

**The
Kite
Trust.**



Gender and sexuality
Supporting young people



RESEARCH REPORT

LGBTQ+ YOUTH & MENTAL HEALTH

IN CAMBRIDGESHIRE
& PETERBOROUGH

EDITED BY

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EXECUTIVE SUMMARY



LGBTQ+ young people experience higher rates of mental illness and distress than their peers but are likely to be underrepresented in accessing mental health services. The Kite Trust wanted to explore the factors that help and hinder LGBTQ+ young people in accessing the mental health support they need, when they need it, and to make recommendations on how this might be improved.




METHODOLOGY

This research explored LGBTQ+ young people's experiences of accessing, or trying to access, mental health support, and their views on how to improve access to appropriate support. LGBTQ+ young people's voices, views and experiences were central to this research. A steering group of 10 LGBTQ+ young people aged 13-25 provided guidance, input and oversight throughout the project. Interviews were undertaken with 16 young people (aged 16-25) identifying as LGBTQ+ and living, working or in education within Cambridgeshire and Peterborough. The lead researcher also undertook case work with LGBTQ+ young people accessing The Kite Trust and currently trying to access mental health support.

FINDINGS


Our key findings relate to LGBTQ+ young people's experiences of trying to access mental health support, their experiences of any support they accessed, and whether support was appropriate and timely. We found that:

- Journeys to accessing mental health support are long and complex;
 - There are barriers in even initiating a search for mental health support;
 - Once accessing services, LGBTQ+ young people's needs are not fully met;
 - Staff lack specific knowledge and understanding relating to LGBTQ+ identities and experiences;
 - LGBTQ+ young people experiencing multiple marginalisation face particular barriers;
 - Wider networks like friends, family and colleges can play a key role in accessing mental health support;
 - LGBTQ+ young people have clear ideas about what good support looks like for them and how services can better support them.
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RECOMMENDATIONS

To address the challenges and barriers highlighted in this research we have made four key recommendations:

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- 1. Adequately resource mental health services**
 - 2. Support young people to navigate mental health services and different forms of support**
 - 3. Adopt inclusive language and data systems**
 - 4. Work collaboratively to create a mental health support system designed for equitable outcomes and experiences**

CALL TO ACTION

It is clear that there are significant challenges preventing LGBTQ+ young people from accessing the care and support that they deserve, which need to be addressed urgently. It is only in collaboration with LGBTQ+ young people, professionals providing services, commissioners and politicians that we will achieve this.



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A note on terminology: The acronym **LGBTQ+** is used within this report, and within The Kite Trust's work, to denote anyone who identifies themselves as lesbian, gay, bi/bisexual, trans, non-binary, queer, asexual, or questioning their sexuality or gender, and anyone else who does not identify as straight and cisgender. Where findings relate to particular subgroups, this is noted.



Mental health support is defined in this project as '*anything that an individual understands as supporting them to have good mental health, or manage their mental health*'. This includes, but is not limited to: NHS, private, voluntary sector, self-directed, community-based and informal support. Young people in the study typically distinguished between 'professional' mental health support, which they understood as provided by NHS and private mental health services, and all other support, including self-directed support, and support provided by the voluntary sector (including youth work), friends, family and others.



INTRODUCTION



LGBTQ+ young people experience higher rates of mental illness and distress than their peers (Bachmann and Gooch, 2018) but are likely to be underrepresented in accessing mental health services. The Kite Trust wanted to explore the factors that help and hinder LGBTQ+ young people in accessing the mental health support they need, when they need it, and to make recommendations on how this might be improved.

"We carried out this research project with the aim of understanding and addressing the barriers facing LGBTQ+ young people in accessing mental health support, and ultimately improving the lives of LGBTQ+ young people. In this report, we make recommendations for anyone involved in providing, or supporting young people to access, mental health support in Cambridgeshire and Peterborough. Although our project is grounded in this local context, we know similar experiences of trying to access mental health support are shared across the UK and beyond. Our findings and recommendations will therefore be of interest and use to others outside this geographical area.

We hope that the outputs produced through this project will be valuable for LGBTQ+ young people, particularly those looking to access mental health support. Throughout this research, a common thread was that of isolation - the feeling of being 'the only one' having a particular experience, feeling disconnected from others, and not knowing where to turn or who to talk to. Above all, we hope this project allows LGBTQ+ young people to share and recognise their stories, and find comfort in knowing that they are not alone."

Dr. Catt Turney & Dr. Pip Gardner


The Kite Trust





INTRODUCTION - CONT.

“I was invited to join the steering group for this project by the Young People’s Counselling Service, who had identified this as an important piece of work for young people with mental health needs locally.



It was obvious from the outset that the skilled team at The Kite Trust intended to produce an unflinching statement on the experience of young LGBTQ+ people when trying to access mental health services. The testimony of the young people who contributed to this project was at times difficult to hear, but important to be heard.”

Peter Williamson

Team Manager, CPFT Liaison Psychiatry North; Trustee, Young People’s Counselling Service


“I am a strong believer in the importance of community-based approaches to supporting the wellbeing of LGBTQ youth, and this TKT project felt like a critical and timely effort to put youth voices at the centre of better understanding their mental health needs. As a queer researcher whose work is based in academic-community collaborations, I felt that my role was most useful in supporting dialogue on the methods and implementation of the project, based on my work with (and as a) LGBTQ youth in the US. A key message from the project: follow the expertise of the community, and build it to become a systems-level intervention.”

Dr. Sonja MacKenzie

*Associate Professor of Public Health Sciences, Santa Clara University;
Visiting Scholar, Cambridge University*



METHODOLOGY



This research explored LGBTQ+ young people's experiences of accessing, or trying to access, mental health support, and their views on how to improve LGBTQ+ young people's access to appropriate support. To address these questions, we spent a year working with steering groups of young people and professionals, conducting interviews, and learning from case work.

CENTRING LGBTQ+ YOUTH

LGBTQ+ young people's voices, views and experiences were central to this research. A steering group of 10 LGBTQ+ young people aged 13-25 provided guidance, input and oversight throughout the project. In-depth, semi-structured interviews were undertaken by lead researcher Dr. Catt Turney with 16 young people (aged 16-25) identifying as LGBTQ+ and living, working or in education within Cambridgeshire and Peterborough. Interviews were undertaken in October – December 2021, in-person or remotely as preferred by the participant.

Alongside this research project, Catt also undertook youth work and case work with LGBTQ+ young people accessing The Kite Trust, particularly those currently trying to access mental health support. All data cited in this report comes from the 16 interviews undertaken with LGBTQ+ young people, who gave informed consent to participate in the project. However, learning from case work and youth work also informed the project, and supported our aim to centre LGBTQ+ young people's voices and experiences in our work.

The steering group and case work involved young people already using The Kite Trusts services, and open calls were published through partners to recruit interviewees from the wider community. A summary of interviewees' demographic characteristics is given on page 46 (please note that all names are pseudonyms).

FINDINGS

Our key findings relate to young people's experiences of trying to access mental health support, their experiences of any support they accessed, and whether support was appropriate and timely. We also gathered their perspectives on the factors that supported or hindered this access, their views of what good mental health support looks like, and their recommendations for change. Overall, we found:

- LGBTQ+ young people's journeys to accessing mental health support are long and complex;
- LGBTQ+ young people face barriers in even initiating a search for mental health support;
- Once accessing services, LGBTQ+ young people's needs are not adequately met;
- Staff lack specific knowledge and understanding relating to LGBTQ+ identities and experiences;
- LGBTQ+ young people face different and additional barriers related to other factors such as age or neurodivergence;
- Wider networks like friends, family and colleges can play a key role in accessing mental health support;
- LGBTQ+ young people have clear ideas about what good support looks like for them and how services can better support them.


ALEX:

"I should have started the process [of seeking support] probably by the time I was twelve. That was my first real panic attack. But I didn't really actually get like my first round of help until my first second term at uni. This is the first time I actually actively went and was like, I need some actual help here. So that was five years."

Alex, 19, enby, pansexual



LGBTQ+ YOUNG PEOPLE'S JOURNEYS TO ACCESSING MENTAL HEALTH SUPPORT ARE LONG AND COMPLEX



The majority of young people we spoke to had sought mental health support of some form, usually through the NHS. Overall, experiences were described as **poor**. Only three participants reported receiving mental health support that was both appropriate and timely: one informally from friends, and two who had paid for private support. In both cases, private support had been sought after poor experiences with NHS services.

Young people described their journeys of seeking support as various combinations of the following: **initiating the search for support; investigating or understanding different options for support; seeking a particular kind of support; referral / signposting; assessment; acceptance/rejection for support; accessing support; completing support**. Different stages often involved different services and/or professionals, and barriers and supportive factors were present at all different stages.

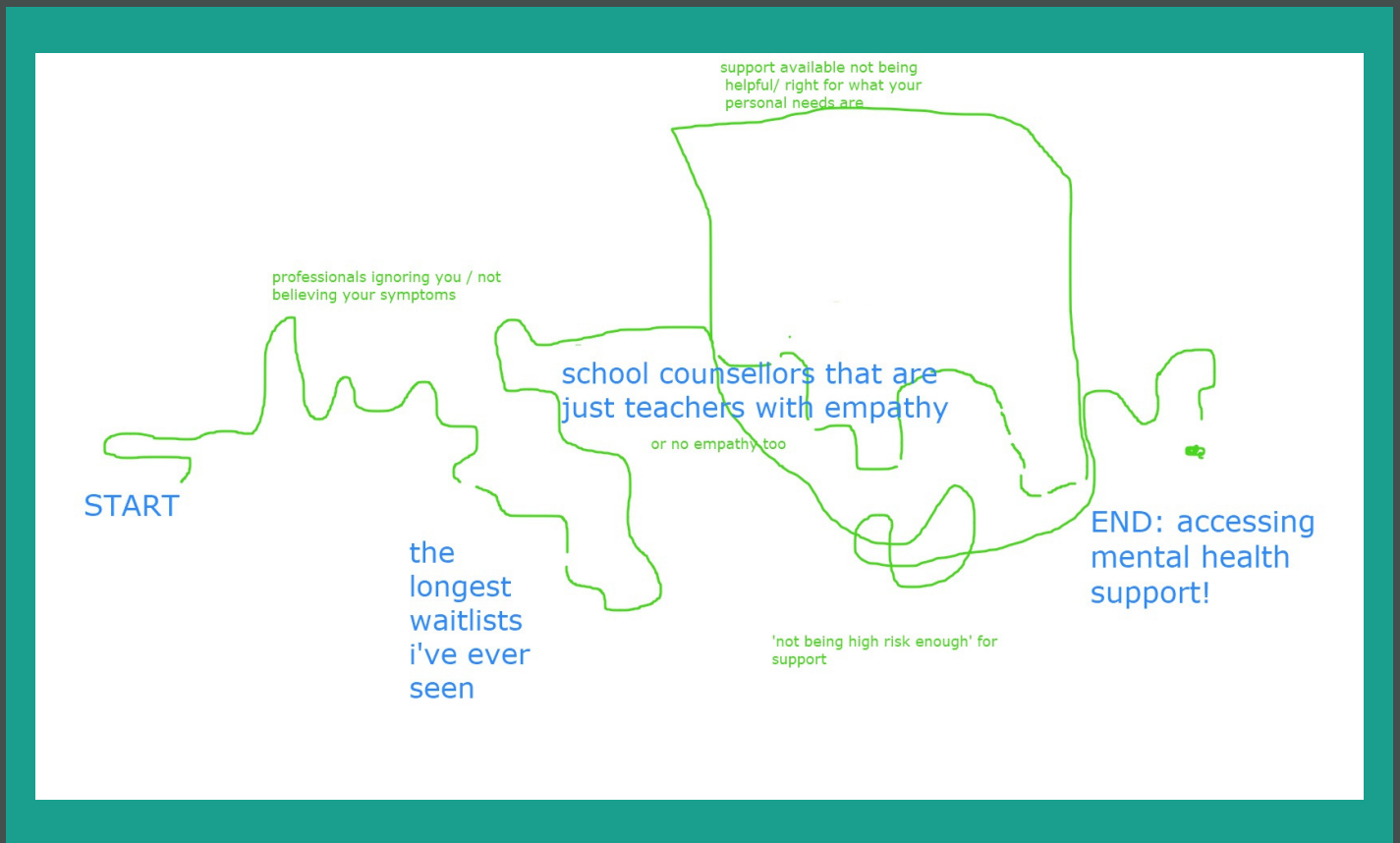
Initiation needs to be understood as a key part of the journey to accessing support. This was where many notable barriers arose, but certain supportive factors could also play an important role (see the following section for more detail).

Young people's journey were long; often the time from starting to look for support and accessing any formal mental health support was months or years.

If support was accessed, it was frequently described as inappropriate for the young person's needs, and negative experiences of mental health services were common. Due in part to the often lengthy and cyclical nature of seeking support, such poor experiences could have a far-reaching impact.

Journeys were not straightforward or linear, often involving movement between different stages multiple times before any support was accessed. Journeys were described as disjointed, with frequent 'gaps' where young people felt disconnected and unsupported, and in some cases were discharged or disengaged altogether.

The following image drawn by the young people's steering group illustrates a typical journey represented in the data:



A response from the young people's steering group to the question 'what might the journey of trying to access mental health support look like for LGBTQ+ young people?'






LGBTQ+ YOUNG PEOPLE FACE BARRIERS IN EVEN INITIATING A SEARCH FOR MENTAL HEALTH SUPPORT

Many young people reported significant barriers to initiating their search for mental health support. They explained that in order to initiate the search for support oneself, it was necessary to **understand that they were experiencing mental health difficulties, believe that seeking support was worthwhile, and be able to take the first steps to seeking support.**

Barriers and supportive factors affecting any of these aspects could therefore support or hinder them starting to seek support. Participants often reflected that they wished now that they had initiated their search for support earlier, with Kaz noting that "you really have to just start trying to get support as soon as possible because it takes so long."




Key barriers were: **not knowing or not admitting that they had mental health difficulties; not wanting to pressure an under-resourced healthcare system; not believing they would get support; not thinking they deserved support; and not feeling they had time.**

Lack of understanding of what mental health issues looked or felt like, when to seek help, and what support was available were also key factors in young people not initiating their search for support. For some, lacking the knowledge, understanding or literacy to understand their own mental health was experienced as similar to making sense of their sexuality or gender. This was particularly notable for asexual and trans young people, who often reported not having the language or knowledge to make sense of their feelings and identity until much later than friends or peers. As with understandings of mental health, this was underpinned by **societal stigma, shame and silence**, often perpetuated by particular individuals in the young person's life.

In some cases, initiating the search for support was not left to the young person themselves, as others initiated this journey for them (with or without their consent).



LILY:




“I knew things were going downhill from the second year of university. I knew that I couldn’t cope at that point. I got through my second year but things were definitely going wrong and I didn’t know at the time that what I needed was mental health support. I knew something wasn’t OK but I didn’t have that knowledge of ‘this is what’s going on, this is where I should be going for help, because this is the kind of help that I need’. Story of my life! Part of the reason I came out [as trans] so late, is I didn’t know what was going on. I thought everyone felt the same as I did. And it was the same thing for me with mental health support. I knew that such a thing as mental health support existed, but I didn’t know that I was a person that it was aimed towards. But then the other big barrier, which, I don’t know, you definitely could tie this in with queerness, was that I had no self worth. I didn’t think that I was worth the effort, to put the time into, to put the resources towards, so I didn’t seek it out for a while. It was only in my third year at uni, I started actually talking to my tutor about mental health support. Because at that point, there wasn’t another way out.”

Lily, 23, trans woman, unsure of sexuality



ONCE ACCESSING SERVICES, LGBTQ+ YOUNG PEOPLE’S NEEDS ARE NOT ADEQUATELY MET

Initiating the search for mental health support presented a significant barrier to LGBTQ+ young people. However, the majority of barriers to accessing appropriate and timely support were experienced by young people during their engagement with NHS mental health services.

Many faced difficulties with initial referral, lacking information on how to self-refer or who to contact for referral to different services. Young people also shared that they did not have access to **clear and consistent information on available support and criteria for access**. Some reported being overwhelmed with available options, whereas others reported not being able to find accessible information on any services that might be appropriate for them.



Communication from NHS services did not meet young people's needs. Young people reported challenges including a lack of information about how to make an appointment or what to expect, being unable to contact their GP or another health professional, and not receiving expected follow-up calls or information about where their care was being held. Maintaining communication with services was particularly difficult for those with severe mental health difficulties, those who were neurodivergent, and those trying to arrange appointments and communication around education or employment.



Many were left without any communication or access to meaningful support during the time they spent on lengthy waiting lists. One participant recalled that after an initial phone call from the GP, "it's pretty much treated like it's not a problem any more...to some degree...like it's a kind of 'okay, we've given you a phone call, that's sorted, and now function like a normal human!'" (Zelda).

When discharged or refused access to a service, young people felt the onward referral or signposting was poor. Many described feeling as though they had to re-start their search for support from the beginning, repeating the process again but with less hope of success.

Young people identified **the administrative burden of researching and accessing appropriate support** as a significant barrier to both initiating and navigating the search for support, particularly when experiencing mental health difficulties.

FLATCAP:

"I went to a doctor three different times. Once was when I was fourteen. And then earlier this year I went to my doctor again and I got no follow up. And so I was like, I just left it. The first time they just directed me to [voluntary sector organisation]. A few years later, I go back again and I get no follow up. And then the same a few months later. Each time, I went to them and tried to get some help, and they were like, 'Okay, we'll get back to you'. But then nothing."

Flatcap, 17, non-binary, queer

RACHEL:

"I'd definitely say the hardest part is kind of this feeling that you have to advocate for yourself. If your mental health is bad, the last thing you want to do is jump through all these hoops, get yourself on a waiting list, email a bunch of people, explain all your problems and then move on and then like finally schedule an appointment. Emailing, calling, being told they don't have availability. I think I would have gone back to therapy sooner if I had been able to just be like, 'hey, find me a therapist, and I will go when you tell me to' instead of having to do all the legwork."

Rachel, 24, cis woman, queer/gay/lesbian

Young people described feeling both that they were given **too much responsibility** for identifying appropriate support and 'getting better', while simultaneously having **too little autonomy or power** over their own care.

This interacted with sometimes strict or inconsistent thresholds for care to leave some young people feeling that they had to argue their case for accessing support, presenting themselves as in crisis in order to access even low-level support.

Young people had clear ideas of what good mental health, or managing their mental health, looked like. However, they reported **tensions between this and professionals' views of what mental health support was aiming to achieve.**

Young people often felt that the support offered was not appropriate for their needs. This included an over-reliance on medication for older young people (those aged 16 reported the opposite); and a lack of access to talking therapies and interventions appropriate to conditions such as PTSD. The support offered was described as frequently too low-intensity for their needs, particularly due to the tendency not to access any support until they were at crisis point.

Young people described NHS professionals as over-reliant on the voluntary sector, which was unable to provide the level or type of support desired. Professionals were seen as fobbing young people off with inappropriate referrals in order to be **seen as doing something**, rather than presenting realistic options. Where support was offered, it was frequently **short-term, without appropriate follow-up care.**

RORY:

"I saw, I think she's what you'd call a psychological wellbeing practitioner. So rubbish. She was the one who said, 'Why won't you do yoga? Are you not taking this seriously?'. I was having panic attacks at school, that's why I referred myself. I was around 15, 16 when the panic attacks were really bad, but I didn't want to go to CAMHS, because I had a friend who had an eating disorder and she had a really bad experience there. So I went to the adult services. I think I went like, three times. And then I just stopped going because this woman was just really patronising. Like, not talking about something that's interesting, or valuable to me. And not asking any of the right questions. It seemed to be like, she's just filling out a form. So I just stopped going, and then tried to Google how to fix things."

Rory, 25, gender ambivalent, pansexual

Participants also described mental health professionals treating their diagnosis or 'problem' in isolation, without engaging with the social or situational factors that were helping or hindering their mental health.

Young people frequently spoke of gatekeeping and the extensive use of strict thresholds, with assessment used as a tool to restrict access to care rather than to identify appropriate support. Participants described how being seen as either '**too sick**' or '**not sick enough**' (and sometimes both concurrently) could leave them ineligible for support. Others reported only being able to access any support if they were **seen to be in immediate danger**. This could lead to harm as they waited or escalated need in order to reach the thresholds for accessing support.

KAZ:


"You have to do a lot of like jumping through hoops, and you have to tread this very careful line of being bad enough that they have to help you but not being too bad, that they say 'No that's not in our remit'. That's something that one of my housemates really struggled with, especially if she was trying to access support for eating disorders...So you kind of have to lie basically to your healthcare provider about how you're actually doing in order to access the treatment. That whole thing was just so awful, she was actively trying to lose weight, so that she would hit the thresholds. Like they were weighing her every week and just - I don't see how that would be helpful at all...it's really terrible."

Kaz, 21, cis female, panromantic asexual



FLATCAP:

“When you do speak to someone they ask all these questions like, ‘Do you feel anxious? Do you have a good sleep schedule?’ and I’m always responding pretty clearly on the lower end. But when they are like, ‘are you happy?’, I pause because I don’t really know how to describe it. I’m conversational, I’m friendly, but that doesn’t mean I’m fine. That doesn’t mean I’m coping well, doesn’t mean I’m doing good. And it’s easy for them to be like, ‘You’re not mentally - sorry, terribly sorry - you’re not mentally ill enough, come back when you’re like on the cusp of jumping off a building.’ So I’m kind of fearful of responding with, ‘Yes, I am happy’. I’m always worried about answering like too truthfully. Because if I say I am happy, then they’re going to start questioning if I’m depressed or not.”



I don’t want to feel like I have to constantly like argue my case. Like, ‘You’re on now, go’ and then I have to be like ‘I am depressed hence exhibit A’. Basically every time I’ve had to go to the GP, I’ve had to collect evidence that I’m mentally ill because they don’t seem to believe that I am. So I had to be coming in there, like, ‘I’ve been feeling like this since I was eight years old. I’ve had family issues with alcoholism, drug use. My family has a history of clinical depression’. And it’s like, do I need all this sh** when I’m clearly saying ‘I need help!’. I should not have to collect a f***ing cork board and red string to convince someone that, ‘Hey, I don’t think I’m doing so well’. And even then, that only resulted in them giving me information on therapy providers, which was just charities.”

Flatcap, 17, non-binary, queer

Young people with **complex or multiple mental health conditions** also reported being told that one mental health condition made them ineligible for a particular service and that they should seek support with an alternative team, but then told that another mental health need made them ineligible for the service to which they had been re-directed.

STAFF LACK SPECIFIC KNOWLEDGE AND UNDERSTANDING OF LGBTQ+ IDENTITIES AND EXPERIENCES

In addition to the barriers discussed so far, the following were identified as relevant specifically to LGBTQ+ young people.

Many young people recounted lacking **space, language or knowledge to make sense of their own sexuality and gender**. Similarly to the experiences of not having the language or knowledge to understand their own mental health needs, this hindered participants in understanding their own need for support.

LILY:

"I've been trying to work out how my mental health connects to being trans, but being heavily in denial – maybe more in ignorance than denial. And how it connects to me trying to block all that out, trying to just go about my day to day life. I don't know how that ties in. I didn't have the awareness myself at the time. Like, I guess maybe people could have said then, 'look, if you're trans, if you're struggling, particularly, there's these places you can go, these places you can look to'. But I wouldn't have known that. There's no way I could. Because I didn't know then that I was trans."

Lily, 23, trans woman, unsure of sexuality

Additionally, mental health services were viewed as hostile to LGBTQ+ young people and/or unable to engage appropriately with their needs and experiences. For many, this led them to be afraid to access mental health services at all. Others felt unable to be 'out' or open about their gender/sexuality to healthcare professionals, even if this was relevant to their mental health needs.

DANIEL:

"Access to mental health support generally has been easy [at university], but my comfort with bringing queer or trans stuff into that environment is ...variable, I would say. And I think I'd quite like a way to talk about some gender things. But I don't particularly feel too comfortable doing that in the uni counselling space, because I don't know if they'll be like, 'Oh, that's not really our expertise'. I didn't want to go through that process of being told 'I don't, I can't help you with that'."

Daniel, 19, non-binary, bisexual

RORY:

"In terms of being queer, I think I wouldn't want to disclose that to anybody who was a medical professional. It's weird when you're talking about really intimate things in a counselling or mental health situation. And you have to be like, 'But I'm not going to tell you this'. I don't really want to have to go through explaining all of the things to them. I can have a conversation about like, feeling suicidal. And that's fine. That's not taboo. But having a girlfriend would be...But then that means there's a lot that is relevant that's not talked about. Like, usually most of my gender stuff happens when I'm not with men. But that would be a conversation that I think would blow some people's minds. And I would not be ready to have the entire therapy session derailed by them being like, 'What do you mean, not a man?'. Overall, just like, can't be bothered. Maybe some of them would be fine about it. But I don't have the time or inclination to make that bet."

Rory, 25, gender ambivalent, pansexual

For some young people, this related to past experiences of **discriminatory, inappropriate or inadequate care in relation to gender or sexuality**. These included incidences of being deadnamed, staff using incorrect pronouns or assuming heterosexuality, and asking inappropriate questions.

Young people frequently recounted a lack of knowledge from healthcare professionals of LGBTQ+ young people's needs, and the interactions between gender, sexuality and mental health. **Young people said they had to 'educate' professionals in relation to LGBTQ+ needs and identities**, which they found tiring and took up time during appointments. Trans, gender questioning and asexual participants in particular reported poor experiences in relation to health professionals' engagement with issues of gender or sexuality.

LUKE:

"I found that a lot of the advice to keep moving and all that kind of stuff, especially exercise, for trans people is....really difficult. Like...no, I don't want to think about the fact that my body exists. And there often aren't the facilities for young trans people to do that safely, even if they wanted to. Like if the advice is, 'every time you feel angry, go for a run'. But I have to bind [my chest]. So I can't go for a run. I think a lot of professionals don't actually know about the practicalities that go into trans life. So often the things you need to do in order to make yourself feel better [in relation to gender dysphoria] involve restricting a part of your body. And then if the advice is like, 'you feel bad? Do some exercise!', and you're like 'actually, I'm gonna really injure myself if I do that. And it's more important right now, for me to bind or to tuck than it is for me to go for a run'."

Luke, 23, trans man, queer

ZELDA:

“The [NHS] system has your birth certificate name, so you’ve got to constantly remind them that they’re not speaking to somebody with that name any more, and it feels really... {sighs} like, can you just stick a post-it note on your records, like Tipp-Ex the name, or something, please? It makes me very reluctant to use any of that [NHS services], which is a pain. It’s a sort of shadow that appears when I suddenly start considering things. And when a [mental health] problem is actually connected to being trans, so like feeling like an outsider, or gender dysphoria, or feeling broken, or feeling like you’re doing something wrong...to actually be able to communicate that to somebody and for it to feel like they’re taking you seriously, they have to have the entire background and I just can’t explain the entire background.

I think the major thing I’d want from a mental health service would just be somebody who knows what the hell they’re talking about in relation to helping queer people. It’s pretty much got to a point of like, I don’t really want to talk to anybody about how I’m doing unless they either know queer people really well or are queer or are present in queer discussions. Because it’s exhausting otherwise and you won’t actually get anything done. You have to explain so much. And I just don’t really want to talk to them about it. I don’t fancy justifying my existence to somebody.”

Zelda, 16, trans girl, asexual, aromantic

For trans and gender questioning young people, an additional barrier arose in the interaction between mental health support and gender-affirming healthcare. Trans and gender questioning young people reported that their mental health difficulties were seen as incompatible with being trans, or as more important and needing to be addressed before professionals would engage with their need for support around gender and gender-affirming care. Other trans and gender questioning young people reported fearing that their access to gender-affirming care would be refused or curtailed if health professionals were aware of their mental health needs.

In many cases, the poor experiences discussed here led to unwillingness to continue engaging with service, or engage with services in future. However, LGBTQ+ young people’s fear of accessing services or of being open about their gender or sexuality was not limited to those with prior poor experiences in healthcare settings. Others reported that past experience of LGBTQ-phobia elsewhere, and knowledge of other LGBTQ+ people’s poor experiences in healthcare settings, left them unable to assume it was safe to access mental health support and/or be open about their gender or sexuality.

LUKE:

"I remember when I was 12 or 13, trying to bring up [sexuality and gender], and just sort of being shut down, them being like, 'Well, we'll focus on your OCD, and then when you're better we can talk about your gender'. My old GP was just useless. They didn't know anything about trans issues, they didn't understand about the intersection of trans issues and mental health. It was like, I could either talk to them about mental health or my trans issues, but not both.

I didn't go to the GP for a really long time because I was afraid that anything I said was gonna make them be like 'Oh, you're probably not well enough and you don't know that you're actually trans, so I won't bother putting you on the waiting list [for the gender clinic]'. I was always afraid that if they knew I was self harming, they would think that I wasn't sound of mind enough to tell them, 'This [gender-affirming care] is what I need'. So, unless it got really dire, I didn't go and talk to them. Because getting a gender clinic referral was like my number one goal. It was like, 'I'll just suck it up until I get to the end of that waiting list'. But then the waiting list is three years. And that's a long time for things to go wrong. And to have to put your mental health care on hold.

I found myself kind of on two spinning plates. Like, if I went in and wanted to talk about my mental health, I was worried they were gonna rip my gender clinic referral away from me, because they thought I wasn't within sound mind for it. But if I went in to talk about my gender clinic referral, they would immediately see my BPD and be like, 'you don't know who you are. So of course you think you're trans'. So I couldn't go in and talk about either thing. I shouldn't have had to worry that if I go in and tell my doctor, 'I feel really unwell mentally', they're gonna be like, 'Oh then you're clearly not prepared for your your gender clinic referral', and pull the rug out from underneath me." - Luke, 23, trans man, queer

Young people also described **societal hostility to LGBTQ+ people** as a backdrop to their search for support and interactions with services. This hostility, particularly the historical demonisation of trans people (especially trans women) could exacerbate young people's fear of accessing services, their assumption that services would not be safe for them, and their desire to not want to be a 'problem' or 'disturbance' in seeking support.

TOM:

"I think a lot of asexual people just like, don't go [to see a mental health professional]. They just say 'Yeah, I don't like this therapist, I'm not going any more'. If I needed mental health support I would go to a counsellor, but I probably wouldn't say that I'm asexual. I'd just put that off, and I'd just go in like, 'Yeah, yeah. I'm just a normal straight man, you know". - Tom, 17, cis male, asexual

LGBTQ+ YOUNG PEOPLE EXPERIENCING MULTIPLE MARGINALISATION FACE PARTICULAR BARRIERS

Participants in this research were not a representative sample of LGBTQ+ young people in Cambridgeshire and Peterborough, as white university educated UK citizens were over-represented in the study. There is a need for further work with LGBTQ+ young people experiencing multiple types of marginalisation, particularly those not represented in this project, to explore their experiences and the impact of different intersecting forms of oppression on their access to mental health support.

Bearing these limitations in mind, the research shed light on particular barriers for LGBTQ+ young people experiencing marginalisation relating to aspects of their identity other than their gender or sexuality. These included disability and neurodivergence, age, nationality, and homelessness.


Young people who were **autistic, neurodivergent and/or disabled** experienced specific barriers due to these factors, independently and in interaction with their sexuality and/or gender. Barriers included stereotypical and discriminatory views of neurodivergence or disability; inappropriate questions relating to disability; assumption that mental health difficulties were due to disability or neurodivergence; refusal to believe that young person could be both autistic and trans, and inaccessibility of mental health systems and processes for accessing support.

RORY:


“My biggest barrier to [getting appropriate mental health support] was executive function. You have to do all of it, which is, for disabled people it's just a big thing. And also, a lot of the time the counsellors, especially the college one - she just kept asking me about me being disabled. And that was not what I'm there for. I happen to not be able to use my hands so much. But that's not why I'm depressed.”

Rory, 25, gender ambivalent, pansexual


A number of young people also reported being **excluded from some informal support**, citing a lack of accessible LGBTQ+ spaces for disabled people and those with commonly stigmatised mental conditions. Given the value attributed by participants to LGBTQ+ spaces and informal networks, this represents an important gap in the support available to these young people.



These barriers sit within the wider context of disabled and neurodivergent trans people's experiences of healthcare; 60% of disabled respondents to a survey conducted by TransActual (2021) reported experiencing ableism in relation to accessing trans-specific healthcare. This survey also found that trans people with disabilities are more likely to experience delays in accessing gender-affirming care than non-disabled trans people (93% and 85% of respondents respectively).




Young people's experiences of trying to access mental health support, and the barriers they encountered, varied greatly according to their age. Child and Adolescent Mental Health Services (CAMHS) were cited as particularly difficult to access due to lack of availability and high thresholds, although the young people interviewed who had accessed CAMHS reported then having support available when they needed it. Additionally, moving between CAMHS and adult services, or seeking support at age 17+ (the top end of the CAMHS age range), presented many barriers to young people.




Some participants were not UK citizens and so were unable to access certain NHS or university-based mental health services. LGBTQ+ young people living in the UK include those who may be asked to pay for these services, who might be unsure of their eligibility to access them, and those who experience other barriers due to their citizenship or nationality. Further work is needed to examine the experiences and needs of these young people in particular.

A minority of young people interviewed **had experienced homelessness**, and explained that this posed a significant barrier to accessing NHS services. Given the over-representation of LGBTQ+ young people in the UK homeless population, again further work is needed to explore the experiences of these young people in relation to accessing mental health support.

Financial circumstances were cited as a significant barrier to support, particularly by limiting access to private mental health support. Due to the barriers faced by trans people in particular in accessing secure employment, our data highlights the need both for free mental health support to be available to LGBTQ+ young people, and for work to ensure this population's access to mental health support to be situated within wider work to address the material circumstances of trans people in the UK.



There was limited data within this project on race and racism, and an under-representation of Black people and other young people of colour. It is likely that these young people experience particular barriers: the majority (53%) of Black people and people of colour (BPOC) report experiencing racism while accessing trans-specific healthcare services (TransActual, 2021). Additionally, BPOC respondents also experienced transphobia from trans-specific healthcare providers at more than double the rate of white respondents (13% compared to 6%).



We therefore wish to draw attention to the existing work in this area, while highlighting the need for further research examining the needs and experiences of young LGBTQ+ people of colour in accessing appropriate and timely mental health support, and the ways racism interacts with other forms of discrimination and oppression to limit access to support.

We recommend resources from Black Beetle Health (www.blackbeetlehealth.co.uk) and Sabah Choudrey (www.sabahchoudrey.com/supportingtpoc/) as a starting point for further reading in this area.

WIDER NETWORKS, LIKE FRIENDS, FAMILY AND COLLEGES, CAN PLAY A KEY ROLE

The majority of supportive factors cited by LGBTQ+ young people related to their social networks and relationships, including family, friends, trusted school/college/university staff, and youth workers. These individuals and organisations both provided support with signposting and accessing other services, and provided direct mental health support themselves.

Almost all of the young people described parents, carers or family as involved in their journey of accessing mental health support in some way. **Parents and carers can be key advocates, particularly for younger people, and particularly for those also trying to access gender-affirming care.**

However, young people in the study also reported significant barriers to family support, including not wanting to worry parents/carers; mental health needs not being acknowledged or taken seriously; homophobia, transphobia and/or denial of LGBTQ+ identity by family; inability to be 'out' as LGBTQ+ to family; and family's lack of understanding of LGBTQ+ identities and needs.

Friends, particularly those who were also LGBTQ+, were commonly described as a **key source of informal mental health support**, providing space to explore, talk through uncertainty, and work things out in an empathetic, accepting and supportive environment. Friends also supported participants in navigating access to formal mental health support, although friends' negative experiences could hinder access to particular services.

Young people clearly stated that there was a limit to what could or should be offered by friends, and not all participants had strong or supportive friendship networks. Strong peer relationships should therefore not to be seen as an alternative to other forms of support.

ALEX:

"When I crashed into crisis, it was probably the saving thing, my friends recognising the signs. I was saying, 'I feel like this, I don't really want to do this and I want to sleep all day'. And they're like, 'That sounds like depression'. They caught it there and I was like, 'Oh my God, this is it. I need actual help'. So I finally got started. I finally got started."

Alex, 19, enby, pansexual

DANIEL:

“It was nice to sort of be able to talk to my family about my mental health and have it be recognised. But then at the same time, because my Mum she had experienced it [poor mental health], she didn't want me to have also experienced it. So even when I was like, ‘These things are symptoms’ or like ‘I think this is a problem’, she would sort of resist it. That happened a little bit with some of the queer stuff as well. I think it's the protective parent thing, they don't want anything to be a problem for you. So, the minute you bring up something like that, if they see it as a problem, they try and downplay it as if it will sort of go away. And you're like, ‘No, I kind of want the recognition of this being a thing!’”

Daniel, 19, non-binary, bisexual

Some **schools and colleges** provided direct support via on-site provision such as counsellors or wellbeing practitioners. Schools and colleges also facilitated access to other services, providing information and in some cases supporting referral. However, many young people described barriers to accessing support through this route. These included feeling they lacked time to seek support due to their academic workload; concern about a blurring of boundaries and relationships; not wanting to speak to teachers about their mental health; and not trusting that school staff would keep their conversations confidential or provide meaningful support. Some participants reported a perceived lack of care from school or college staff, believing that staff valued their academic attainment above their wellbeing.

DANIEL:

“In my experience, if you're someone who can drive yourself to almost burn out, the result of that is going to be something where schools are like ‘Ah, yeah, well done. You work so hard and look how many hours of study you do and look at your dedication to the subject and all of your grades...’, and it's like, well actually this is really hurting. And you kind of can't have those conversations because the kind of language around mental health at my secondary school was always like, ‘If you have mental health problems, you can talk to us so that we can get you back on track to study’. It was sort of like ‘Your mental health problems are only kind of something that we want to address insofar as they affect you being able to get the grades that we want you to get, or you being able to do the work that we want to set you’. And so, I never really saw mental health support at school. There was sort of always a conflict. Always feeling like ‘Well, no, because you only care that it's affecting my studying and study wise, you definitely don't think that's a problem because I've been doing pretty well’.”

Daniel, 19, non-binary, bisexual

FLATCAP:

"My school was very negligent in a lot of ways. I experienced like quite a bit of homophobia out there. I remember the first time I heard the F slur. It made me feel unsafe. And I go to this person [school staff member] and say, 'I have—I feel like there's a real problem of homophobia in this school', and she's like, 'Well, that's kind of an overarching issue. Unless you have specific names we can't do anything'. And I remember, I have this scored into my brain, she said, 'You getting bullied for being gay is the same—is a lot like a kid getting bullied for liking My Little Pony.' And I'm like, 'I am sorry, what the f***! Pardon the f***!' You know? Like—and I told this to someone I know, who's asexual. And they were like, 'I don't think anyone's been killed for liking My Little Pony'. Like, just the mental gymnastics you have to do to compare a systematic issue where thousands have died, to some kid being like, 'Haha, you like this rainbow toy'. Like, what? What? And after that I was like, 'Okay, I don't think I want to come back to you'."

Flatcap, 17, non-binary, queer

Young people frequently reported **not being open with school/college staff about their gender or sexuality, due to discomfort about discussing this with staff and fears around confidentiality and being 'outed'**. In many cases, this was situated within a **wider school environment of heteronormativity and LGBTQ+phobia**.

Similarly, universities could **provide direct support, information and signposting**, with more extensive support available than in secondary settings. However, some of the same barriers relating to **trust, boundaries/blurring of relationships, workload, confidentiality and care** operated to limit students' access to support through their university.

University students also reported feeling stuck in a situation where they were not able to keep up with academic work to mental health difficulties, but felt unable to seek support due to worrying they would not be allowed to stay at university. Students also reported an additional tension between university-based and NHS mental health services, with poor communication, information exchange and referral both within and between these two services. International students faced additional barriers, including being unable to access services in the UK when COVID lockdowns meant they were in a different country.



RORY:

“They will try and throw you out of the university, under the ‘fitness to study’ rules. So, you don’t really want to get that far, because then you are really getting in really dangerous territory... I have friends who’ve been made to leave the university. Because they’ve been too ill. Too ill!...I think a lot of the time, it does feel like you’re being punished rather than you’re being helped. It definitely felt like that at school, and it definitely feels like that at university. It was sort of like, if you tell anybody that you’re too ill to be here, then it’ll be a problem. The fact that you are not doing well is not the issue; it’s the fact that people know about it... So you’re basically encouraged to just get on with it and be quiet, rather than actually get help for it.”



Rory, 25, gender ambivalent, pansexual

LILY:

“For counselling I was pointed towards the university counselling service, because they were more likely to get it done in a timely manner, and also slightly more specialised. But I did not go for counselling. I did not have the time. My first year, by some small miracle, went fine, but I didn’t have time to spare. My second year, things were not going particularly well, and I didn’t have time to spare. Then in my third year, everything was tumbling down around my ears. Like, 75% of my coursework was not getting done, I definitely did not have the time for this. Because my priority all this time was, I had to work. That’s the kind of space I was in. In retrospect, I didn’t have a sense of self worth. All that mattered was my academic results. And so when that started to slip, because I’d internalised all that, the idea that all that was actually worthwhile was my results, things started to get very bad very quickly.”

Lily, 23, trans woman, unsure of sexuality



Young people emphasised the value of **LGBTQ+ spaces** and social connections as a form of mental health support and in facilitating access to other support. They explained that both formal LGBTQ+ spaces and informal connections to other LGBTQ+ people through friends and communities could be vital in maintaining their wellbeing and accessing formal mental health support. These were described as fulfilling young people’s need to safely explore their identity and access relevant information in a space that was supportive and affirming, as well as allowing them to explore, learn and make social connections with others with similar experiences.

LGBTQ+ YOUNG PEOPLE HAVE CLEAR IDEAS ABOUT WHAT GOOD SUPPORT LOOKS LIKE FOR THEM

Young people said that good mental health support should:

- Be **accessible, welcoming and person-centred for all young people**, and work to ensure young people feel cared for and deserving of care.
- Be **appropriate to need**. They emphasised the need for early access to preventative and low-level support when appropriate, but also access to more intensive or high-level support when needed.
- Be **available in different spaces** – e.g. school, college, university, voluntary sector, NHS. Young people also emphasised the need for appropriate **communication, signposting and referral** between different services and the young person, regardless of point of entry.
- Be holistic and flexible, taking into account **young people's lives, priorities and commitments**. This includes ensuring young people have permission and support (including emotional, academic and/or financial support) to engage in mental health support.
- Build spaces, information and the trust necessary to have **open conversations and ask questions** about mental health, and gender and sexuality, without fear of judgement or of putting their care, employment or education at risk.
- Give young people meaningful **autonomy and control over their care**. Young people wanted mental health professionals to listen to them, and recognise their knowledge of their own experience (in relation to both mental health and LGBTQ+ identities), without exerting pressure on young people to know their own mental health needs or be certain about their sexuality or gender.
- Adopt an **asset-based approach**. Young people called for health professionals to recognise young people's strengths, knowledge and social networks while ensuring access to **expert support and knowledge** where needed.



CHARLIE:

“This is probably kind of a basic thing, but just listening to what people are asking and telling you. If someone's giving you a cry for help, then don't second-guess it and be like, 'I don't know'... don't make it into something that's their problem. If someone's asking for support then help them get support! Because when I was first asking for support, I felt bad about asking. So making it okay to ask for support, and not having to be worried that the support you get isn't going to be inclusive to all aspects of things that you need support for.”

Charlie, 16, female, bi



LUKE:

“At the moment, it [the support I receive] is actually really good. My GP is so understanding. And really helpful, like with writing me sick notes if I need time to rest. Because we have found out that the number one way to minimise my suicidal ideation is to just let me f***ing have a kip. So he's like, 'If you need it, you can, I'll just sign you off of work. And then you can rest and stay alive'. Which is really helpful. And they're really co-operative with sorting my medication as well. And changing it when I don't feel right, when it's not working for me. And they also do all my trans related care as well, at no point have I been fearful about that. They also do all my injections for my transition as well, which at my old GP, they didn't, they refused. And at no point at this new GP have I felt like either thing [gender-affirming healthcare and mental health support] is in conflict with the other, they just accept that I'm a human person who has multiple facets.”

Luke, 23, trans man, queer

ALEX:


“A lot of the time at university, I felt like my mental health was trivialised. There was always this message like 'maybe it's not like that that bad.. Can you still work? Can you do ten, fifteen minutes?' It was only my academic supervisor who actually said 'Sometimes you just can't. Take some time off. Just do.' And that was big, because this one academic person was the only person telling me to take care of myself first, not to do academic things. Whereas everyone else was seeing if I could still do my normal life first. If it wasn't for him, who I trusted more than anything – when he said that I was able to be like, 'Okay, I'm not going to do anything. I can take time off'. But I could only do that because my advisor said, 'Don't worry about school'. It became my new - instead of becoming a full-time student, it was a full-time self caretaker, which was really important. I needed that time off. There was - I couldn't do that without it. There was no way.”

Alex, 19, enby, pansexual



LUCY:

“[I think an important thing for health professionals is] just knowing about LGBTQ+ identities. Being as accepting as humanly possible. Maybe having like enough information, so that somebody who thinks that they have a certain sexuality or gender identity can come to this professional, and sort of explain what's going on, and the professional will be able to give helpful advice. Because if you go to talk to someone who's like, 'Don't worry, you can tell me everything' and then you bring in your [LGBTQ+] identity, and they're judgmental about it, you'd be bit concerned about how much you can trust them, and how much you can talk to them, and how reliable their advice and information is going to be. If they can't accept this massive part of who you are. You need to have people that you know you can turn to when you're struggling. You need to have people that you're really comfortable around and that you know are gonna be accepting of you. That's a really big contributor to the ability to open up and speak out about your struggles.”



Lucy, 17, genderflux genderfluid, bisexual


ZELDA:

“I think....it's good when all the available options are kind of present, but I think there's a difficult middle ground between having options available, showing that there are options, but not overwhelming with all the options. So maybe having a quite simple like 'Here is what we can do' and then you pick the one that suits you for help. Otherwise it can feel like they're asking you to tell them what you need. But you might not necessarily know what you need, or it's difficult to explain. But if you've got options of 'We can help you with this and we can do this', like the different options for you to choose from.”

Zelda, 16, trans girl, asexual, aromantic

Young people also stressed that support should include specialist provision for LGBTQ+ young people and greater inclusion of and provision for LGBTQ+ young people within mainstream mental health and youth services.

The value of services and spaces **specifically for LGBTQ+ young people** was highlighted. Both formal and informal groups and services were described as providing valuable space to **find out information about different identities and experiences; explore one's own identity; form social connections; access relevant and appropriate information about LGBTQ-specific topics; and receive support and affirmation for identities that were often stigmatised.** However, work is needed to ensure these spaces are **available, accessible and appropriate for all LGBTQ+ young people**, including those experiencing commonly stigmatised mental health difficulties and/or other forms of multiple marginalisation.



Additionally, participants argued that **LGBTQ+ young people need to be safe, comfortable and receive appropriate care when accessing mainstream services.** Good support must therefore include mental health professionals **having knowledge of LGBTQ+ identities, experiences and needs, including interactions between sexuality, gender and mental health.** This knowledge also needs to be **clearly advertised and communicated,** as many LGBTQ+ young people said they would otherwise not assume that healthcare spaces were 'safe'. This was particularly the case for young people who were asexual or trans, who explained that these identities were very commonly misunderstood or pathologised both by health professionals and within wider society.

TOM:

"It would be good to have a progressive therapist that actually understands modern ideas. So being educated on LGBTQ+ spheres, and different identities. And being able to understand the modern pressures that young people face, especially those that aren't straight. For me [as an asexual person], it's very difficult to be recognised, because it [asexuality] has just not been given the attention and education that other sexualities might have. When something isn't educated about, people become ignorant to it existing. And then, you have to constantly have to be explaining yourself to anyone you meet. It can be quite taxing sometimes." - *Tom, 17, cis male, asexual*

JOSH:

"Firstly [mental health professionals need to have] very good, well versed information for trans people. They need to understand exactly what it means to be trans or gay or queer, and try to understand how young people feel. Because I don't think there's really any other way to understand or be able to help young people." - *Josh, 16, trans man, bi*

DANIEL:


"I think it would be nice if mental health professionals had the kind of capacity to be like, 'Okay, a) we can kind of address and talk about those things [gender and sexuality]. And b) when we do, we can kind of appreciate that it's sort of complicated and it has results for lots of different things'. As opposed to treating it as a problem on its own, because it's not a problem in isolation. It's not like 'Oh, and now we're going to talk about the gender for a while'. It's more complicated than that. Like one of the consequences [of questioning one's gender] is it relates to how other people see you, which is obviously tied up in lots of other mental health stuff. So if you could get into all of those things with gender as a part of it, rather than sort of like separately. That would be good."
- *Daniel, 19, non-binary, bisexual*



RECOMMENDATIONS




Building on the findings from our research, we propose some recommendations for how these can be addressed. We need to:

- 
- 1. Adequately resource mental health services**
 - 2. Support young people to navigate mental health services and different forms of support**
 - 3. Adopt inclusive language and data systems**
 - 4. Work collaboratively to create a mental health support system designed for equitable outcomes and experiences**



RECOMMENDATION 1: ADEQUATELY RESOURCE MENTAL HEALTH SERVICES

- **Increase investment in all forms of mental health support**



In this research, young people shared examples of long waiting times and strict thresholds that limited access to timely and appropriate care. The young people we spoke to were aware that lack of access to mental health support is in part due to limited resources. Everybody should be able to get behind this first ask - to invest more in all forms of mental health support.


There is no doubt that those working across all forms of mental health support are trying to do their best with the capacity they have, but there is at present simply not enough resourcing of these services to provide the capacity that we need. This is a national problem but is particularly acute locally. In 2020/21, spend per capita on mental health services in Cambridgeshire and Peterborough was £173.17, compared to an average of £202.21 for all of England, and £239.87 in neighbouring Lincolnshire. Whilst this represents an increase of 5.5% in the last year locally, this lags behind a 6.7% increase in the national average and so Cambridgeshire and Peterborough risk falling even further behind (RCPsych, 2022).

There is a need for local reprioritisation to enable increased investment in mental health services, and the chronic under-funding of NHS services as a whole must be addressed, particularly given the increasing demand for mental health services. Crisis services might seem appealing as a site for investment due to their ability to prevent the greatest harms. However, additional investment is required in services across both the statutory and voluntary sectors, and across all levels of urgency and severity - from preventative to crisis care. Our findings show the importance of strong social networks as a facilitator for young people seeking mental health support, and investment in services which aid LGBTQ+ young people to build these networks should be considered part of the preventative mental health services system.



RECOMMENDATION 1: ADEQUATELY RESOURCE MENTAL HEALTH SERVICES

- **Map the services available to identify and address gaps**



Several young people told us their needs were labelled as either too complex or not urgent enough, and were left with no care as they fell into gaps between commissioned services. Commissioners should take stock of the services they are commissioning, take note of the evidence of where there are gaps, and identify how these can be addressed through restructuring existing services and commissioning new ones.

This mapping should also identify targeted services for different demographics, including those provided nationally and regionally. LGBTQ+ young people told us they want the option of LGBTQ+ specific support as a possibility amongst other universal services, therefore it's important to know where these exist and where they may need to be commissioned.


- **Provide support to prevent crisis and ongoing care after crisis**

A clear need identified in our data is for additional services for those with moderate to severe mental health needs, but who are not currently in crisis. Thresholds for different services need to overlap and clear pathways between them need to exist, to ensure that young people are supported to receive ongoing care as their needs become more or less severe. In particular, access to ongoing care and support for those who have been de-escalated from crisis seems to be missing locally.




RECOMMENDATION 1: ADEQUATELY RESOURCE MENTAL HEALTH SERVICES

- **Provide tailored services for young people up to 25 years old**



Additionally, this project highlights the gaps in support that can occur when young people moved between child and adult mental health services or between geographical areas, as also seen in previous work undertaken locally by Healthwatch (2021).



Whilst the newly developed YOUnited service in Cambridgeshire & Peterborough aims to provide support for those up to the age of 25, there is a need for further development of the support available for those aged 18-25. Whilst YOUnited provides a single point of access model for 0-17-year-olds, the referral information for those aged 18-25 currently advises young people to self-refer to two voluntary sector services or to access primary care mental health services through their GP. Young people are not provided with an explanation of the distinguishing features of each service or advice on how to proceed if these services are not appropriate or accessible (CPFT, 2022) .

Further development is needed to both provide clarity to young adults on how to navigate the mental health system, and to provide increased access to services that recognise and respond to the particular needs of their age group.

RECOMMENDATION 2: SUPPORT YOUNG PEOPLE TO NAVIGATE MENTAL HEALTH SUPPORT

- **Build trust through clear communication**

Information about services available needs to be clearly communicated in ways that can be easily understood by young adults and those with no medical training (such as those who may be supporting young people). Our findings show that knowing what is available and how to access it is a crucial first step in the journey to seeking out mental health support.

Information communicated to young people and those who support them needs to include explicit messages of inclusion. Childhood experiences of LGBTQ+ bullying, phobic behaviour and hate crime lead young adults to expect to be discriminated against (Hudson-Sharp et al., 2016). Our research demonstrates these fears are often borne out when LGBTQ+ young people try to access mental health support, and lead them to avoid engaging with services or hiding their gender or sexuality. Efforts need to be actively made to show LGBTQ+ young people that they are welcome and that services will adequately and appropriately address their needs.

- **Provide a range of support whilst on waiting lists**

Being added to a waiting list is not perceived by young people as a form of care or support in itself. Young people explained that being added to a waiting list without meaningful support while they waited, and with poor communication about the length of the waiting list, could exacerbate their mental health difficulties. Young people frequently wait many months between being added to a waiting list and beginning to receive care from a specialist service.

All mental health services should identify how they provide care to those on waiting lists and maintain communication with service users about the length of wait and what help will be available. Services should provide self-help resources, group workshops and a duty/support line to give access to positive coping mechanisms and work to prevent the worsening of an individual's mental health whilst waiting. Thought should also be given to escalation routes within and between services if the need for mental health support changes whilst awaiting a service.

RECOMMENDATION 2: SUPPORT YOUNG PEOPLE TO NAVIGATE MENTAL HEALTH SUPPORT

- **Increase access to 'care co-ordinators'**

Young people found the system of mental health services available to 16 to 25-year-olds incredibly complex to navigate. Young adults would benefit from the opportunity of having the support of a care co-ordinator – a named individual to help them navigate this system from assessment to treatment, potentially multiple times if accessing different forms of support.

The researcher in this project took on this role with a small caseload of young people, providing a supportive ally who could help them to understand and navigate the options that might be right for them, undertake administrative tasks, and advocate for them in mental health settings. A similar role, located within NHS mental health services, could provide a guide to facilitate access to more flexible pathways of support. Care co-ordinator roles have already been created within Gender Identity Clinic pilots to aid patients in understanding the range of gender affirming healthcare available to them, and in mental health services elsewhere in England.


Having a care co-ordinator allows young people to feel listened to and cared for, going some way to address the fear and disengagement from mental health services that was prevalent among our participants. Additionally, the care co-ordinator role could be vital in facilitating 'warm handovers' between different services as needs change, ensuring young people are engaged in the next service rather than leaving them with gaps in access or communication.

Creating and expanding the availability of care co-ordination roles should take into consideration the experiences of marginalisation faced by many young people who would benefit most from this support. An awareness of LGBTQ+ specific support provided both locally and nationally, as well as specific support for people of colour, disabled people, survivors of violence and other experiences of marginalisation, should form part of the training, resources and expectations for staff in these roles.



RECOMMENDATION 3: ADOPT INCLUSIVE LANGUAGE AND DATA SYSTEMS


- **Implement guidance on data items of gender**



Guidance for all organisations who submit data to the Mental Health Services Data Set outlines how questions related to gender and sex assigned at birth should be asked in a consistent way (see NHS Digital, 2022). Adopting this approach comprehensively would support health care professionals to ensure they are collecting data related to gender in a sensitive and inclusive way. The importance of collecting this data is explained by LGBT Foundation in their guide, 'If we're not counted, we don't count' (LGBT Foundation, 2021).


- **Reflect on language use to challenge stigma and improve access**

Co-production and consultation work with young people is needed to further explore how the language used presents barriers to accessing the care they deserve. Young people in the research recounted feeling that they did not want to be a 'burden' to mental health services that are under-resourced, and in other circumstances identified feeling that they were not seen as human beings with feelings. LGBTQ+ young people may already be more likely than non-LGBTQ+ peers to be struggling with feelings of a lack of self-worth. There is need for further work exploring how language around mental health support can be used in an empowering way by those delivering services, in order to support LGBTQ+ young people to access the care they need and deserve.




RECOMMENDATION 3: ADOPT INCLUSIVE LANGUAGE AND DATA SYSTEMS

- **Provide training in LGBTQ+ inclusion**



Whilst true inclusive practice cannot be achieved through a one-off training session, there is a role for an introductory LGBTQ+ awareness training as part of the core professional development of all healthcare staff. Such a training can ensure that all staff are introduced to a range of vocabulary they might need to have conversations with service users, and have space to challenge myths and misconceptions that can lead to prejudice in healthcare settings.


Additional training would then be beneficial for those who are likely to work with large numbers of LGBTQ+ patients. Amongst 16-24 year olds around 10% now described their sexuality as LGBQ+ (ONS, 2022) and around 5% of teenagers in Cambridgeshire report a gender identity other than male or female (SHEU, 2021). Therefore it is highly likely that those delivering mental health support to young people will need more substantial training in this area.





RECOMMENDATION 4: COLLABORATE TO CREATE A SYSTEM DESIGNED FOR EQUITABLE OUTCOMES AND EXPERIENCES

A recent briefing from the Centre for Mental Health (2020) identifies six qualities of a system designed for equalities of outcome and experience for all. These are:


- 
- An enhanced community sector role in mental health support
 - Co-production at every level and in every service
 - Culturally competent and trauma-informed approaches
 - A commitment to meet all needs
 - A whole system approach
 - Accountability and transparency

With regards to a system to deliver equitable outcomes for LGBTQ+ young people in Cambridgeshire and Peterborough, the following recommendations set out how these qualities could be realised in more detail:

- **Ensure all health care professionals are equipped to make their practice anti-oppressive**

The LGBTQ+ community is not homogenous and training for healthcare professionals, both as part of their core practitioner training and ongoing professional development, needs to include an understanding of intersectionality. Experiences of different sexual orientations and gender identities are nuanced by additional factors and other forms of oppression associated with race, disability, neurodiversity, income, citizenship, geographical location, and experiences of trauma, amongst others.


Introductory training on LGBTQ+ awareness or inclusion rarely gives enough space to go into depth about these variations in experience or allow practitioners to gain an understanding of topics such as the complexity of family relationships for LGBTQ+ youth. Embedding this content from initial practitioner training onwards would allow healthcare professionals to bring anti-oppressive practice into their work and ultimately deliver more equitable outcomes for all.






RECOMMENDATION 4: COLLABORATE TO CREATE A SYSTEM DESIGNED FOR EQUITABLE OUTCOMES AND EXPERIENCES

- **Adopt a whole-organisation and whole-system approach to LGBTQ+ inclusion**



The Kite Trust and partners have found increased success in their work with schools using the Rainbow Flag Award's whole-school approach to LGBTQ+ inclusion, and believe a similar whole-organisation and whole-system approach could be beneficial to mental health services. Whilst introductory LGBTQ+ awareness training is often focused on staff in patient-facing roles, attention to organisation-wide systems, structures and policies, as well as support for administrative and managerial staff, is also needed in order to address structural forms of discrimination and barriers to access.



- **Commission tailored services for the LGBTQ+ community**


With both increasing mental health needs and an increasing size of the local LGBTQ+ population, the case for commissioning services to provide tailored support in this area is also growing. Learning from such services in other geographic areas should inform service design and development, for example GYRO run LGBTQ+ specific services within CAMHS in Liverpool (www.liverpoolcamhs.com/support/gyro-ypas); MindOut is a LGBTQ+ specific mental health service in Brighton and Hove (mindout.org.uk); and Bristol Mind and Mind in Somerset run Mindline Trans+, an emotional and mental health support helpline (mindlinetrans.org.uk).






RECOMMENDATION 4: COLLABORATE TO CREATE A SYSTEM DESIGNED FOR EQUITABLE OUTCOMES AND EXPERIENCES

- **Deliver integrated care to meet the needs of the whole person**



Ultimately, better communication and collaboration between services will enable better care for people in a wide range of circumstances, as many people concurrently experience both mental and physical health needs. However, there are particular benefits to a more integrated approach to care for trans people who are seeking gender affirming healthcare.




Many trans young people in this research reported experiencing a conflict (both perceived and actual) between trying to access mental health services and gender-affirming healthcare, feeling the need to choose between these or prioritise one aspect. Emerging good practice and learning should be drawn from the Gender Identity Clinic pilot projects in London, Manchester and Liverpool, and can be implemented locally as the new East of England GIC satellite clinic is established with Cambridgeshire and Peterborough NHS Foundation Trust.



CONCLUSIONS

"I am incredibly humbled by and grateful to the LGBTQ+ young people who took part in this project – from interviewees, to our steering group, and especially those who trusted us to support them in navigating mental health services.



It is clear that there are significant challenges preventing LGBTQ+ young people from accessing the care and support that they deserve, and I, along with The Kite Trust more widely, am committed to addressing these. And it is only in collaboration with LGBTQ+ young people; professionals providing services; commissioners and politicians that we will achieve this.

I believe this project has highlighted three key areas where we at The Kite Trust must immediately begin further work:

- **Amplifying the call for increased funding and resources for mental health services**, especially those targeted at adolescents and young adults. The events of the last two years have put increasing strain on already under-resourced provision, and our collective advocacy is needed to bring about change.
- **Piloting and expanding new preventative and early intervention mental health support** within the LGBTQ+ inclusive environment of our youth work programme, whilst continuing to advocate for our young people who need more specialised services.
- **Developing a more extensive range of training and programmes for healthcare providers** which are based on a whole-organisation approach to inclusion. Whilst our existing introductory training has merit in giving professionals the language to have conversations with their patients, there is learning we can take from our delivery of schools programmes to amplify the impact we can have in building an LGBTQ+ inclusive health sector.

The Kite Trust's vision is for an inclusive society where LGBTQ+ young people are healthy, successful and celebrated. Receiving adequate, appropriate and timely mental health support is essential to this goal, and we look forward to collaborating with anyone who wants to work with us to achieve it."



Dr. Pip Gardner

Chief Executive, The Kite Trust

CONCLUSIONS

“Fullscope’s Mission is to effect a more accessible, relevant and equitable system to support CYPC with their mental wellbeing, and this project absolutely speaks to that intention. The co-production and consultation with young people has been central to the project, ensuring that young people are listened to – and that we, and the wider system, can learn from them. We would hope for the learnings and recommendations to be taken forward by partners across the region, to ensure better and more equitable access to mental health support for LGBTQ+ young people – and that the work can have a national influence too.”

Katie Edwards

Fullscope Programme Co-ordinator

“It is evident that young LGBTQ+ people in the area are affected not only by all the same barriers of availability and appropriateness of services as any young people, but with the additional difficulties of uncertainty how well services will understand their needs, even whether they will face discrimination when trying to get help. I have learned that mental health services that support young people must do more to visibly demonstrate that they are welcoming and understanding of LGBTQ+ issues and back that up with well trained staff.”

Peter Williamson

Team Manager, CPFT Liaison Psychiatry North & Trustee, YPCS

“I think an important message from this research is that our current system is beyond flawed. It has failed so many LGBTQ+ young people and it needs to improve. I want healthcare professionals, specifically, to learn from our experiences of being in the mental health care system and tailor how they work to be more inclusive and for them to work with us productively and non judgementally.”

NT


Young People's Steering Group Member



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We are also immensely grateful to all the young people who took part in the research. Thank you so much for allowing us to share and learn from your experiences, and being so honest, engaged and eloquent. We appreciate every word you shared and we hope this report feels like an honest reflection of your experiences.

INTERVIEWEES

A summary of interviewees' demographic characteristics is given below. Please note that all names are pseudonyms, and all information was given in response to open questions.

Name	Age	Gender	Sexuality	Ethnicity
Alex (they/them)	19	Enby	Pansexual	Prefer not to say
Charlie (she/her)	16	Female	Bi	White British
Daniel (he/they)	19	Non-binary	Bisexual	White
Emma (she/her)	19	Cis woman	Bisexual	Not given
Flatcap (they/them)	17	Non-binary	Queer	White
Harry (he/she/they)	18	Not given	Pansexual	White British
Jamie (she/they)	23	Female	Lesbian	Prefer not to say
Josh (he/him)	16	Trans man	Bi	White European
Kaz (she/her)	21	Cis female	Panromantic asexual	Mixed
Lily (she/her)	23	Female	Don't know	White British
Lucy (they/them/she/her)	17	Genderflux genderfluid	Bisexual	White British
Luke (he/him)	23	Trans man	Queer	White British
Rachel (she/her)	24	Cis woman	Gay/queer/probably a lesbian	White
Rory (she/they)	25	Gender ambivalent	Pansexual	White British
Tom (he/him)	17	Male	Asexual (no romantic orientation)	White
Zelda (she/her)	16	Trans girl	Asexual aromantic	White British

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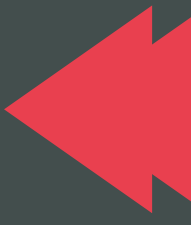
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