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Equitable Access to mental Health Support for LGBTQ+ Young People: A Feminist Intersectional Youth-Rights Approach

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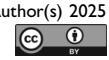
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Abstract

The global burden of young people's poor mental health has stimulated increased attention on improving access to mental health services. However, young people are reluctant to seek help for mental health problems, and this is most often framed as an individual deficit. The power relations that disadvantage youth, such as age, gender, sexual orientation, race/ethnicity, and poverty, are rarely included in research. Our U.K. study made power central through a feminist intersectional youth-rights approach to improving accessibility for LGBTQ+ youth to mental health support. Using a case-study theory-driven evaluation methodology across 12 mental health support sites, data were collected via (a) interviews with LGBTQ+ youth, parents, and staff; (b) documentary review; and (c) nonparticipant observation. Data analysis involved a multiphase "explanation-building" analytical technique. We found that to improve access, power must be addressed across four domains: (a) structurally through

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provision of well resourced, legitimated services; (b) culturally by building cultural safety for LGBTQ+ identities; (c) disciplinary by designing services that not burden youth; and (d) interpersonal through open relationships that provide comfortable engagement. Equitable access requires policy and practice to take a feminist intersectional youth-rights approach that tackle the multiple power relations that make LGBTQ+ youth hesitant about help-seeking.

Keywords
intersectionality, LGBTQ+, mental health, service accessibility, United Kingdom, youth

The recognition of the global burden of young people's poor mental health has resulted in increasing attention from policy, practice, and research on how to improve access to mental health services and support. The World Health Organization's (WHO) Mental Health Action Plan 2023–2030 states that mental health services for children and adolescents must be evidenced-based, culturally appropriate, and human-rights-orientated (WHO, 2021).

Evidence demonstrates, however, that young people are reluctant to access mental health services and ask for help (Sadler et al., 2018). Consequently, there has been a proliferation of research that attempts to improve our understanding of this hesitancy. Numerous systematic reviews suggest that the main barriers to access include stigma, family and cultural beliefs about mental health, lack of mental health literacy and emotional competency, and previous poor experience of services (Barrow & Thomas, 2022; Cox et al., 2024; Eigenhuis et al., 2021; Gulliver et al., 2010; Michelmore & Hindley, 2012; Rowe et al., 2014; Velasco et al., 2020). To a lesser extent, structural factors such as cost, time, and transport have been identified (Radez et al., 2021; Velasco et al., 2020). These same reviews suggest there is much less research focused on factors facilitating mental health service access, but significantly, identify the presence of a trusted adult, perceived confidentiality and nonjudgement, mental health literacy, previous positive experiences of services, social support and community engagement, and familiarisation with the help-seeking process as key to improving access (Barrow & Thomas, 2022; Cox et al., 2024; Radez et al., 2021; Velasco et al., 2020).

Cox et al. (2024) argue that what is missing from research on young people's mental health and help-seeking is a greater examination of the facilitators of access to support, and a wider consideration of the broader systemic factors that influence help-seeking. They used a systems approach in their systematic review of help-seeking and self-harm, and found that research was overly focused on service delivery and individual barriers to help-seeking. Less often considered were factors relating to government and regulatory systems. We take this argument further and posit that without taking into consideration the wider systems of interlocking power that shape young people's lives, we will not be successful in improving their access, uptake, and engagement with mental health

support and services. This is especially the case for those young people most at risk of suffering from poor mental health, for example, trans and nonbinary young people (Lucas et al., 2024), those minoritised due to their race/ethnicity (Lu et al., 2021; Wang et al., 2020), and LGBTQ+ youth (Higgins et al., 2021; McDermott, 2015; McDermott et al., 2018). For these young people help-seeking takes place in a life context whereby they may be marginalised and discriminated against on the basis on their age, gender, sexuality, race/ethnicity, and socioeconomic status, and these experiences and structures influence their ability to access mental health support.

Lesbian, gay, bisexual, trans, queer and questioning (LGBTQ+)[1] young people experience poorer mental health outcomes than their cis-heterosexual counterparts (Semlyen et al., 2016); for example, trans youth are 6 times, bisexual youth 5 times, and lesbian and gay youth 4 times more likely than their cis-heterosexual peers to attempt suicide (di Giacomo et al., 2018). This disproportionate level of poor mental health is widely understood as resulting from "minority stress" (Meyer, 2003), that is, the marginalisation, discrimination, and victimisation due to homo/bi/trans phobia and pressure of cis-heteronormativity (Wilson & Cariola, 2020). Despite this mental health inequality, research indicates that a significant proportion of LGBTQ+ young people do not ask for help (Lytle et al., 2018; McDermott, 2015; McDermott et al., 2018; Williams & Chapman, 2011), and if they do access services and support, they often find them unhelpful (Higgins et al., 2021; McDermott et al., 2018).

The reluctance of LGBTQ+ young people to use mental health services is due, evidence suggests, to specific additional issues relating to sexual and gender diversity. These include anticipated and direct discrimination when seeking help (Holt et al., 2024; Hubach, 2017; Kcomt et al., 2020; McDermott et al., 2018; McDermott & Roen, 2016), concerns about confidentiality and risks of being "outed" (Hubach, 2017; Lucas et al., 2024; Wilson & Cariola, 2020), lack of LGBTQ+ knowledgeable services (Higgins et al., 2021; McDermott et al., 2024; Moore et al., 2020), lack of support from family and fears of parents finding out about LGBTQ+ status (Lucas et al., 2024), and poor relationships with parents who are required to consent or facilitate services (Higgins et al., 2021).

Furthermore, evidence reveals that access is made more difficult by multiple marginalisation, especially for trans and nonbinary young people and/or those ethnically and culturally minoritised (Lu et al., 2021; Moore et al., 2021; Wong & Menkes, 2018). Lucas et al. (2024) found in a U.S. large-scale survey that trans and nonbinary youth were more likely than cisgender youth to report barriers to accessing mental health services because they felt afraid, did not know how to get help, and were fearful of parents finding out. Rusow et al.'s (2022) study, with a sample of 108 gender-diverse youth of colour, found that although 85% expressed a need for mental health support, only 30% obtained mental health services, and more nonbinary than binary-aligned youth reported needing services. Although studies that examine mental health help-seeking, service utilisation, and LGBTQ+ youth of colour are rare, research suggests that the multiple stigmas of mental health and LGBTQ+ identities within some ethnic cultures, and intersectional discrimination in services, are barriers to receiving appropriate care (Moore et al., 2020, 2021). Roulston et al.'s (2023) study found that sexual minority youth of colour were more

likely to access mental health care during the COVID-19 pandemic if they lived in areas with lower homophobia and anti-Black racism. However, an emerging stream of literature demonstrates that acts of resistance and building community resilience among LGBTQ+ populations can address these power dynamics and provide the possibilities for positive mental health and help-seeking (McDermott et al., 2024; Parmenter et al., 2024). This body of research illustrates the importance of considering diverse structural factors and applying an intersectional lens when investigating access to mental health support and care among multiply marginalised youth.

A further problem with the help-seeking literature is the lack of theorisation of the concept of youth, which is presented as a variable, a number, or a biologically determined fact. There are very few explicit efforts to think about young people as a population group that are positioned without power in relation to adults (for exceptions, see Fullagar, 2005; LeFrançois, 2013; McDermott, 2015). Gibson's monograph (2021) is notable for explicitly addressing young people's power when examining access to mental health services. She argues that young people's autonomy and agency are crucial to successful mental health care, but these are usually constrained by the lack of power they have in society. Her critique suggests "young people's lack of access to power is normalised and is treated as a necessary part of this life stage" (Gibson, 2021, p. 68). As a consequence, one of the main reasons for not seeking help is that young people fear adults taking control of their lives.

Albeit not specific to LGBTQ+, Gibson's (2021) work presents an uncommon example of power centralisation as a factor in relation to young people's mental health service access that contrasts with mainstream approaches where age power relations are typically absent. In our study, we focused on the multiple interlocking power systems that may impact on LGBTQ+ young people's access to mental health care. Crucially, we take a youth-rights approach that acknowledges, as the United Nations (UN) does, that adolescents are disadvantaged due to their age/identities, and that specific measures must be enacted to ensure their human rights are guaranteed, including access to mental health services (McDermott et al., 2024; United Nations Committee on the Rights of the Child [UNCRC], 2016). Our aim was to provide new knowledge on what facilitates access to mental health support for this marginalised group of young people. We report from the Queer Futures 2 study that examined "what works best" in U.K. early intervention mental health support for LGBTQ+ youth (McDermott et al., 2021, 2024). In this paper, we specifically answer one research question: How can LGBTQ+ young people be encouraged to access and engage with mental health early intervention services?

Theoretical Approach

Our research takes a critical approach to mental health. What we mean by this, in this context, is that we prioritise consideration of social factors implicated in youth distress and how the experience of such distress for LGBTQ+ youth at an "early intervention" stage is a reflection of "normal" human feelings that arise from the burden of wider oppressive social systems (e.g., cis-heteronormativity) rather than individual (psycho) pathology. These impacts may be defined in psychological terms as minority stress

(Meyer, 2003). We consider our analytical approach to offer a complement to minority stress through attention to social systems of power.

We utilised an inclusive feminist intersectional framework to address the impacts of multiple discriminations arising from intersecting systems of oppression such as gender, racism, homo/transphobia, ableism, and ageism. The feminist ethic of care and attention to power imbalances within and across the research project and the research team were accompanied by the use of an intersectional methodology and analytic strategy.

Ussher (2009) made clear in this journal that we must be "wary of denying diversity and difference" (p. 561) in investigating LGBTQ+ health research and care. Similarly, Huang et al. (2020) argue in their systematic review that there is a need for intersectional theory to be thoroughly embedded in research on LGBTQ+ mental health to ensure results are applicable to all people. Our approach followed Black feminist thought and utilised Collins's (2015, p. 1) definition of intersectionality as "the critical insight 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." Cognisant of the ways in which intersectionality has been reduced in some academic spheres to an attention to identity alone, and with a commitment to social justice, we honour the rich histories of intersectionality's development, including but also going beyond Crenshaw's noted "coining" of the term (1989). Intersectionality is a feminist knowledge project stemming from Black, indigenous, and women of colour activist struggle and analysis of the "interlocking" systems of oppression that shape their lives (Combahee River Collective, 1977, para. 1). Therefore, we remained vigilant to keeping race and structural analysis as a central focus, including White privilege. In this study, we emphasise "structural intersectionality" with an analysis of the ways in which structural power dynamics intersect and shape LGBTQ+ youth's intersectional identities/subjectivities and experiences of mental health support services and help-seeking (Cho et al., 2013).

In operationalising our definition of intersectionality to shape data collection, analysis, and output, we were guided by Collins and Bilge's (2020) four domains of power—structural, cultural, disciplinary, and interpersonal—in the design of the study (see Table 1 for definition of the four domains of power). Our application of the intersectional framework worked with the idea that categories have porous boundaries that are always permeated by other categories, and this process is fluid and changing as the dynamics of power change (Cho et al., 2013). In this paper, we use the four domains of power as an organising structure for the findings reported in the subsequent sections.

Methodology

Feminist and queer scholars in particular have debated the challenges of employing methodologies that capture the complexities of intersectionality in an empirical setting (see e.g., Bailey et al., 2019; Cho et al., 2013; Collins & Bilge, 2020; Huang et al., 2020). There is, however, consistent agreement that methodologies aiming to have an intersectional approach should involve and privilege the perspectives of those who have knowledge and experience of the interlocking systems of subordination (Cho et al., 2013;

Table 1. Collins and Bilge's* Definitions of Intersectionality's Four Domains of Power.

Domain of power	Definition
Structural	the fundamental structures of social institutions such as job markets, housing, education, and health
Cultural	increasing significance of ideas and culture in the organisation of power relations
Disciplinary	refers to how rules and regulations are fairly or unfairly applied to people based on race, sexuality, class, gender … as individuals and groups we are 'disciplined' to fit into and/or challenge the existing status quo, often not by overt pressure, but by ongoing disciplinary practices
Interpersonal	how individuals experience the convergence of structural, cultural and disciplinary power. Such power shapes intersecting identities of race, class, gender, sexuality, nation and age that in turn organise social interactions

Note. *Collins and Bilge (2020, pp. 6–15).

Collins & Bilge, 2020; Huang et al., 2020). Our study aim was to find out "what works" in early intervention mental health care for LGBTQ+ youth, and how to encourage access and engagement with those services. Taking an intersectional approach, we placed LGBTQ+ young people at the heart of the research in terms of collaboration with them and through mixed-methods qualitative research that prioritises real-life experiences. In addition, the research team and research advisory group comprised a range of LGBTQ+ identities and ages, including trans, nonbinary, and people of colour, as well as those with neurodiversity, disability, and lived experience of mental health care.

Following Yin (2014, 2018), we employed a case-study, theory-driven evaluation methodology appropriate for cases where there is little evidence on the effectiveness or acceptability of services. Theory-driven methodologies seek to understand why a service may work and to detail the underlying theory of why it may work (Coryn et al., 2011; Yin, 2014). We used a mixed-methods collective case study across 12 case-study sites (for further detail, see McDermott et al., 2024). 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 (Crowe et al., 2011). Yin (2014, 2018) defines "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 study, we defined case as a "mental health early intervention and self-care support service for LGBTQ+ young people in the UK."

The 12 case studies were purposively selected from statutory and nonstatutory providers of mental health early intervention support services in the UK (McDermott et al., 2024). The study included seven case-study sites from the LGBTQ+ charity/nongovernmental (NGO) sector; three from joint mental health provision (charity and local authority); one statutory health (National Health Service [NHS]) site; and one education site. At each case-study site, data were collected via (a) WhatsApp interviews with LGBTQ+ young people ($N = 45$), and online interviews with family members ($N = 6$) and service staff ($N = 42$); (b) documentary review; (c) nonparticipant observation.

Recruitment and Sampling

LGBTQ+ youth aged 12–25 years were recruited via digital flyers distributed through their support workers, service websites, and social media. Staff were recruited via email invitation. LGBTQ+ young people were purposively selected with guidance from service staff to ensure sample diversity and that they could safely participate in the research. This was important as fieldwork took place during national COVID-19 lockdowns (April 2020–December 2021). Staff were also purposively selected to offer a range of perspectives by role (e.g., LGBTQ+ youth workers, clinicians, service managers). Parent and carer participants were only recruited when the services hosted specific parent/carer support projects (for full sample demographics, see McDermott et al., 2024). Specific recruitment strategies were employed to ensure that the intersections of identities/experience relevant to this study, especially trans and nonbinary, minoritised ethnicity, and neurodiverse youth, were included. This involved, for example, working with LGBTQ+ youth of colour groups as well as gender-diverse groups that operated at case-study sites.

Data Collection

WhatsApp text interviews were selected following input from LGBTQ+ young people about preferred methods of online engagement and security features (end-to-end data encryption) during COVID-19 lockdown. The aim of the interviews was to generate in-depth data (Braun & Clarke, 2013) about LGBTQ+ youth (and parent/carer) experience of barriers/facilitators to accessing services, including what the service did that was supportive/unhelpful and how it was carried out. We asked LGBTQ+ youth specific questions, including how they learnt about the service, and factors that made getting support easier or harder. With staff and parents/carers, we asked about first contacts of LGBTQ+ young people with the service, as well as barriers and factors impacting sustained engagement. For staff, we also explored the values underpinning support to LGBTQ+ youth, and the associated challenges. Interviews with LGBTQ+ youth, staff, and parents/carers lasted on average 1–1.5 hr. Nonstaff participants were thanked with £20 gift vouchers.

Case-study site observations and documents were monitored for specific intersectionality factors regarding accessibility, including attending to what was missing in terms of silences and privileges. We reviewed young people's intersectional accessibility needs, assessed the intersectionality of staff demographics and their visibility, and how services dealt with homophobia as well as transphobia, racism, ableism, ageism, and misogyny both inside and outside the service. These data were recorded in each case-study workbook, devised to standardise data collection across case-study sites.

LGBTQ+ Youth Involvement

An LGBTQ+ young person with lived experience of mental health care was a member of the research team for the duration of the study. Their involvement was facilitated via an LGBTQ+ youth worker. We had a consultation group of LGBTQ+ young people on

Table 2. Intersectionality-Specific Codes.

Code	Definition
Deductive: Intersectionality: Structural	Fundamental social structures (e.g., housing, education, and health) that maintain LGBTQ+ youth (mental health) inequalities.
Deductive: Intersectionality: Cultural	Ideas and culture that perpetuate unequal power relations; and those that redress power imbalance.
Deductive: Intersectionality: Disciplinary	Rules/regulations/practices that are unfairly applied to people based on race, sexuality, class, gender, and disability.
Deductive: Intersectionality: Interpersonal	How individuals experience the convergence of structural, cultural, and disciplinary power.
Inductive: White privilege and racism	How Whiteness/privilege is addressed; and how racism and its intersections are understood and addressed by the service.

Facebook to inform about the research questions, methods, and young person involvement for the research grant application and project initiation. Overall, we had extensive collaboration with LGBTQ+ young people throughout the study both face-to-face (prior to COVID-19 lockdowns) and online. LGBTQ+ young people significantly shaped the entire study from devising the research questions, to advising on whether to waive parental consent and how best to do this, to study materials (e.g., project website design, participant information videos) and methods (such as interview questions/graphics, choice of methods). Our findings were validated and outputs informed through workshops with LGBTQ+ youth groups at our case-study sites (e.g., production of "know your rights" mental health support videos for LGBTQ+ young people; https://queerfutures2.co.uk/resources/).

Analysis

This theory-driven evaluation methodology drew on Yin's (2014, 2018) explanation-building (EB) data analysis strategy. EB is designed for multisite case studies and aims, through iterative stages, to build an overarching explanatory framework that fit each individual case. Yin (2014, p. 142) states that this is "analogous to creating overall explanation, in science, for findings from multiple experiments." EB is used where "how" and "why" questions (i.e., causal questions) are posed regarding complex, difficult to measure topics. Coding began with a deductive framework developed from a theoretical model produced in Stage 1 of the study (McDermott et al., 2021). Inductive codes derived through the primary (deductive) coding process were then integrated into the coding framework. Holding intersectionality analytically central, we used codes related to the four domains of power (structural, cultural, disciplinary, and interpersonal) in the deductive (D) and inductive (I) coding phases (see Table 2 for intersectionality code definitions).

In the inductive phase, we also coded for "accessibility," defined as data related to factors that facilitate or inhibit access and engagement. Co-occurrence of the intersectionality codes with "accessibility" was instrumental in the analysis forming this paper.

The analysis that informs this paper was conducted by a predominantly White research team with diverse genders and sexualities (majority LGBTQ+ identifying). In addition to lived experience, many of the team members brought a diversity of experience working in health and social care as well as community settings, including with LGBTQ+ and young people, in addition to their academic training.

Ethics

This study received ethical approval from the NHS Research Ethics Committee. Project information was provided in text and captioned video. Informed consent was given by all participants before taking part in the study. LGBTQ+ youth aged 12–15 were able to consent without parental/guardian involvement to avoid placing them at risk, as disclosure of LGBTQ+ identity can have potentially harmful consequences, such as familial rejection, abuse, homelessness, and violence (Salerno et al., 2022). This study did not recruit young people in mental health crisis; it focused on views and experiences of mental health services as opposed to mental health difficulties, gender, or sexuality. Additional care practices were formulated for LGBTQ+ young participants. Namely, WhatsApp interviews were arranged in co-ordination with their support workers so check-in followed immediately after participation. Data were anonymised, pseudonyms were used, and "raw" data were destroyed once anonymised versions of the dataset were generated. All data were stored on a secure, password-protected university server that was accessed only by the immediate research team.

Results

We report here the results of our analysis examining how best to improve access and engagement with mental health support for LGBTQ+ young people. In the subsequent sections, we outline how access and sustained engagement are contingent on addressing intersectional power relations at the (a) structural, (b) cultural, (c) disciplinary, and (d) and interpersonal levels.

Structural Facilitators of Access

These findings relate to how access to mental health services by LGBTQ+ young people is impacted by the physical availability of appropriate services and the power dynamics across statutory and nonstatutory services.

The mental health services in our case studies were mainly provided by the charity and voluntary sector, often delivered because of the absence of appropriate mainstream services. The services in this sector were reliant on nonstatutory and charity funding, and consequently they were vulnerable to the instability of funding from external sources. This is a clear structural way in which access to appropriate mental health services for LGBTQ+ young people is made difficult because statutory services largely did not acknowledge existing inequities or did not attempt to remove these barriers. In other words, there were very few appropriate services available to LGBTQ+ young people.

Statutory (NHS) mental health services largely did not recognise that LGBTQ+ young people underutilised their services, or that they had a poor experience of these services (Pattinson et al., 2021). This was in stark contrast to nonstatutory LGBTQ+ youth specialist mental health services that explicitly recognised the unsuitability of "mainstream" services for LGBTQ+ young people. For example, Jen, an LGBTQ+ young person, recounts her experience of statutory Children & Adolescent Mental Health Services (CAMHS):

> CAMHS encouraged me not to go [to the LGBTQ+ service], but I went anyway and I had a couple of friends who went there so I felt more comfortable. [CAMHS discouraged me] because they said that my gender dysphoria would pass, and that it was because of my [disability]. It was heavily implied that going to the LGBTQ+ service would just make it worse

Our case-study organisations frequently identified that if they had more resources, this would improve LGBTQ+ young people's access through offering more services in a greater variety of sites (e.g., physical locations or remotely). Our analysis showed that accessibility and engagement were improved where there were hybrid flexible provision and financial support for young people to cover transport costs. The lack of resources and precarious funding underpinning nonstatutory services impeded access for LGBTQ+ young people.

In addition to resource insecurity and a lack of appropriate services, we found there was an imbalance in structural power between statutory mainstream services and nonstatutory organisations in terms of the provision of LGBTQ+ youth early mental health support. Mimi, a staff member, explains the predicament:

> We're not a statutory service, don't have access to certain types of power and we're not a state provision. We don't have the information and money that might make it easier to [find an LGBTQ+ young person]. And while that's not a barrier for a young person initially accessing our services it's a barrier for us being able to do the work to keep them engaged if they don't return and we don't know why.

Within our case-study sites, there was the expertise to provide appropriate and effective mental health support to LGBTQ+ young people. These services were not in a clinical setting and, in the main, worked with a nonpathologising social justice model of mental health rather than with dominant biomedical psychiatric models. Our case-study sites' services orientated to affirming marginalised sexual and gender identities, and were cognisant of the ways LGBTQ+ young people can encounter hostility, discrimination, and victimisation within wider societal cis-heteronorms and how this may impact on their mental health. This conceptualisation of mental health stands outside of biomedical models and, as a consequence, has less power and influence, it is less legitimated.

Structural institutional power imbalances like these affected accessibility because our case-study sites relied on the co-operation of other institutions (e.g., school, youth services, social services) to enable LGBTQ+ youth to locate appropriate support. Our analysis pointed to improved accessibility where service provision was legitimated by

mainstream youth services. LGBTQ+ youth were often successfully engaged with our case-study sites because mainstream services such as schools had signposted them when unable to address needs themselves. Tomi, an LGBTQ+ young person, describes how they accessed the service:

> My teacher told me about the support they have for lgbtq teens and ive never been given an opportunity to talk to people about not only my mental health, but also my identity. Imediately i felt comfortable because i knew that i wouldnt be judged

In our case-study sites, there were examples of formally funded partnerships between statutory/mainstream services and charity LGBTQ+ organisations, and our analysis suggested that this facilitated access at a structural level for LGBTQ+ young people. These service partnerships improved access because they (a) offered appropriate LGBTQ+ specific and resourced support and (b) reinforced the legitimacy and expertise of non-statutory services with LGBTQ+ specialism. This increased the likelihood of young people being directed to the service, and of them trusting the service, thus overcoming the oppressive systems and associated discriminations (e.g., cis-heteronormativity, racism) that are barriers to access.

Cultural Facilitators of Access

This finding relates to how accessibility was dependent upon an active demonstration by mental health services of an LGBTQ+ inclusive culture whereby all LGBTQ+ identities were welcome and "worthy" of seeking support.

Our analysis reinforces the idea that mental health services must employ a "cultural safety framework" that be cognisant of multiple systems of power and equipped to challenge them and support all LGBTQ+ young people (Curtis et al., 2019). Our data showed that services actively demonstrated an LGBTQ+ affirming environment reflective of a multiplicity of LGBTQ+ identities. This approach rejected both cis-heterosexist norms and homo/trans norms that, for example, position LGBTQ+ young people as monosexual, White, and middle class. Where services visibly tackled stereotypes about LGBTQ + identities—such as by challenging narrow understandings of the "right" ways for young people to be trans and nonbinary, or by challenging "homosecularism" (the assumption that LGBTQ+ identity is at odds with religious belief)—this encouraged inclusion and improved accessibility and engagement with the service. Kai, an LGBTQ+ young person, explains why they felt safe to access the service:

> There were lots of little things like: "Oh that staff member is wearing they/them pronoun pin so obviously they feel comfortable with that which then by extension means i should be able to be comfortable being nonbinary in the group too? … and my mum said i was nervous bc im autistic and this is the first non-autistic specific group id been to in a while and he was like, oh yeah loads of our group are neurodiverse … which really helped me feel like, okay cool im not gonna be weird here.

We found that the inclusion of multiple LGBTQ+ identities needed to be explicit (e.g., in service information) and active throughout service provision. The LGBTQ+ young people in our study often had previous discriminatory experiences in mainstream services and therefore needed visible reassurance that a mental health services setting was "friendly." Once "in" the service, the authenticity of what was represented from "the outside" was appraised by the LGBTQ+ young person, and it made a difference in terms of sustained engagement. One way in which an inclusive culture was established was through openly LGBTQ+ staff and representation of the diversity of LGBTQ+ people. "Doing" representation requires an understanding of the implications of norms or stereotypes related to LGBTQ+ culture(s), for example, how LGBTQ+ people of colour are erased by (over)representation of White LGBTQ+ lives. Resisting norms and assumptions as well as uplifting LGBTQ+ youth of colour and diverse LGBTQ+ identities helped facilitate a diffusion of power away from hegemonic versions of LGBTQ+ youth (and services) as White, monosexual, middle class. Adele, an LGBTQ+ young person, explains the importance of inclusivity:

> It seemed like a more inclusive space and the workers seemed more understanding than the support I was getting at that time … I think as well to my knowledge it was the only charity that I knew had a space for LGBT POC so that was good.

In addition, our analysis revealed that access was enhanced by acknowledging and addressing the power differentials between youth and adults. The LGBTQ+ young people in our study had experiences of mainstream services not understanding the limitations on young people's autonomy, for example, them being reliant on an adult to attend appointments. Our findings suggest that access can be improved where youth's autonomy limitations are recognised and services adapted to encourage engagement, for example, appointments and sessions run at times that do not clash with compulsory education.

Disciplinary Facilitators of Access

This finding demonstrates that accessibility to mental health services was increased when disciplinary regulatory systems (such as referral processes) did not burden the young person or exclude them.

Many rules, systems, and service guidance at national and service levels can obstruct LGBTQ+ young people's access to mental health support. Our data analysis suggested that the burden of these regulatory systems must be alleviated in collaboration with the young person to increase accessibility and engagement with mental health services. For example, Jack, an LGBTQ+ young person, describes how the service helped with their difficulties of having no prior experience of accessing services:

> [The referral form] was probably the most stressful part as I had no clue what to put for some answers since I was doing it for myself. But I emailed and they offered to call me and guide me through it which helped a lot.

Our analysis indicated that considering the way in which interlocking systems of oppression operate in service policy and procedures was crucial to unlocking access to services.

This included ensuring referral processes were not pathologising and that LGBTQ+ identity was not included as a "presenting factor" in the mental health assessment. LGBTQ+ young people were distressed by this conflation effected by the service they had approached for help.

We found, instead, that procedures which provided options to self-identify and be "unsure," especially in relation to gender and sexual orientation, communicated that the service understood and validated fluidity and nonnormative identities. Our analysis revealed that where services made explicit the space to be questioning of gender and sexual identity in their referral procedures, this facilitated access. We did find a tendency in our case-study sites to reinforce existing ethnicity hierarchies and, in turn, exclusionary norms, for example, by including "White British" at the top of lists for ethnicity. When diverse and self-defined demographic options were included across service systems, including pronouns and whether these were context-specific (e.g., what to use in front of parents/carers), services were perceived as "LGBTQ+ or trans friendly" and presumed to provide safe support.

LGBTQ+ young people are governed by rules related to age, including safeguarding and duties of care which can conflict with their needs for confidentiality in mental health services. Our data included many accounts of how these tensions can be negotiated effectively through collaboration between the service and the young person, which enabled navigation of organisational guidelines, national policies, and legal frameworks. Georgie, an LGBTQ+ young person, describes their experience:

> I had to complete a form … As I was only 14 at the time, I also had to provide the contact details of my mum, in case of an emergency. I was reassured that they would only ever contact her if they absolutely had to, showing that they had high levels of respect for my confidentiality.

The data analysis indicated that transparency about service confidentiality was essential from the first point of contact within a service (e.g., on websites and self-referral forms). We found that services offering confidential, straightforward, and transparent systems cognisant of LGBTQ+ identities, encouraged accessibility. Open information sharing helped manage power differentials, a practice demonstrated across accounts in our data. Accessible services, our analysis suggests, were transparent and collaborative with young people, thus helping to resist norms and hierarchies that serve to exclude or burden them. Collaboration was also beneficial for building trust in relationships, shifting what would otherwise be a potentially threatening power imbalance between the service and LGBTQ+ youth to a safer place.

Interpersonal Facilitators of Access

This finding relates to the importance of, at an interpersonal level, fostering comfort and safety via a "proof of suitability" of the mental health service for LGBTQ+ young people.

Whether supporting arrival at the service in the first instance, reinforcing the multiplicity of LGBTQ+ identities, or emphasising confidentiality and safety, our data were saturated with examples of the relational aspects of supporting LGBTQ+ young people and their mental health. Facilitating "comfort" and the importance of being "comfortable"

cannot be underestimated. When comfort was achieved, services were understood as "always open" (despite the fact that none of our case-study sites were actually open at all times). Adam, an LGBTQ+ young person, explains: "Being open to me when ever i need it, and knowing ive got they're 100% support and going out their way just to help is amazing."

In our findings, power differentials between staff and LGBTQ+ young people were disrupted at the interpersonal level by openness in the form of reciprocity, transparency, and care. Key to accessibility was service staff understanding and actively addressing the stigmatising and marginalising systems underpinning the lives of LGBTQ+ youth, and their understanding of the emotionality this provoked.

Our analysis strongly indicated that access and engagement improved when staff employed a deliberate emotion-centred approach that was cognisant of the fear, uncertainty, anxiety, and worry that accessing mental health support can elicit in LGBTQ+ youth. In other words, service provision that attempted to ease the emotional effects of accessing mental health services encouraged access and sustained engagement. This included reassurance from the service that LGBTQ+ young people could change their mind; offers to meet or talk alone, or be shown around before "officially" visiting; and the management of expectations (e.g., what might happen in the service and how). This "professional relationship work" included staff's active outreach to LGBTQ+ young people that facilitated trusting relationships, securing not only access but also sustained service engagement.

Discussion

Our findings suggest that expanding conceptualisations of "accessibility" to explicitly address power and systems of oppression across multiple levels fosters accessibility to mental health support for LGBTQ+ youth. One way this is made possible is through an emphasis on youth rights, which means that principles such as autonomy and nondiscrimination function as central tenets when configuring ways to address power imbalances across the four domains: structural, cultural, disciplinary, and interpersonal. An emphasis on rights supports recent evidence about protective factors for LGBTI+ youth's well-being (Ceatha et al., 2021), alongside international acknowledgement of youth rights' relationship to mental health (McDermott et al., 2024; United Nations Children's Fund [UNICEF], 2021).

Further, a feminist intersectional youth-rights approach helps illuminate the fundamental systems of oppression that underpin mental health services and LGBTQ+ young people's discriminatory experiences. The pervasiveness and impact of these systems are typically overlooked in conversations about "improving accessibility." In our project, heterosexism, cisgenderism, racism, ageism, and saneism/ableism were necessarily foregrounded from the outset. The implication of these fundamentals should be considered actively and transparently (not denied or avoided) across structural, cultural, disciplinary, and interpersonal domains when working towards accessible mental health services and support.

Our analysis across four domains of powers "makes visible" aspects of accessibility that have previously been hidden. At a structural level, we propose that mental health services for LGBTQ+ youth need to be adequately resourced and available. The social, rights-based model of mental health must also be promoted and understood as a legitimate and appropriate way to improve access; specifically, the legitimation of LGBTQ+ youth experts as able to effectively deliver mental health support across services. At the cultural level, our analysis reinforces a shift towards cultural safety as a way to disrupt hegemonic versions of LGBTQ+ youth (and services) as White, monosexual, middle class; and to ensure organisations understand and accommodate LGBTQ+ young people, not the other way around. Collaboration is key when it comes to resisting norms and hierarchies in the disciplinary systems of services that typically serve to exclude or burden LGBTQ+ young people—building trust in relationships and redressing power imbalances between services and LGBTQ+ youth to foster a safer place. Power imbalances between service staff and LGBTQ+ youth are disrupted at the interpersonal level through openness via reciprocity, transparency, and comfort-building, underscoring how the openness of a service is more a feeling than a sign on the door.

Our findings concur with Gibson's (2021) work on improving young people's access to mental health services in Australia, which emphasises the importance of having services that are nonintimidating, soothing and relaxing, friendly, flexible, safe, and confidential. Our study findings explicitly centre on the ways accessibility needs to be addressed for LGBTQ+ young people, who are at the nexus of interlocking power systems that make help-seeking problematic.

Our study is limited in a number of ways. It has a U.K. focus, so the findings are specific to the configuration of mental health services within the country and the funding arrangement for access. The case-study sites were mainly in England, with one in Scotland; we failed to recruit any appropriate sites in Wales or Northern Ireland, and this limits the generalisability of the findings. The fieldwork was conducted during COVID-19, and consequently, a number of methodological adaptations were necessary, including conducting all fieldwork online. We also lost two case-study sites, one in Scotland, the other in Northern Ireland. As a result, this U.K. study is biased toward mental health services within England. We acknowledge that online methods may be exclusionary for some people, such as those without internet access or without a private environment. Our study is also limited by the lack of services specific for LGBTQ+ youth of colour. This is largely because mental health services for this group of young people are scarce despite, as our study indicates, being crucial for improving their mental health.

Despite these limitations, this study makes a significant contribution to our understanding of the facilitators of LGBTQ+ youth's access to mental health services and support. This is the first study that provides an analysis of how to improve access for this marginalised group of young people. Failure to rectify LGBTQ+ youth's underuse of services is falling short of a duty of care to LGBTQ+ young people. The UN Convention on the Rights of the Child acknowledges good mental health and support as a right (UNICEF, 2021), which obliges all participatory nations to ensure rights are upheld for people under 18 years of age. This means current systems, though unintentionally, may be violating agreed human rights standards.

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Ethics Approval and Consent to Participate

Written consent was obtained from all participants who took part in this research. This study received ethical approval from NHS Northwest, Greater Manchester Central Research Ethics Committee.

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Declaration of Conflicting Interests

Stephanie Davis is currently employed by the company Healing Justice London. At the time of working directly on Queer Futures 2, Davis was employed by the University of Brighton. Davis's current role is unconnected to Queer Futures 2 and has no bearing upon the analysis presented. Steven Pryjmachuk is an unpaid nonexecutive director of Six Degrees CIC, a mental health social enterprise based in northwest England. The remaining authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

Data Availability

The datasets generated and/or analysed during the current study are not publicly available due to requirements to protect the anonymity of participants.

Note

1. Our nomenclature was decided for Queer Futures 2 by young people. The "+" sign represents inclusion of other non-cis-heterosexual people who may use different terms.

References

Bailey, J., Steeves, V., Burkell, J., Shade, L. R., Ruparelia, R., & Regan, P. (2019). Getting at equality: Research methods informed by the lessons of intersectionality. *International Journal of Qualitative Methods*, *18*. https://doi.org/10.1177/1609406919846753

Barrow, E., & Thomas, G. (2022). Exploring perceived barriers and facilitators to mental health help-seeking in adolescents: A systematic literature review. *Educational Psychology in Practice*, *38*(2), 173–193. https://doi.org/10.1080/02667363.2022.2051441

Braun, V., & Clarke, V. (2013). *Successful qualitative research*. Sage.

Ceatha, N., Koay, A. C. C., Buggy, C., James, O., Tully, L., Bustillo, M., & Crowley, D. (2021). Protective factors for LGBTI+ youth wellbeing: A scoping review underpinned by recognition theory. *International Journal of Environmental Research and Public Health, 18*(21), Article 11682. https://doi.org/10.3390/ijerph182111682

Cho, S., Crenshaw, K. W., & McCall, L. (2013). Toward a field of intersectionality studies: Theory, *applications, and praxis. Signs: Journal of Women in Culture and Society*, *38*(4), 785–810. https://doi.org/10.1086/669608

Collins, P. H. (2015). Intersectionality's definitional dilemmas. *Annual Review of Sociology*, *41*, 1–20. https://doi.org/10.1146/annurev-soc-073014-112142

Collins, P. H., & Bilge, S. (2020). *Intersectionality: Key concepts* (2nd ed.). Polity Press.

Combahee River Collective. (1977). *The Combahee River Collective statement*. https://combaheerivercollective.weebly.com/the-combahee-river-collective-statement.html

Coryn, C. L. S., Noakes, L. A., Westine, C. D., & Schröter, D. C. (2011). A systematic review of theory-driven evaluation practice from 1990 to 2009. *American Journal of Evaluation*, *32*(2), 199–226. https://doi.org/10.1177/1098214010389321

Cox, J. A., Mills, L., Hermens, D. F., Read, G. J. M., & Salmon, P. M. (2024). A systematic review of the facilitators and barriers to help-seeking for self-harm in young people: A systems thinking perspective. *Adolescent Research Review*, *9*, 411–434. https://doi.org/10.1007/s40894-024-00241-3

Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A Black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *University of Chicago Legal Forum*, *1989*(1), 139–167. https://chicagounbound.uchicago.edu/uclf/vol1989/iss1/8

Crowe, S., Cresswell, K., Robertson, A., Huby, G., Avery, A., & Sheikh, A. (2011). The case study approach. *BMC Medical Research Methodology*, *11*, Article 100. https://doi.org/10.1186/1471-2288-11-100

Curtis, E., Jones, R., Tipene-Leach, D., Walker, C., Loring, B., Paine, S., & Reid, P. (2019). Why cultural safety rather than cultural competency is required to achieve health equity: A literature review and recommended definition. *International Journal for Equity in Health*, *18*(1), Article 174. https://doi.org/10.1186/s12939-019-1082-3

di Giacomo, E., M. Krausz, F. Colmegna, F. Aspesi, & M. Clerici (2018). Estimating the risk of attempted suicide among sexual minority youths: A systematic review and meta-analysis. *JAMA Pediatrics*, *172*(12), 1145–1152. https://doi.org/10.1001/jamapediatrics.2018.2731

Eigenhuis, E., R. C. Waumans, A. D. T. Muntingh, M. J. Westerman, M. van Meijel, N. M. Batelaan, & A. J. L. M. van Balkom (2021). Facilitating factors and barriers in help-seeking behaviour in adolescents and young adults with depressive symptoms: A qualitative study. *PLoS One*, *16*(3), Article e0247516. https://doi.org/10.1371/journal.pone.0247516

Fullagar, S. (2005). The paradox of promoting help-seeking: Suicide, risk and the governance of youth. *International Journal of Critical Psychology*, *14*, 31–51.

Gibson, K. (2021). *What young people want from mental health services*. Routledge.

Gulliver, A., Griffiths, K. M., & Christensen, H. (2010). Perceived barriers and facilitators to mental health help-seeking in young people: A systematic review. *BMC Psychiatry*, *10*(1), Article 113. https://doi.org/10.1186/1471-244X-10-113

Higgins, A., Downes, C., Murphy, R., Sharek, D., Begley, T., McCann, E., Sheerin, F., Smyth, S., De Vries, J., & Doyle, L. (2021). LGBT+ young people's perceptions of barriers to accessing mental health services in Ireland. *Journal of Nursing Management*, *29*(1), 58–67. https://doi.org/10.1111/jonm.13186

Holt, N. R., Botelho, E., Wolford-Clevenger, C., & Clark, K. A. (2024). Previous mental health care and help-seeking experiences: Perspectives from sexual and gender minority survivors of near-fatal suicide attempts. *Psychological Services*, *21*(1), 24–33. https://doi.org/10.1037/ser0000745

Huang, Y., Tung, Y., Craig, S. L., Fu Keung Wong, D., & Forth, M. (2020). How intersectional are mental health interventions for sexual minority people? A systematic review. *LGBT Health*, *7*(5), 220–236. https://doi.org/10.1089/lgbt.2019.0328

Hubach, R. D. (2017). Disclosure matters: Enhancing patient–provider communication is necessary to improve the health of sexual minority adolescents. *The Journal of Adolescent Health: Official Publication of the Society for Adolescent Medicine*, *61*(5), 537–538. https://doi.org/10.1016/j.jadohealth.2017.08.021

Kcomt, L., Gorey, K. M., Barrett, B. J., & McCabe, S. E. (2020). Healthcare avoidance due to anticipated discrimination among transgender people: A call to create trans-affirmative environments. *SSM Population Health*, *11*, Article 100608. https://doi.org/10.1016/j.ssmph.2020.100608

LeFrançois, B. A. (2013). Queering child and adolescent mental health services: The subversion of heteronormativity in practice. *Children & Society*, *27*(1), 1–12. https://doi.org/10.1111/j.1099-0860.2011.00371.x

Lu, W. H., Todhunter-Reid, A., Mitsdarffer, M. L., Muñoz-Laboy, M., Yoon, A. S., & Xu, L. (2021). Barriers and facilitators for mental health service use among racial/ethnic minority adolescents: A systematic review of literature. *Frontiers in Public Health*, *9*, Article 641605. https://doi.org/10.3389/fpubh.2021.641605

Lucas, R., Geierstanger, S., & Soleimanpour, S. (2024). Mental health needs, barriers, and receipt of care among transgender and nonbinary adolescents. *The Journal of Adolescent Health*, *75*(2), 267–274. https://doi.org/10.1016/j.jadohealth.2024.03.009

Lytle, M. C., Silenzio, V. M. B., Homan, C. M., Schneider, P., & Caine, E. D. (2018). Suicidal and help-seeking behaviors among youth in an online lesbian, gay, bisexual, transgender, queer, and questioning social network. *Journal of Homosexuality*, *65*(13), 1916–1933. https://doi.org/10.1080/00918369.2017.1391552

McDermott, E. (2015). Asking for help online: Lesbian, gay, bisexual and trans youth, self-harm and articulating the "failed" self. *Health*, *19*(6), 561–577. https://doi.org/10.1177/1363459314557967

McDermott, E., Eastham, R., Hughes, E., Johnson, K., Davis, S., Pryjmachuk, S., Mateus, C., McNulty, F., & Jenzen, O. (2024). "What works" to support LGBTQ+ young people's mental health: An intersectional youth rights approach. *International Journal of Social Determinants of Health and Health Services*, *54*(2), 108–120. https://doi.org/10.1177/27551938241230766

McDermott, E., Eastham, R., Hughes, E., Pattinson, E., Johnson, K., Davis, S., Pryjmachuk, S., Mateus, M. D. C. C., & Jenzen, O. (2021). Explaining effective mental health support for LGBTQ+ youth: A meta-narrative review. *SSM – Mental Health*, *1*, Article 100004. https://doi.org/10.1016/j.ssmmh.2021.100004

McDermott, E., Hughes, E., & Rawlings, V. (2018). Norms and normalisation: Understanding lesbian, gay, bisexual, transgender and queer youth, suicidality and help-seeking. *Culture, Health & Sexuality*, *20*(2), 156–172. https://doi.org/10.1080/13691058.2017.1335435

McDermott, E., & Roen, K. (2016). *Queer youth, suicide and self-harm: Troubled subjects, troubling norms*. Springer.

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin*, *129*(5), 674–697. https://doi.org/10.1037/0033-2909.129.5.674

Michelmore, L., & Hindley, P. (2012). Help-seeking for suicidal thoughts and self-harm in young people: A systematic review. *Suicide and Life-Threatening Behavior*, *42*(5), 507–524. https://doi.org/10.1111/j.1943-278X.2012.00108.x

Moore, K. L., Camacho, D., & Munson, M. R. (2020). Identity negotiation processes among Black and Latinx sexual minority young adult mental health service users. *Journal of Gay & Lesbian Social Services*, *32*(1), 21–48. https://doi.org/10.1080/10538720.2019.1677542

Moore, K., Camacho, D., & Spencer-Suarez, K. N. (2021). A mixed-methods study of social identities in mental health care among LGBTQ young adults of color. *American Journal of Orthopsychiatry*, *91*(6), 724–737. https://doi.org/10.1037/ort0000570

Parmenter, J. G., Wong, E. G., Khan, N. S., Pradell, L., & Galliher, R. V. (2024). Even when I feel alone, I always know I'm not really alone: An intersectional analysis of LGBTQIA+ BIPOC's experiences of community and resistance. *Feminism & Psychology*, *34*(3), 361–383. https://doi.org/10.1177/09593535241238073

Pattinson, E., McDermott, E., Eastham, R., Hughes, E., Johnson, K., Davis, S., Pryjmachuk, S., Jenzen, O., & Mateus, C. (2021). Tackling LGBTQ+ youth mental health inequality: mapping mental health support across the UK. *The British Student Doctor Journal*, *5*(3), 20–29.

Radez, J., Reardon, T., Creswell, C., Lawrence, P. J., Evdoka-Burton, G., & Waite, P. (2021). Why do children and adolescents (not) seek and access professional help for their mental health problems? A systematic review of quantitative and qualitative studies. *European Child & Adolescent Psychiatry*, *30*(2), 183–211. https://doi.org/10.1007/s00787-019-01469-4

Roulston, C., McKetta, S., Price, M., Fox, K. R., & Schleider, J. L. (2023). Structural correlates of mental health support access among sexual minority youth of color during COVID-19. *Journal of Clinical Child and Adolescent Psychology*, *52*(5), 649–658.

Rowe, S. L., French, R. S., Henderson, C., Ougrin, D., Slade, M., & Moran, P. (2014). Help-seeking behaviour and adolescent self-harm: A systematic review. *Australian & New Zealand Journal of Psychiatry*, *48*(12), 1083–1095. https://doi.org/10.1177/0004867414555718

Rusow, J. A., Hidalgo, M. A., Calvetti, S., Quint, M., Wu, S., Bray, B. C., & Kipke, M. D. (2022). Health and service utilization among a sample of gender-diverse youth of color: The TRUTH study. *BMC Public Health*, *22*(1), Article 2312. https://doi.org/10.1186/s12889-022-14585-9

Sadler, K., Vizard, T., Ford, T., Goodman, A., Goodman, R., & McManus, S. (2018). *Mental health of children and young people in England, 2017*. NHS England. https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2017/2017

Salerno, J. P., Gattamorta, K. A., & Williams, N. D. (2022). Impact of family rejection and racism on sexual and gender minority stress among LGBTQ young people of color during COVID-19.

Psychological Trauma: Theory, Research, Practice, and Policy, *15*(4), 637–647. https://doi.org/10.1037/tra0001254

Semlyen, J., King, M., Varney, J., & Hagger-Johnson, G. (2016). Sexual orientation and symptoms of common mental disorder or low wellbeing: Combined meta-analysis of 12 UK population health surveys. *BMC Psychiatry*, *16*, Article 67. https://doi.org/10.1186/s12888-016-0767-z

United Nations Children's Fund (UNICEF). (2021). *The state of the world's children 2021. On my mind: Promoting, protecting and caring for children's mental health*. https://www.unicef.org/media/114636/file/SOWC-2021-full-report-English.pdf

United Nations Committee on the Rights of the Child (UNCRC). (2016, December 6). *General Comment No. 20 on the implementation of the rights of the child during adolescence*. https://digitallibrary.un.org/record/855544?ln=en&v=pdf

Ussher, J. M. (2009). Heterocentric practices in health research and health care: Implications for mental health and subjectivity of LGBTQ individuals. *Feminism & Psychology*, *19*(4), 561–567. https://doi.org/10.1177/0959353509342933

Velasco, A. A., Cruz, I. S. S., Billings, J., Jimenez, M., & Rowe, S. (2020). What are the barriers, facilitators and interventions targeting help-seeking behaviours for common mental health problems in adolescents? A systematic review. *BMC Psychiatry*, *20*, Article 293. https://doi.org/10.1186/s12888-020-02659-0

Wang, C., Barlis, J., Do, K. A., Chen, J., & Alami, S. (2020). Barriers to mental health help seeking at school for Asian- and Latinx-American adolescents. *School Mental Health*, *12*(1), 182–194. https://doi.org/10.1007/s12310-019-09344-y

Williams, K. A., & Chapman, M. V. (2011). Comparing health and mental health needs, service use, and barriers to services among sexual minority youths and their peers. *Health & Social Work*, *36*(3), 197–206. https://doi.org/10.1093/hsw/36.3.197

Wilson, C., & Cariola, L. A. (2020). LGBTQI+ youth and mental health: A systematic review of qualitative research. *Adolescent Research Review*, *5*, 187–211. https://doi.org/10.1007/s40894-019-00118-w

Wong, N., & Menkes, D. B. (2018). Ethnic youth and sexual identity: The role of clinical and social support for "double minorities." *Australasian Psychiatry*, *26*(2), 181–183. https://doi.org/10.1177/1039856217748809

World Health Organization (WHO, September 21). (2021). *Comprehensive mental health action plan 2013–2030*. https://www.who.int/publications/i/item/9789240031029

Yin, R. K. (2014). *Case study research: Design and methods*. Sage.

Yin, R. K. (2018). *Case study research and applications: Design and methods (6th ed.)*. Sage.

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