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"What Works" to Support LGBTQ+ Young People's Mental Health: An Intersectional Youth Rights Approach

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Abstract

Despite overwhelming international evidence of elevated rates of poor mental health in LGBTQ+ youth compared to their cis-heterosexual peers, we know relatively little about effective mental health services for this population group. This study aims to produce the first early intervention model of "what works" to support LGBTQ+ youth with emerging mental health problems. Utilizing a mixed method case study, we collected data across 12 UK mental health service case study sites that involved: (*a*) interviews with young people, parents, and mental health practitioners (n = 93); (*b*) documentary analysis; (*c*) nonparticipant observation. The data analysis strategy was theoretical using the "explanation-building" analytical technique. Our analysis suggests an intersectional youth rights approach with 13 principles that must be enacted to provide good mental health services as advocated by the United Nations Convention on the Rights of the Child and World Health Organization. This approach should address the multiple forms of marginalization and stigmatization that LGBTQ+ youth may experience, enable informed independent decision-making, and uphold the right to freedom of safe self-expression. A rights-based approach to mental health services for LGBTQ+ young people is not prominent. This needs to change if we are to tackle this mental health inequality and improve the mental well-being of LGBTQ+ youth worldwide.

Keywords

LGBTQ+, young people, mental health support, early intervention, gender minorities, sexual minorities, human rights, intersectional, youth rights

There is worldwide concern about the prevalence of young people's mental health problems and the COVID-19 pandemic has catapulted young people's mental health to the top of the global health agenda. The United Nations Children Fund (UNICEF) 2021 report "On My Mind: The State of the World's Children" concentrated for the first time on promoting, protecting, and caring for children's mental health. They argue that mental health is a global issue and little attention has been paid to either the problem or potential solutions.[1]

The consensus from the United Nations, UNICEF, and the World Health Organization (WHO) is that there is a fundamental relationship between human rights and mental health. The consensus posits that the most effective, human-rights enhancing approach to young people's mental health care should be based on public health and psychosocial support rather than overmedicalization and institutionalization.[2,3] Importantly, the United Nations has recognized that young people are often forgotten in the human rights framework and specific approaches should be used to ensure the realization of the rights of adolescents because they differ significantly from those of younger children.[2] The problem of ensuring how these rights are

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promoted and protected is identified in this document specifically because the right to development (article 6) is compromised by "the widespread negative characterization of adolescence leading to narrow problem-focused interventions and services, rather than a commitment to building optimum environments to guarantee the rights of adolescents and support the development of their physical, psychological, spiritual, social, emotional, cognitive, cultural and economic capacities".[2(p5)] The United Nations also recognizes that LGBTQ+ young people and ethnic minority/indigenous young people commonly face difficulties because their age and identities can expose them to discrimination, social exclusion, marginalization, bullying, social injustice, and non-inclusion in public spaces. This increases their vulnerability to poverty, mental health issues—including disproportionately high suicide rates—homelessness, poor educational outcomes, and high levels of detention within the criminal justice system.[2]

There is now substantial international evidence that LGBTQ+ young people report significantly higher rates of depression, self-harm, suicidality, and poor mental health than cisgender and heterosexual youth.[4–6] The evidence has been consistent internationally over the last three decades, reinforced through systematic reviews and large-scale survey data. For example, in a 2016 pooled analysis of 12 UK population surveys, people under the age of 35 who identified as lesbian, gay, and bisexual were twice as likely to report symptoms of poor mental health compared with heterosexual peers.[6] Meta-analyses of studies of suicidality in youth have found that, compared to cisgender and heterosexual youth, LGBTQ+ youth have an elevated risk of suicidality.[7,8] Di Giancomo et al. found trans youth were six times, bisexual youth five times, and lesbian or gay youth four times more likely to report a history of attempted suicide.[8] Longitudinal evidence also demonstrates that in the United Kingdom, these mental health disparities start as early as 10 years old, increasing throughout adolescence and peaking between the ages of 13 and 19.[5]

Despite this pronounced inequality, young LGBTQ+ people underuse mental health services compared to their cis-heterosexual peers.[9–13] Studies have found that LGBTQ+ young people are reluctant to access mental health services because of experiences of homophobia, biphobia, and transphobia; cis-heteronormativity (fear that their sexual orientation or gender identity would be scrutinized or blamed for their mental health problems); racism; difficulties disclosing their sexual and/or gender identity; fears of being misunderstood or judged by adults because they were young; stigma related to having mental health problems; issues of accessibility; previous experiences of mental health services; and a lack of understanding of intersectional LGBTQ+ lives.[13–16] These barriers to accessing mental health support are further exacerbated for LGBTQ+ youth of color because services are usually not culturally or linguistically appropriate, and providers can have racist and discriminatory attitudes.[17–19] Research suggests in order to access mental health support, LGBTQ+ youth of color have to navigate social norms related to cultural background and religion that may stigmatize mental health help-seeking.[18]

Furthermore, studies suggest LGBTQ+ young people have poor overall experience of mental health services and school-based support.[9,20–23] Discriminatory and marginalizing experiences include service staff using the incorrect name or pronouns for the young person, it being assumed that every young person is cisgender and heterosexual by default, and service staff asking inappropriate questions.[23] Limited staff awareness and understanding of LGBTQ+ issues and cultural diversity is a problem raised by both LGBTQ+ young people and staff working in mental health services.[11] Research indicates that culturally relevant and social justice-based training of staff who provide mental health support is especially required to ensure LGBTQ+ youth of color receive effective support.[17,24,25] It is critical that an intersectional approach is utilized to understand the diverse and multiple factors impacting access to mental health support for LGBTQ+ youth of color.[19]

Despite the recognition that LGBTQ+ youth are less likely to access mainstream mental health services and have a poor experience, the literature that examines LGBTQ+ youth mental health support needs and service preferences is very limited. A systematic review of qualitative evidence produced between 2008 and 2018 (n = 34 included studies) found that research was more likely to identify barriers to accessing mental health support rather than facilitators to encourage engagement.[26] In addition, there is an absence of focus on intersectional factors such as ethnicity, socioeconomic status, and disability in LGBTQ+ youth mental health care.[27] The study reported here aims to address this knowledge gap by examining "what works" for supporting LGBTQ+ young people who have emerging mental health problems.

Theoretical Framing for the Study

This study worked with the understanding of mental health as a complex phenomenon arising from the social, psychological, economic, political, and environmental context in which human beings exist (biopsychosocial models, social determinants, ecological models). The WHO firmly advocates that youth mental health can only be improved through following an ecological model of mental health.[28] Our approach takes this further and centralizes the workings of power, norms, and socio-economic material conditions that are maintained through institutions, laws, discourse, and people, and affect LGBTQ+ youth mental health. These factors affect how a LGBTQ+ young person may think about themselves, the actions they may take, their access to resources, how others may interact with them, and the rights they may be afforded.

The theoretical framing of the study was developed through a meta-narrative review[29] and is a theory-driven

intersectional youth rights framework informed by four theoretical strands: intersectionality, cis-heteronormativity, youth rights, and critical mental health. This framework centralizes an intersectional approach drawing on Collins's definition "that race, class, gender, sexuality, ethnicity, nation, ability, and age operate not as unitary, mutually exclusive entities, but as reciprocally constructing phenomena that in turn shape complex social inequalities".[30(p1)] Of paramount importance to good mental health is the ability to be able to express identity freely and safely, a right that is enshrined in the United Nations Convention on the Rights of the Child (UNCRC; 2). However, despite legislative improvements for LGBTQ+ populations in some countries, inequalities persist, and we contend that cis-heteronormativity (the assumption of binary gender and an alignment with gender assigned at birth, and everyone is assumed heterosexual) continues to marginalize, stigmatize, and discriminate against those with diverse sexualities and genders. A youth rights approach concurs with the UN acknowledgement that "youth" are subject to discrimination based on their age.[2] Young people are not afforded the same agency or autonomy as adults, are positioned as passive subjects, and are constrained by laws, policy, systems, and life experience that can limit their decision-making and how seriously they are taken by others. Critical mental health critiques the pathologizing of emotional distress, difficult feelings/thoughts, and behaviors as signs of mental illness. We argue this has a negative impact on individuals, especially young people whose emotional distress is pathologized, ignored, and temporalized, e.g., as a "hormonal phase" (see [29] for further details).

This article reports on the third stage of a UK study (www.queerfutures2.co.uk). In the first stage, we reviewed international evidence to develop a theoretical framework to explain effective mental health support and used this to guide stage three (see[29] for more details). Stage two mapped LGBTQ+ youth mental health support across the UK and the 12 case study sites for stage three were selected from the results (see[31] for more details). This article reports from stage three and answers the following research questions: How, why and in what context do mental health early intervention services work for LGBTQ+ young people? How can LGBTQ+ young people be encouraged to access and engage with mental health early intervention services support?

Method

The study used a theory-driven evaluation methodology, which is appropriate as there is little evidence on the effectiveness or acceptability of services and interventions. Experimental designs are excellent to assess the effectiveness of services and interventions, but they cannot assess how or why services achieve particular outcomes in a variety of contexts. Theory-driven evaluation approaches seek not only to understand why a service may work but also to detail the underlying logic or theory of why it may work.

We utilized a collective case study evaluation of mental health early intervention services for LGBTQ+ youth comprising 12 case study sites. A case study is an empirical enquiry that focuses on a single phenomenon in its real-life context, especially useful (as in our circumstances) when description or explanation is required.[32] Collective case studies are those in which multiple cases are studied simultaneously or sequentially in an attempt to generate a broad appreciation of a particular issue. Yin[32,33] defines a "case" as a "bounded entity," a broad and flexible definition that allows the case to be as varied as an event, an individual, a service, or a policy. In this project we have defined the case as "mental health early intervention support service for LGBTQ+ young people in the UK."

The 12 case studies were purposely selected from statutory and non-statutory providers of mental health early intervention support services in the United Kingdom (England n = 10, Scotland n = 1, Northern Ireland n = 1). We estimated that 12 would be an adequate number of cases to capture the range of services identified from stage two of the research (for greater detail see[31]). The study included seven case study sites from the LGBTQ+ charity/NGO sector, three sites from mainstream mental health provision (charity and local authority), one NHS, and one education site.

LGBTQ+ Young People's Involvement

LGBTQ+ young people, the public, service providers and commissioners were involved from the outset to help us ask the right questions in the right way and gain an in-depth, rigorous understanding of the mental health support needs of LGBTQ+ young people. In addition, a young person from the LGBTQ+ community with direct experience and knowledge of mental health services was a research team member. We also had LGBTQ+ young people, aged 12 to 25, from four LGBTQ+ organizations advise the research team through face-to-face and online meetings with the team and an online forum. In addition, the study was advised by a range of stakeholders with experience of mental health service delivery across the NHS, education sector, mental health policy and charity sector for LGBTQ+ support services.

Sampling and Recruitment

Sampling within the case study sites was purposive to ensure that a diverse range of appropriate stakeholders were invited to participate. For service staff, the inclusion criteria were that they worked for the case study site service and had experience supporting the mental health of LGBTQ+ young people. For parent/carers, inclusion criteria were that they had experience caring for an LGBTQ+ young person with common mental health difficulties who had sought mental health support. For LGBTQ+ young people, the inclusion criteria for participation were: 12–25 years old; identified

as LGBTQ+; experience of seeking support for a common mental health difficulty; currently engaged with the case study site service; and not experiencing an acute mental health crisis at the time of recruitment.

Recruitment of LGBTQ+ young people was conducted via digital flyers and posters circulated by the service staff. The flyers contained a brief summary of the aims of the study, what was involved, and how to contact the research team if interested. In some cases, research staff attended online youth group sessions to introduce the study and invite participation. Individual LGBTQ+ young people were selected to ensure we involved a diverse range of LGBTQ+ young people covering gender and sexual identity, ethnicity, and disability. Recruitment of service staff was purposive to gain diverse insights into LGBTQ+ youth mental health support. Parents/carers were recruited only through specific parent/carer support groups that received digital flyers.

The identities of the participants recruited from the case study sites were monitored to ensure the sample was diverse in terms of sexual orientation, gender identity, disability, ethnicity, and socioeconomic status. To boost representation within the sample we specifically targeted recruitment in terms of both ethnicity and gender. The ethnicity of the sample was increased through working with key case study sites that either employed staff of color or had a specific service provision for LGBTQ+ young people of color.

Data Collection

Data collection was conducted mainly remotely due to the COVID-19 pandemic. Methods were designed to facilitate data collection from key stakeholders in each of the case study sites about factors such as service acceptability, gaps in provision, barriers/facilitators to access, views on service improvement, and encouraging access/engagement. At each case study site, we collected data via semi-structured online interviews with service staff, parent/carers, and LGBTQ+ young people; non-participant observation (online and offline); documentary review (online); and a service cost survey (online).

In consultation with LGBTQ+ young people, WhatsApp text chat was used for interviewing because it was a familiar platform, it offered some data security via end-to-end encryption, and if offered the anonymity and privacy not otherwise available via video interviewing. Questions were standardized and made youth-friendly and accessible through the use of images. Qualtrics survey software was used to collect demographic information and service cost data as part of the WhatsApp interviews. All topic guides for the individual interviews were co-produced and piloted with our LGBTQ+ Youth Advisory Group. Non-professional participants (e.g., young people and parents/carers) were offered £20 in gift vouchers as a token of thanks for participation.

All documentary data and non-participant observations were recorded in a case study workbook template that was designed to standardize data collection across the sites. Relevant documentary and non-participation observation data were collected from each site such as policies and procedures (e.g., safeguarding), service evaluations, and information leaflets. The case study workbooks were written up and analyzed as part of the data analysis process.

Ethics

Research ethics permission was granted by an NHS Research Ethics Committee. Informed consent was gained from all participants through an electronic signature on a data secure form before taking part in the interview. It was viewed as an ongoing process, with participants being reminded of their right to withdraw at intervals throughout the study. LGBTQ+ young people aged 12–15 were afforded the right to give consent without the need to involve their parents/guardians. Requiring parental consent may have placed the young person at risk of hostility, abuse, and rejection if their parents were previously unaware of their sexual orientation or gender diversity. There is evidence that disclosure of LGBTQ+ identity to some parents and carers can have potentially harmful consequences and risks familial rejection, abuse, homelessness, and violence.[11,34,35]

It was important to ensure that the project information was accessible to assure comprehensibility and informed consent for all participants. In addition, we provided infographics and made an audio-described information video for young people. The video was linked to the LGBTQ+ young person at the commencement of each WhatsApp interview to ensure that they were aware what was going to happen and how their privacy and anonymity would be upheld. All data were exported direct to a secure, password-protected data store. The data were then anonymized, and the original recordings destroyed. Pseudonyms for the participants are used throughout this article. We worked with each of the case study services to devise a safeguarding and care strategy for LGBTQ+ young participants which involved the direct check-in of service staff with LGBTQ+ young people after their interview.

Data Analysis

The data set—interview transcripts, non-participant observation, and documentary evidence—from each individual case study site were imported into Atlas.ti.9 computer software. The resulting data set was extensive, and we drew on Yin's[33] explanation-building (EB) data analysis strategy, which is designed for case studies with multiple case sites and aims to build a general explanation that fits each individual case. Yin states this method is "analogous to creating overall explanation, in science, for findings from multiple experiments".[33(p142)] EB analysis is used where "how" and "why" questions (i.e., causal questions) are asked regarding complex topics that are difficult to measure.

There were four iterations of analysis conducted by multiple members of the research team. In phase one, we conducted a deductive within-case analysis to test the theoretical model produced from the meta-narrative review.[29] We designed a deductive coding schema (see Appendix 1) that contained all the components of the theoretical model, and the data was coded for each case study site. Once coded, a thematic reading of the coded data within each site was conducted to address the deductive analytical questions: Do these components feature in the case study site data? How are these components important in the specific case study site (if at all)? What is missing? How is intersectionality present in the case study site data? Revisions to the model were recorded and possible inductive codes noted.

The second phase was a deductive/inductive cross-case analysis that aimed to improve the model and develop the inductive analysis. Using the model revisions recorded from each case study site in phase one, a cross-case analysis of the model revisions was used to refine the model. In addition, an inductive coding schema (see Appendix 2) was developed for phase three. The penultimate phase was an inductive within-case thematic analysis to further develop the model. Using the inductive code schema developed in phase two, the data in each case study site was coded and then a thematic analysis undertaken. Each case study inductive analysis informed a model revision that was recorded. The fourth analytical phase was an inductive cross-case analysis to produce the final model (see Figure 1).

Findings

In total 93 participants took part in the study; 45 LGBTQ+ young people; 42 service staff; 6 parent/carers across the 12 case study services. Table 1 demonstrates the diversity of the participants in terms of sexual orientation, gender, age, ethnicity, and disability.

Our data analysis produced a model of early intervention mental health support for LGBTQ+ young people. The model we produced from the analysis includes 13 principles (see Figure 1). These 13 principles are youth rights, intersectionality, accessibility, body, space, time, people, safety, belonging, recognition, agency, possibility, and emotion. In the subsequent sections, we explain each of these 13 principles that underpin beneficial mental health support for LGBTQ+ young people. All 13 principles should be seen as interacting to provide appropriate mental health care.

Youth Rights

In the model of what works to support LGBTQ+ mental health (see Figure 1), a youth rights approach is imperative because it acknowledges, as does the United Nations, that young people are disadvantaged by their age. In the case study data, there was an understanding that rights and power are not explicitly understood and defined in relation to young people in the UK context, and that the resources and support that allow young people to understand their rights are limited. Consequently, their mental health and ability to access mental health care was affected. Sandy (a staff member) explains:

> I think confidence is being able to say "actually, my rights are this, I can wear this uniform," or "under the legislation of the Equality Act, I can use the toilet that is assigned to my gender identity," because I think the confusion that young people have, in my experience, can create unease and anxiety. We've had young people who won't use their school toilet for the whole day until they get home, but with an advocate who informs them, "actually, your right is to be able to use the toilet that is most suitable for you," all of these are contributing factors into affecting a young person's mental health and well-being.

Our data analysis, which aimed to investigate what works to support LGBTQ+ youth mental health, suggests that to be effective, support has to take a youth-centered and rights-informed approach. This approach included providing and co-designing resources for LGBTQ+ young people to understand their rights and help them link their rights (and their infringements) with LGBTQ+ young people's mental health.

Intersectionality

In our findings, an intersectional approach to mental health provision was imperative to recognize the multiple forms of discrimination and marginalization that LGBTQ+ young people may experience, in addition to forms of privilege such as whiteness. Across the case studies, experiences related to age, different LGBTQ+ identities, chronic illness, disabilities, racism and colorism, neurodiversity, homelessness and poverty, and being in the care system were relevant to the type of support LGBTQ+ young people needed. Blue (a young person) described their difficulties:

> Yeah, being a trans person of color is extra difficult and it's another one of those things that you have to either censor yourself about or give people a crash course on racism and either try to convince them that the whole "I don't see race" thing is part of the problem or just give up and pretend they've got it.

Our analysis highlights the necessity of anti-oppressive and reflexive mental health practice. We found good examples of intersectional support and inclusion for intersectional identities across the case studies including groups for young LGBTQ+ people of color and the provision of time-out space(s) to support access related to neurodiversity. These practices were delivered by staff usually sharing those intersectional identities, e.g., trans people of color, which was important to young people.

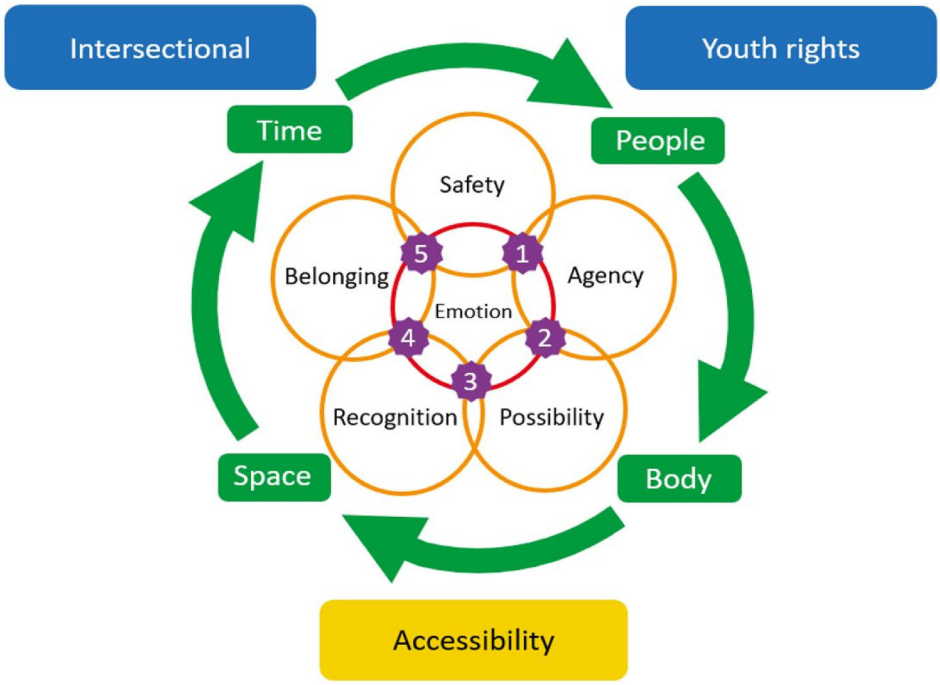

Figure 1. Model for "what works" in early intervention mental health support for LGBTQ+ young people.

Agency, Time and Space

The analysis of the case study data demonstrated that to best support LGBTQ+ young people's mental health, services need to facilitate agentic autonomous decision-making, and position LGBTQ+ young people as experts of their own experience. This agency is critical in the delivery of effective support given young people's transition from a situation of dependency to one of greater autonomy. In the case studies, support was delivered collaboratively with LGBTQ + young people to ensure that young people felt actively involved in provision and not as though things were being done to rather than with them. Transparency regarding confidentiality, privacy, and safeguarding processes showed how services integrated into practice an awareness of the power imbalances between young people and adults. This support was nondirective and options-based, allowing for decision-making including the option for young people to say "no." Devon (a young person) describes their experience:

> They gave me a list of things and what those types of support would do and let me choose, they didn't really keep anything from me or make me feel like I wasn't in control of the decision, but if I didn't know what I needed, they would advise me in what they think might be best but still let me choose.

Our analysis also found that time was fundamental to young people's capacity to make their own choices about mental health support. Delivering support that was aligned with LGBTQ+ young people's pace facilitated their autonomy because they had the time necessary to make fully informed decisions about their care, i.e., time to ask questions, think, and change their minds. In addition, sufficient time enabled young people to build trust with service practitioners and made it easier for them to talk about their feelings, experiences, and needs. Long waiting times to access mental health services and/or gender affirming care can have a particularly burdensome impact.[36] A rapid response to initial contact or offering remote access via phone or internet and "while you wait" support (e.g., online and face-to-face activities and "drop-ins") reduced the possibility of LGBTQ+ young people falling through gaps in provision and improved access pathways to support.

The space in which mental health support was provided was also important in upholding respect for evolving capacities; LGBTQ+ young people felt that most spaces they inhabited were owned, controlled, surveilled, and designed by adults. Services in our case study sites, prioritized building familiarity and ownership of the service space by LGBTQ+ young people, including awareness that the space was not for parents/carers and uninvited adults. This allowed for the freedom and safety to explore and express LGBTQ+ identities and mental health needs. Meeting with other adults/professionals in spaces that were considered the "territory" of LGBTQ+ young people was a way to address power imbalances between LGBTQ+ young people and adults. Laurel (a staff member) elucidates:

> We've set up an appointment to share with the psychiatrist, a community psychiatric nurse, and the young person, and that's worked really well when we've been able to have

Table 1. Sample Demographics.

Variable	Classification	Young people (N = 45)	Service staff/ volunteers (N = 42)	Parents/ carers (N = 6)
Age	12–16	11		
	17–20	23	2	
	21–25	11	4	
	26–35		16	
	36–45		12	1
	46–55		6	5
	56–65		2	
Gender	Man/boy	18	13	
	Woman/girl	8	23	6
	Non-binary	13	3	
	Other*	6	3	
Are you trans?	Yes	32	7	
	No	8	33	6
	Unsure	2	1	
	Prefer not to say	3	1	
Ethnicity	Black African		1	
	Black British	1		1
	Black Caribbean		1	
	Chinese	1		
	Irish		3	
	Latino	1		
	Mixed ethnicity White/ Asian	2	2	
	Mixed ethnicity White/ Black Caribbean	3		
	Other	1		
	Other (mixed ethnicity)*	2	2	
	Pakistani		1	
	Prefer not to say		1	
	White (other)	5	2	1
	White English/Irish/ Scottish/ Welsh/ British	29	29	4
Sexual orientation	Asexual	7		
	Bisexual	6	7	2
	Gay	8	9	
	Heterosexual	2	10	4
	Lesbian	2	6	
	Pansexual	4	1	
	Queer	9	7	
	Questioning	2	1	
	Other*	5	1	
Are you disabled?	Yes	21	6	
	No	20	35	6
	Prefer not to say	4	1	
Type of disability	Chronic illness	2	2	
	Learning disability	9	1	
	Mental health condition	27	4	
	Mobility impairment	4	1	
	Neurodiversity	12		
	Other*	1		
	Prefer not to say		1	
	Sensory impairment	4		
	Undiagnosed mental health condition	26		
Highest qualification	No qualifications	6		
	GCSE	16		
	AS Levels	1	1	
	A Levels	15	2	2
	HE Diploma	2	2	1
	First Degree	2	20	1
	Higher Degree	2	15	2
	Trade apprenticeship	1		
	Prefer not to say		2	
Employment	Student	28	2	
	Unemployed	9		
	Full-time employment	1	26	5
	Part-time employment	4	12	1
	Other	3	1	
	Prefer not to say		1	
Parent degree	Yes	23		
	No	16		
	Unsure	6		
Free school meals	Yes	18		
	No	19		
	Unsure	8		

*Where "Other" classifications are marked with an asterisk, this indicates that a number of responses have been combined. While we recognize the problems inherent in identifying individuals as "other," this was not a category that was offered by Queer Futures 2. Instead we have made the decision to represent characteristics like this to ensure anonymity.

> that onsite—that's familiar to the young person. They've come in beforehand, and we've laid out the chairs. It's trying to think about their empowerment, to help them and to have their voice heard in a place where they feel that they're already listened to, it's not medical.

Recognition, Body, Possibility

A strong and consistent finding in the study showed that effective mental health support must actively recognize LGBTQ+ identities in the wider context that undermines them. Cal (a staff member) described the importance of service affirmation of sexual and gender identity:

> I may be the only adult in that young person's life that celebrates their queer identity openly and unashamedly, unabashedly. Most of the stories they tell us, not all, but most of the stories they tell are of ignorant adults in their lives and I think it weighs on them.

The recognition of diverse LGBTQ+ identities is concerned with the fundamental sense of a young person

being valued, respected, and affirmed within a service. Affirmation needs to balance a "normalization" of LGBTQ+ identities that does not stray into the territory of fetishizing or othering; and an understanding that identities are fluid, not linear, and that becoming LGBTQ+ (or anything else) has no fixed destination. Being "unsure" is also a valid option and should be included in service forms and conversations about LGBTQ+ identities. Stevie (a young person) explains:

> I feel safe, welcomed, appreciated. The service is very inclusive. You don't need to have anything figured out. They make sure they always include "unsure" options. This is very welcoming and makes you feel like you can get support even if you don't know.

Across the case study sites, we found that upholding and advocating for the bodily autonomy of LGBTQ+ young people was paramount to effective mental health support. This was achieved through the provision of practical, emotional, and affirming support for gender exploration, expression, and transition, including in relation to GIDS/GIC referrals. Providing spaces for and posting signs about resources where young people could explore the body and self-expression were invaluable for the validation of LGBTQ+ identities, building self-confidence, facilitating informed decisions about young people's own bodies, and supporting mental health.

The analysis suggests that case study sites understood that LGBTQ+ youth can feel hopeless about their futures because they do not fit within the cis-heteronormative trajectories of future adulthood. The principle of possibility relates to LGBTQ+ young people's ability to imagine happy and fulfilled futures for themselves on their own terms. Services nurtured and uplifted LGBTQ+ young people's sense of possible futures through a range of practices, such as psychoeducation to develop LGBTQ+ young people's understanding of cis-heteronorms; community building and modeling diverse LGBTQ+ futures through mixed age group work; employing diverse "out" staff; and hosting LGBTQ+ adult guests to talk about careers, family building, or other aspects of adult life. Tomi (a young person) expounds:

> As an LGBTQ person in a particularly homophobic school to be welcomed with such open arms was so good. I remember after my first session feeling like I could do anything I wanted to because I knew who I am isn't a bad thing it's something to be celebrated.

In the model we have produced (see Figure 1), the people delivering mental health support were crucial for appropriate mental health support for LGBTQ+ young people. This was because, for mental health care to be effective, LGBTQ+ young people need to be able to express their views and feelings and be taken seriously by adults. However, difficulties trusting adults complicates this process for LGBTQ+ young people. Our research indicated that LGBTQ+ young people may feel unsafe in relationships with adults, including authority figures, and institutions, such as social workers and the police. This distrust may be exacerbated due to multiple marginalization and discrimination, e.g., institutional racism, and poor experiences navigating health care services.[37] Billie (a staff member) explains:

> We're a mental health service, so we sometimes suffer from that lack of trust that young people might have in professionals if they've been burnt before where someone has handled something in the wrong way, someone's betrayed their trust, that's quite a common problem.

Reciprocity in relationships with mental health support staff, e.g., listening and talking on both sides, helped to address power imbalances inherent between an adult and young person and fostered trust and security. The analysis suggests that mental health support services should not presume that LGBTQ+ young people trust adults or have a trusted adult in their lives. Services should actively seek to build trust between LGBTQ+ young people and adults but assumptions about relationship hierarchies should also be avoided, e.g., parents and family are "most important." For many, familial relationships could be the source of distress, harm, or violence. Instead, the diversity of different relationships in a LGBTQ+ young person's life should be supported. Where relevant, supporting LGBTQ+ young people as they navigate their relationships with their family/carers or teachers/school may be helpful.

Safety and Belonging

In our model (see Figure 1), safety and belonging were critical to good mental health support. LGBTQ+ young people often feel unsafe or insecure in areas of their lives (e.g., family, at school, public space) due to bullying and harassment in relation to their gender or sexuality, age, and ethnicity. The fear experienced as a result creates widespread uncertainty for LGBTQ+ young people about what may happen to them, including within mental health support services, with fears arising around the possibility of being judged or being outed to parents or carers by services. Jasmine (a staff member) explains:

> They're so scared that somebody will find out, and somebody will judge, and all that sort of thing. So when the young person comes to talk to us, we need to open up those layers that they find frightening.

Our analysis suggests that active reassurance of confidentiality and anonymity is crucial to fostering safety in mental health support settings for LGBTQ+ young people. Support services ensured LGBTQ+ young people understood that nothing would happen "to them" without either informed consent and agreement, or at least with knowledge about

what was going to happen in the case of safeguarding interventions that necessitate confidence breaking. Transparent and honest communication between mental health support services and LGBTQ+ young people encouraged the young people to feel trust and safety. Blue (a young person) explains the importance of safety:

> Experiencing emotions was beneficial, the service was just the only place where I felt safe to do so. So my sometimes having strong negative feelings in group was a result of me feeling safe.

Some of the practicalities of creating safety for LGBTQ+ young people across the case study sites included the provision of all gender toilets and using an online presence to manage expectations about "what will happen when you visit," such as video service walk-throughs and offering "taster" sessions. Service staff moderation of both in-person and online support was welcoming and non-threatening.

Our analysis found that providing safe mental health support required services that foster belonging and promoted comfort and care for LGBTQ+ young people. These care practices included helping a young person to "settle in" to a group through checking in, reassurance, and buddying with another LGBTQ+ young person. This active reassurance and inclusion enabled young people to sustain a meaningful engagement with the service. To develop safety and belonging, case studies sites provided protected spaces such as annual residentials or specific identity groups that enabled connection to other LGBTQ+ young people and adults. Sammy (a young person) explains:

> It enables trans youth to connect with each other, which allows people to explore their identities more and just exist with other trans people, which I think in itself is very empowering and good for my mental health.

Accessibility and Emotion

As the United Nations rightly asserts, health services are seldom designed to address the specific health needs of young people. In the model that we have generated from our analysis, it is envisaged that all 13 principles are integrated to support LGBTQ+ young people's mental health to improve access to services and to promote a sustained engagement with that support to improve mental health. At the center of this model is the validation of LGBTQ+ young people's distress as a logical response to marginalization and stigma. We found that the most effective mental health support centered the young person's emotion and moved away from the usual position of deficit in which something is "wrong" with an LGBTQ+ young person to focus, instead, on developing skills and trust in communicating about feelings. The de-pathologizing of feelings and emotions, the findings indicate, included ensuring a diagnosis is not a requirement to access the service and an understanding of the complex role of mental health diagnosis to young people. Maria (a staff member) explains:

> We're conscious that young people often have a lot of diagnoses. For some, that will have been a relief to have a diagnosis. And for some it is not something they feel happy about, and it feels that it was imposed on them. So diagnosis is important but more in terms of how that person views their own life choices.

Our analysis identified that an emotion-centered approach that involves non-pathologizing and making it usual to communicate feelings was beneficial in validating the experience of LGBTQ+ young people. The feelings of LGBTQ+ young people were taken seriously, and staff were cautious not to minimize their emotions and feelings.

Discussion

This study provides the first large scale theory-led evaluation of early intervention mental health support for LGBTQ+ young people with common mental health problems. Currently the evidence base on LGBTQ+ young people's mental health is dominated by studies demonstrating prevalence and charting risk and resilience factors. Research investigating ways of addressing mental health problems in this population group is much less prominent. As a result, this study directly provides the means to tackle the elevated prevalence of mental health problems in this group of young people.

Our findings suggest that intersectional youth rights should underpin the delivery of mental health support for LGBTQ+ young people to address the multiple and overlapping marginalization, isolation, and stigmatization they may experience. This approach will enable young people to make informed, independent decisions about their own bodies and lives, and for the right to freedom of safe self-expression to be upheld. This intersectional, youth rights approach concurs with Gibson's[38] excellent "youth informed" mental health care that clearly recognizes the importance of understanding young people's distress from their perspective, treating young people as experts in their experience, the centrality of identities to effective mental health support, and the critical importance of youth agency and autonomy. At the center of our youth rights approach is the acknowledgment that young people's knowledge about their lives and mental health is "subjugated," and we do not value their contribution. This is an "epistemic injustice" in the sense that it is "a wrong done to someone specifically in their capacity as knower".[39(p1)] Mental health support must be premised upon the recognition and respect for the dignity, experiences, and agency of young people.

The fundamental basis of our model to support LGBTQ+ youth mental health is to understand that they live in a

cis-heteronormative world that, despite improvements, continues to either explicitly denigrate LGBTQ+ identities or marginalize and silence those lives. Our findings strongly demonstrated that to uphold the right to non-discrimination, young people must be supported to exist within and to resist these difficult normative environments. An intersectional approach is required to ensure nondiscrimination (UNCRC article 2) on the basis of age, sexual orientation, gender identity, ethnicity, social class, and disability, and the right to development (UNCRC article 6). LGBTQ+ identities are often represented in homogenous ways with homo/trans norms conferring understandings of LGBTQ+ young people as a homogenous group (white, middle class, etc.). When thinking about the experience and impacts of violence, discrimination, marginalization, and neglect, identity categories are often conceived as discrete from each other and static rather than fluid and overlapping. This is why an intersectional youth rights approach to mental health provision is crucial; in this approach young people are positioned as rights holders, underscoring the requirements of duty-bearers—including governments—to meet these rights in line with international human rights instruments across multiple identity categories. Our rights-based approach recognizes the basic human dignity of each young person, and it provides a framework to ensure the LGBTQ+ young people's rights are met within mental health support.

We know LGBTQ+ youth may not access mental health services when they need support because their marginalized position makes access difficult compared to their cis/heterosexual peers. The analysis from the case study evaluation is premised upon the idea that improving early intervention mental health support overall will also increase access to, navigation of, and engagement with those services. However, our findings indicate that there are some deeply seated, multi-factored complexities to LGBTQ+ young people seeking help and accessing appropriate mental health services. Our analysis suggests that the navigation of mental health services and access and engagement with these services are contingent on the power differential between LGBTQ+ young people and the adults they seek help from.[12,38] Key to our model is the understanding that being young is associated with a lack of power that can affect the ability to access services. When LGBTQ+ youth feel more powerful and confident, there is greater likelihood they will ask for help from mental health services and remain engaged to receive support.

There are some limitations to the study. Conducting research during the COVID-19 pandemic was extremely demanding, particularly given the focus was LGBTQ+ young people's mental health. The pressure on mental health services during the data collection period was immense, and there were instances where charity-provided services had to dramatically reduce their service provision or even close altogether due to loss of funding. This meant we were not able to fully recruit sites across the four nations. We were unable to recruit any case study site in Wales and one site in Scotland was unable to participate in the study because they were overburdened with providing support and services to LGBTQ+ young people. We had to revise the methodology, which meant reconfiguring data collection tools and data security. WhatsApp was used for interviews with LGBTQ+ young people and we acknowledge that digital technologies and the requirement to use a digital device to participate (e.g., smartphones or laptops) is exclusionary for some young people. For some we were aware that disabilities, digital poverty, or living circumstances (e.g., being in care home settings) would limit participation remotely; however, in the context of COVID-19 UK national lockdowns, we were unable to offer a face-to-face alternative.

The study findings indicated that there is a gap in mental health provision for LGBTQ+ young people of color. Few of the case study sites had incorporated working practices that provided for this group of young people and, consequently, this absence is a shortcoming in the findings of our research. Further research is required on why LGBTQ+ young people of color may have elevated rates of poor mental health and how best to improve mental health in this population group.

Conclusion

The UNCRC makes explicit the importance of valuing youth as a positive life stage and that ensuring supportive environments to safely develop and explore identities is fundamental to good mental health.[2] In the United Kingdom, a rights-based approach to mental health service provision is not prominent or mainstream. There is very little evidence that young people's rights are of concern in the realm of mental health services. Research suggests that current practice in the United Kingdom's Child and Adolescent Mental Health Services highlights some disparities in services, which result in questions about human rights for young people.[13,40–42] In addition, LGBTQ+ young people are facing active legislative and policy attacks on their human rights; the United Kingdom was identified alongside Hungary and Poland in a 2021 Council of Europe report condemning attacks on LGBTQ+ human rights, particularly for trans people.[43] Legislative attacks have placed young people's access to gender-affirming health care at risk,[44,45] and trans and gender-diverse young people have been excluded from the development of legislation banning conversion practices. Within this uncertain landscape, it is more important than ever to center and uphold children and young people's human rights in mental health services and support.

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Supplemental Material

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