBT people who feel suicidal or are self-harming. There is very little international research that has evaluated online suicide prevention interventions for young people.

7.2.2 LGBT specific mental health support

In this study LGBT specific support was chosen by young people as their favoured form of support. Given the reluctance of participants to contact formal mental health services, the provision of LGBT specific mental health services outside the clinical setting may encourage young people to seek help. There are examples of good practice across the country but these are very few and invariably poorly funded. Examples of LGBT youth specific mental health support services include:

- Placing CAMHS services in LGBT youth groups e.g. self-harm support groups, individual counselling, gender identity groups
- Placing a CAMHS funded trans youth worker in a LGBT youth group
- Funding specialist LGBT youth mental health practitioners to work for CAMHS
- CAMHS or Early Intervention services employing outreach LGBT mental health practitioners
- Provision of online LGBT mental health support. This is currently provided by LGBT voluntary organisations such as MindOut (Brighton), LGBT Foundation (Manchester)
- Training LGBT youth group workers in crisis intervention

These above initiatives and services require further research on whether these interventions reduce LGBT youth self-harm and suicide.

7.2.3 Mental health and gender identity NHS services

Mental health services were in the main found to be unhelpful. Further research investigating why LGBT young peoples' experiences were poor, and how services can be improved is a priority. There is dearth of evidence on LGBT youth use of mental health services and gender identity clinics in the UK and internationally.

Evidence from mental health service staff suggests training in LGBT awareness and young people's self-harm and suicide across the sector is a vital first step to improving services. A key recommendation is that mental health service organisations need to support staff working with young people, and ensure adequate training on LGBT awareness, self-harm and suicide.

GPs fared better but most were not rated as helpful. This may point to the need for GPs to develop greater knowledge of the challenges that young people with diverse sexual orientations and gender identities may face and the various resources that are available to them. Further research investigating why LGBT young people's experience was less than satisfactory, and how primary care services can be improved is a priority.

Gender identity clinics were also criticised for problems with access, waiting times and difficult clinical environments, and much more research is required to understand the experiences of trans

young people in these services, and how they can be improved. This is crucial given that compared to cisgender participants, trans young people had higher rates of planned and attempted suicide.

7.3 Key recommendations

The key recommendations from this report are:

Preventing LGBT Youth suicide:

- NIHR commission research to provide evidence of what works in preventing suicide in this high risk group
- National policy implemented that tackles homophobic, biphobic and transphobic bullying in schools, colleges and education institutions
- National policies to ensure that schools, colleges and higher education institutions are safe and supportive for gender and sexuality diverse young people
- The development of school-based suicide and self-harm awareness programmes which are embedded in mental health education as part of the curriculum
- Further research is required on how the internet can be utilized for suicide prevention and self-harm reduction in LGBT young people
- NIHR commission research to investigate youth group-based community suicide prevention interventions which specifically target LGBT youth

Improving mental health support and services:

- Development of online mental health support targeting LGBT youth
- Development of LGBT specific mental health support outside the clinical environment
- NIHR commission research to investigate online provision of mental health services targeted at LGBT youth
- NIHR commission research to investigate LGBT specific mental health interventions aimed at preventing LGBT youth self-harm and suicide.
- National mandatory LGBT awareness training for all mental health service staff (as part of equality and diversity training for example)
- NIHR commission research to investigate LGBT young peoples' experiences of mental health services and how they can be improved
- NIHR commission research to investigate LGBT young people's experience of primary care and how this may be improved
- NIHR commission research to understand the experiences of trans young people in gender identity services, and how they can be improved

Key recommendations from the Queer Futures conference held on 6th May 2016:

The conference attendees included LGBT young people, health, youth and education practitioners, commissioners and policy-makers. After listening to the findings of the research, the following additional measures were recommended:

- Schools
Addressing homophobia, transphobia and biphobia in schools

Ensuring safe environment for LGBT youth e.g. Gay-Straight Alliances, inclusive PSHE, visible signs e.g. rainbow stickers in classroom doors

Referral system from school to appropriate agencies e.g. LGBT youth groups, online support

Including support services with practitioners from outside school that young people can trust

Ensuring there is a trusted adult/mentor for LGBT youth (confidentiality essential)

Mandatory LGBT awareness training for all school staff (e.g. teachers, cleaners, school nurses)

- Families

Research on the role of families in LGBT youth suicide and self-harm

Support, training and education for families with LGBT youth

- Youth provision

Improve funding of LGBT youth groups

Develop support for suicidal and self-harm LGBT youth

Self-harm and suicide crisis training for youth workers

- Mental health services

Mandatory LGBT awareness training for all staff (in –service and initial training)

Research on collaborations between CAMHS and LGBT youth groups and the provision of mental health services in non-clinical settings

More focus on parents of LGBT youth in CAMHS

- Social Services

Provision of LGBT trained foster carers

Recruit LGBT foster carers

- Other services (police, ambulance, A&E)

Mandatory LGBT awareness training for all staff (in –service and initial training)

- Universal monitoring of sexual and gender identity across education, health and social care services

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