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'Bigotry is all around us, and we have to deal with that': Exploring LGBTQ+ young people's experiences and understandings of health inequalities in North East England.

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ABSTRACT

Background: Lesbian, gay, bisexual, transgender, queer/questioning, intersex, asexual/agender+ (LGBTQ + hereafter) people report poorer health and worse experiences of healthcare than the general population, compounded by growing inequalities in health seen across the UK. Correspondingly, LGBTQ + youth have higher rates of several negative health outcomes, particularly depression, anxiety, and suicide ideation.
Methods: This paper explores the views and experiences of LGBTQ + youth in North East England in relation to health inequalities, with data collected from two youth groups (n = 20) situated within socio-economically deprived areas (according to IMD measures). Three 1.5 h focus-groups with each youth group were conducted.
Findings: Participants faced discrimination in most areas of life, with damaging and long-lasting impacts on mental, physical and emotional health and well-being. Participants were acutely aware of such disadvantages and attributed them to lack of awareness, a need for education, lack of commitment to inclusion and access, negative and bigoted attitudes (worsened by media and political discourses), and active discrimination.
Conclusions: Addressing systemic discrimination faced by LGBTQ + youth must be seen as a public health priority. LGBTQ + youth must be included in decision-making (policy and practice) that impacts them and their health. Meanwhile, the vital sanctuary and support provided by LGBTQ + youth groups must be bolstered to address limitations and gaps in provision due to growing public sector cuts. This is necessary to reduce or buffer the multiple intersecting inequalities faced by LGBTQ + youth. Finally, more research is needed to fully understand the crisis of health inequalities faced by LGBTQ + youth in England.

1. Introduction

Lesbian, gay, bisexual, transgender, queer/questioning, intersex, asexual/agender+ (LGBTQ + hereafter) people report poorer health and worse experiences of healthcare than the general population (McDermott, Gabb, et al., 2021; Carlile, 2020; Westwood et al., 2020; Gnan et al., 2019; Jaspal et al., 2022). In line with a social determinants of health (SDH) perspective, this paper looks beyond the healthcare setting to view health as situated within wider complex health systems, by reflecting on injustices that result from power imbalances and unequal access to resources and reduced opportunities to lead healthier lives (Marmot et al., 2020). However, existing research focusing on LGBTQ + health inequalities tends to have a clinical, biomedical, or lifestyle focus, and thus lacks explanation of the underlying structural mechanisms that may influence LGBTQ + health inequality (McDermott, Gabb, et al., 2021). This can result in narratives that emphasise individual blame and responsibility for health status (Kriznik et al., 2018; Medvedyuk et al., 2018). A recent systematic review from McGowan et al. (2021) demonstrated a lack of routinely collected sexual orientation and gender identity data within published and unpublished research. Such omissions have been mirrored within policy and practice where, despite recognition of the health and social inequalities faced by LGBTQ + communities (Government Equalities Office, 2018), there has, to date, been little by way of UK government response (Griffin et al., 2022; Phillips, 2021).

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LGBTQ + young people have higher rates of negative health outcomes such as depression, anxiety, and suicide ideation (Adelson et al., 2021; Wilson & Cariola, 2020). They are also more likely to engage in health risk behaviours such as self-harm and substance abuse (Fish et al., 2020; Williams et al., 2021). However, LGBTQ + communities are not homogeneous and LGBTQ + young people's experiences of health and social inequality can vary also depending on intersections with other axes such as age, ethnicity, income, social class, geography, and disability status (Williams et al., 2021; Zeeman et al., 2019). Further, systemic heteronormativity and other forms of discrimination all play into worsening health and socio-economic outcomes for LGBTQ + young people, whose lives tend to be further compounded by disadvantage, stigma and oppression, leading to intersecting layers of vulnerability (Higgins et al., 2021; Stevens et al., 2021; Zeeman et al., 2019). Despite this, there is a dearth of research which extrapolates differential experiences and risks faced by LGBTQ + populations in relation to health and health inequalities, and far less which focuses on *young* LGBTQ + people specifically (McDermott, Gabb, et al., 2021; Williams, 2021).

The present study is part of a larger body of work which explored young people's perspectives on inequalities in health throughout England (Fairbrother et al., 2022; Woodrow et al., 2021). Research exploring the views of children and young people in relation to health inequalities remains limited (Smith & Anderson, 2018; Woodrow et al., 2021), yet experiences in early life have a lasting effect on adult health both directly and through influencing adult health behaviours (Pickett et al., 2021). Further, it is increasingly recognised that young people have a developing sense of awareness of the systemic inequalities that disadvantage them or others in their community and demonstrate nuanced and dynamic understandings of how socioeconomic circumstances shape health outcomes for them and others (Haffejee et al., 2022; Fairbrother et al., 2022). Here, we address aforementioned gaps in knowledge by focusing specifically on LGBTQ + young people living in socio-economically disadvantaged communities, drawing on academic literature on impact of Minority Stress Theory (Meyer, 2003) and it's implications for young LGBTQ + health.

2. Methods and materials

2.1. Study context

This paper draws upon data collected from 2 LGBTQ + youth groups recruited as part of a larger project. Further details on methodological and ethical challenges are described elsewhere (Woodrow et al., 2021) and full procedures are described by Fairbrother et al. (2022). Due to our focus on LGBTQ + young people, these data were subsequently supplemented (and strengthened) by the recruitment of a second youth group, also situated in the North East of England. Data were collected within the geography of two local authorities with high levels of deprivation and which are typically described as 'post-industrial'. The geographical focus of this study is important as the social and political fallout from the restructuring of the North East economy in the 1970s and the deindustrialisation of coal and steel industries in the 1980s are still acutely felt (Förster et al., 2018; Fairbrother et al., 2022). Under austerity these trends of economic decline continued, with the North East hit harder by cuts in spending and economic conditions leaving it more vulnerable to welfare cutbacks, further exacerbated by the COVID-19 pandemic (Corris et al., 2020; Ford et al., 2021).

2.2. Sampling and recruitment

Participants were attendees at one of two pre-existing community youth groups that provide spaces of support and socialising for LGBTQ + young people aged 12–18 years old. Participating youth groups were all situated in the most deprived quintile based on the 2019 English indices of multiple deprivation (IMD). Youth group workers we approached saw issues around health inequalities as pertinent in their areas and thus recognised the study as important to engage with. In order to recruit young people, we worked closely with the leaders of each of the youth groups who acted as a gatekeeper and a champion of this research, and led on safeguarding. All participating young people knew the youth workers present but had varying levels of familiarity with each other (with some meeting for the first time in the initial session). It was clear, however, that the young people felt safe and comfortable in the space of their youth group and with their youth workers which inevitably helped to facilitate discussions. The youth workers supported the research team and the young people, before, during and after focus group sessions to help ensure the whole experience was sensitive to the needs of the young people. The lead researcher [N.G] also attended youth group sessions, in-person and online, in advance of data collection, to explain the research and build rapport and trust with the young people which has been shown to be particularly important for minority groups (Wilson & Hodgson, 2012).

2.3. Data collection

Between May 2021 and January 2022, we conducted three consecutive qualitative focus groups with 2 youth groups with members aged 12–18. The sessions were held two weeks apart for each group of young people, resulting in six focus group discussions overall. One youth group (N1) took part online (via Zoom) and the other (N2) took part face-to-face. All focus groups were held during the youth group's regular weekly sessions and lasted approximately 1.5 h. For the online sessions, however, the lead author [N.G] was able to attend sessions in person before the focus groups started and after they had finished, around COVID-19 restrictions. The lead author [N.G] facilitated the focus groups, supported by other members of the research team [M.C, E.H, N.W & E.T]. All sessions followed the same format: introductions, warm-up activity, main activity (in smaller breakout groups to encourage and optimise participation) and close and cool-down activity. Focus group 1 explored participants' understandings of what impacts the health of young people in their local area, focus group 2 explored their perceptions of the social determinants of health using newspaper headlines and, finally, focus group 3 explored priorities for action and change.

All sessions (both online and in person) were recorded via encrypted Dictaphones, with data anonymised at point of transcription. Due to the nature of focus group discussions, and the ethical commitment to anonymity, demographic information was collected but not attributed to individual participants in the focus groups. Quotes, therefore, are not assigned to specific individuals based on demographic information. Instead, each focus group session was assigned a code and this has been used to contextualise verbatim quotes (see Fig. 1 where codes used for verbatim quotes are explained). Ethical approval for this study was received by University of Sheffield and Durham University ethics committees. All participants involved in the study provided written, informed consent (made available in an information form as well as in a youth friendly video format). Parent/guardian consent was obtained for those under 16 years. Participants were made aware that data collection would be anonymous and reminders of their right to withdraw (and opportunities to withdraw) were repeated at the beginning of each session, with check-ins by youth workers throughout. Youth organisations received £2500 for their time and each young person received a £20 voucher per focus group.

2.4. Data analysis

An inductive thematic approach allowed key themes from the data to develop, with flexibility, to ensure analysis adequately captured the views of the young people themselves (Roberts et al., 2019). This approach was rigorously tested through piloting of methods and regular analysis meetings. Sense-checking sessions were held with participants to validate emerging themes (Hadi & Closs, 2016). An initial coding framework was developed collaboratively by researchers based on the

Focus group session topics:	1: ' What impacts the health of young people in your local area' (Session1)	2: 'Exploring the social determinants of health' (Session 2)	3: 'Priorities for action and change' (Session 3)
Code for Youth Group 1 (N1):	N1 S1	N1 S2	N1 S3
Code for Youth Group 2 (N2):	N2 S1	N2 S2	N2 S3

Fig. 1. Focus group sessions and codes key.

research questions and initial analysis through repeated reading (Braun & Clarke, 2006). This stage also facilitated familiarisation with the data and allowed addition of any important themes that developed through the coding framework (Roberts et al., 2019). The coding framework was piloted by researchers across the team, who coded two full focus group transcripts using Nvivo software, increasing validity through triangulation (Hadi & Closs, 2016). Pilot coded transcripts were then merged within Nvivo, with any outliers reviewed collectively and added to the coding framework where necessary. Then all remaining transcripts were coded by two researchers separately then discussed between the two researchers with a third researcher drawn upon to support with any conflicting decisions. Core themes were established and researchers were assigned themes to explore in more depth [N.G, P.K, M.C., S.S]. Further detail of our approach to data analysis is provided by Fairbrother et al. (2022).

3. Findings

Our final sample consisted of 20 young people with 7 in the N1 youth group (aged 15–17 years), and 13 in N2 (aged 12–18 years). Collected participant characteristics are presented in Table 1. Most focus group participants had lived experience of mental health issues, some had accessed formal support such as Child and Adolescent Mental Health Services (CAMHS). Original codes and sub-theme categories yielded three central themes: (1) 'Discrimination in all spaces' - intersecting inequalities faced by LGBTQ + young people; (2) 'Hiding your true self' - understanding the health impacts of discrimination; and (3) 'Where do we start' – prioritising change. Nevertheless, these themes should not be considered in silo as themes explored in each interacted, amplified and overlayed in young people's lives. The themes are explored below and illustrated using verbatim participant quotations to provide rich description and faithful accounts of the views and experiences of study participants. At times, young people's narratives contained both explicit and offensive language. However, so as not to take away what little power and autonomy these young people had, we have not sanitised or censored young people's accounts, so please note that some words used may cause upset or offence.

Table 1
Participant demographics.

Age (years)	12 (n = 1) 13 (n = 5) 14 (n = 2) 15 (n = 5) 16 (n = 3) 17 (n = 3) 18 (n = 1)
Gender[a]	Male (n = 3) Female (n = 3) Non-binary (n = 4) Transgender male (n = 9) Trans-masculine (n = 1)
Ethnicity[a]	White British (n = 18) Mixed/other (n = 1) Mixed White/Asian (n = 1)

[a] Identity markers as reported by youth organisations.

3.1. 'Discrimination in all spaces' - Intersecting inequalities faced by LGBTQ + young people

Participants overwhelmingly expressed that discrimination permeated just about every area of their life: school; home; public spaces and services (including sport and leisure facilities); time spent among peers; in media, political and health discourses; in online spaces; and in healthcare settings. Participants appeared to feel particularly disadvantaged and disenfranchised in relation to school, which was a focus of much discussion, with participants drawing upon day-to-day examples of discrimination and its subsequent impact on their health and wellbeing. Specifically, the majority of our participants found their school's awareness of, and commitment to, the needs of LGBTQ + students lacking:

> *"Not at all, there is no sort of awareness. There is no sort of lesson or anything on what a trans person was in our school. So no-one had the knowledge of what they were. And we, our group of, well, our friendship group in secondary school, we were known as the kids who change our names, essentially."* [N1 S3].

Young people highlighted inadequate and inconsistent responses from school staff to bullying, the exclusion of non-heteronormative representation, and inadequacies in sex education, as particularly problematic:

> *"We talked about having … more inclusive sex education. Because I know a lot of us, I don't know about anyone else's experiences but I remember me and [name], our sex education in secondary was sat in our exam hall, having the woman at the front sort of talking to us about STDs and not getting pregnant as a teenager. And it just felt, especially some of the language they used, felt really like inaccessible to us"* [N1 S3]

Certain spaces in schools, such as changing rooms and bathrooms were described as unsafe by participants. Further, even where changes to promote greater inclusivity had been made, this equated to accommodations made on a case-by-case, individual basis (for example, responding to individual requests to provide a gender-neutral bathroom or changing room) rather than representing institutional level shifts in policy and ethos, and therefore not conducive to an environment in which that accommodation is enabled 'system wide':

> *"My nana, who I live with, is an ex-teacher and she consulted the school about if they had a trans policy, and, "Oh, yes, yes, we have one," but they wouldn't let us see it, because they didn't. They were writing one, because they realised like, "Oh, we need one of these," and they shit themselves and just quickly wrote one, after she asked. And I'm pretty sure basically all it says is, "The school will act if someone is discriminated against."* [N2 S1]

Young people recognised their lack of power and they felt that they

(and their allies) were not necessarily equipped to challenge explicit inequality in such a way. Some only felt able to do this when supported by a trusted, and vocal, adult, who made them feel safe, secure and heard. Thus, the same LGBTQ + young person suggested:

> "*I feel like my nana's a very loud person as well. So if there was someone who wasn't out to their parents or the parents weren't wanting to get involved, nothing would be done."* [N2 S1]

The majority of participants also shared stories of experiencing barriers within healthcare settings as a result of failings by individual professionals and the health system as a whole. The majority of these examples were in the context of mental health services and specialist gender services (particularly in relation to gender affirming healthcare) but references were also made to experiences of barriers and active discrimination experienced within wider healthcare settings. There was an overwhelming sense from the majority of our participants that mental health services are particularly important for LGBTQ + young people, but that the available services are not serving them well. Participants referenced long waiting times as problematic, stating that even in times of mental health crisis, support was either not available, inadequate, or in several examples given, damaging. Participants saw the inadequacies within CAMHS as ill-equipped to support LGBTQ + youth as related to both a lack of proper training, a lack of funding, and a general undermining of young people's experiences.

> *'If I said, "Oh, I really want to kill myself," "No, you're young. You'll get over it. Just have a bath and it'll be OK."* [N2 S1]

> '*CAMHS and stuff like that. Since that is heavily unfunded and a lot of staff don't really know what they're doing, essentially, because they haven't got the experience and the proper training since it's been un - funded, not that well.'* [N1 S3]

Active discrimination experienced in healthcare settings was particularly acute for trans and non-binary participants. For example, one participant described an experience of discrimination in a G.P. setting whereby they were forced to discuss their gender identity, even when their gender identity was not the topic of the consultation. They described how they were denied respect through misgendering and 'deadnaming', meaning being referred to by the name they were given at birth rather than their chosen name (Brown et al., 2020; Sinclair-Palm & Chokly, 2022):

> *"I've been told by CAMHS before that I was sabotaging myself and that nothing will ever change, that I was born as a girl, even though I wasn't there for trans-related support. So that's nothing to do with anything that I was trying to tell her about. So I've been told, "People still think of you as a girl. Nothing will ever change, that you are biologically a girl." The worker I have at the moment, in the past like if I'm talking about me before I transitioned, I still use like [participant name], and she doesn't. She just dead names me. "*[N3 S1]

Ultimately, LGBTQ + young people in our study felt they lacked power and autonomy in relation to decisions concerning their health and wellbeing. Whilst they referenced the attitudes of individuals within institutional settings as problematic, they also linked the behaviour of individuals to a lack of structural or systematic imperatives for change. To this end, some young people felt that their experiences and decisions around gender identity and sexuality were diminished and trivialised by adults, including parents and healthcare professionals:

> '*Yes, the parents think that then when they're trying to choose their gender or some sort that they're thinking, "It's going to pass soon," and then there's other people in the world that think "Oh, they can't decide their gender. They're just young and it's just a phase.*" [N2 S2].

Thus, due to the constraints within the current system, some young people described feeling powerless and unable to stand up for themselves or to demand better treatment in health care settings in case it affects their current or future treatment, reflected in a lack of faith or trust in services:

> *"But it also comes back to like if you complain to the people that actively give – because I still need antidepressants and if I actively complain to them I'm at risk of being dropped by them and not having antidepressants anymore, and going through the whole seven-year process again and even possibly even being denied because I would be discharged from them and poorly after calling them – you know getting angry with them … And I'm kind of stuck in a situation where I can't complain because they might discharge me, and I'll have it on my record forever and it will take me probably longer to get antidepressants."* [N2 S2].

Again, when young people did protest, they felt labelled as 'loud', 'disruptive', 'the bad guy' or 'making a big deal out of something' [N2 S2]. Much like one participant's 'loud' grandma mentioned earlier, LGBTQ + young people saw this as their only way to enact change, and that, arguably, it was more acceptable for a grandparent to be 'loud' than them. These tensions, barriers and disadvantages were compounded by structural factors such as where they lived, and young people were cognisant of the far-reaching impacts that poverty had on the lives of themselves and others.

Of particular significance to our participants were the issues that this caused when trying to access gender-focused health services. They referenced increasingly long waiting lists, difficulty in accessing hormone therapy and unequal geographical distribution of Gender Dysphoria Clinics, making them inaccessible to many. The stark consequences of waiting lists for both mental health support and referrals for gender affirming healthcare, was illustrated by one participant:

> *'Most of the time people on waiting lists like trans healthcare … they end up killing themselves on that waiting list because it's so long' [N2 S2]*

Finally, despite the far-reaching disadvantage and discrimination faced by the young people in our study, participants highlighted some spaces of sanctuary in their lives. This included local community (if tightknit) and secluded spots ('*there's a massive forest which is a great space to just ignore people*' [N1S1]), though the latter raises additional concerns around safety, invisibility and concealment. In other words, seeking out spaces and environments which made them feel safe often meant being outside in public spaces when and where other people do not want to be. However, the core space of sanctuary for LGBTQ + young people in our study was their youth group setting, which was highlighted numerous times as welcoming, inclusive and, most importantly, safe.

> *P2: … we have the LGBT one, basically, which helps us meet new people that have the same stories and stuff and know what we're going through. Whereas before, I went to another youth group and it wasn't like obvious [Youth Group leader name]'s at all. It was filled with … not the nicest of people, let's say … Obviously, we can meet people who are the same sexuality, maybe, and get to know others who have the same preferences. It's easier in a sense, whereas if you're just going to a normal one …*
>
> *P1: I used to go to a youth group along [street name] , I think it was, I think. And someone there threw a fork at me.*
>
> [N1 S2]

Participants highlighted the severe impact that long waiting lists when seeking formal support had on their physical, social and emotional lives, and recognised the importance of the voluntary sector, particularly tailored youth groups, in helping to navigate difficult experiences and practical barriers to treatment and more formal support. Thus, for LGBTQ + young people, their youth group was celebrated as a space where participants felt safe, felt like they belonged, where they could have fun with other young people with shared experiences, and where they could get emotional and practical support from knowledgeable youth workers. The group was seen as vital for their health, with

comments throughout narratives about how lucky they were to have access to an LGBTQ + focused group when other LGBTQ + youth may not.

3.2. 'Hiding your true self' - understanding the health impacts of discrimination

Several young people were subject to frequent street-level harassment, which meant they felt a constant need to risk assess situations: *"Well, I've been called a faggot a hundred times by the fucking stupid kids like riding home on their bikes in my school so more education might get those dipshits to stop calling me a faggot"* [N2 S1].

'You do feel quite unsafe usually around here, because it's such a – it's not a very nice town.' [N2 S1]

Participants also highlighted the multiplicity of disadvantage in their lives (poverty, class, gender identity, sexuality, racism):

'Participant 3: Inequality all together like comes as different things, not just one, and you can't circle it down to one, because it'll never just be one.'

[NE3 S2]

When each strand of disadvantage coalesced with another, this heightened the impact they felt – socially, emotionally, financially - and this was physically and mentally draining for the participants in our study.

Participants described how the impact of discrimination led to fears around safety, isolation and hiding their true selves, which they in turn linked to mental health problems; namely anxiety and depression:

'I have no reason to go out. I have no friends, apart from these people, and I'm not lying, I'm not crying for attention. The people in here are my only friends and I'm leaving school, so I only have these guys and my online friends, so I have no reason to leave my house' [N2 S3].

Participants shared their own experiences of 'coming out' to family, friends and peers - and fears of being outed, even to close friends - linking some of this back to tensions within their school environments. Young people described stressors related to being visibly their '*true selves*' in public (one young person described moving schools due to bullying, for example) as well as stressors related to hiding their true self, meaning the impact of stress on mental health and wellbeing is present either way:

P1: But that I get deadnamed because I'm not out, but then I'm also scared to actually come out because everybody will just take the mick out of me.

Facilitator 2: But there's no other places that you feel like you can just go along as a kind of new person?

P1: No, because if it's like school and that – no. Because there's a chance that somebody in my year is going to be there and if I'm like, "Oh hi, I'm [participant name]," they will be like, "What do you mean you're [participant name]? What do you mean you're a boy? No, you're not. No, you're not."

P2: Luckily, because I'm from [other place name], there's no-one from [there] here.

[N2 S3]

Though discussions predominantly focused on the mental health impacts of discrimination and exclusion, young people also described taking actions to limit their exposure to physical and/or verbal abuse when out in public spaces from adults and peers. This was reflected in a lack of inclusion by others, as well as self-removal, from physical activity, sport and other health-promoting behaviours, impacting upon physical and mental health: '*I really enjoy going on walks at night, but I just feel like really unsafe doing it, so I can't anymore*' [N2 S1]. Concerns around inclusivity in relation to physical activity and sport were particularly raised, with barriers caused by gendered rules, homophobia and transphobia experienced, regulations (particularly around uniforms), and inadequate changing facilities making them inaccessible to many LGBTQ + young people, for example:

'I did trampolining competitively … I was just getting to a point where I wasn't comfortable. Because I was still having to wear the girl's uniform … when you look at the differences between the uniforms, it's really stark' [N1 S2]

Finally, participants linked their own health and well-being at an individual level to wider media and political discourses, referencing in particular, an increase in transphobia in media and political discourses in recent years, exacerbating levels of stigma in society, and thus fear and discrimination experienced by participants. One participant referred to politicians and journalists manipulating data for an 'anti-trans agenda':

'*On the BBC. This is the people who when Boris Johnson passed the law saying that trans people under 16 can't get access to healthcare for like their hormones and that, they used a woman who de-transitioned as a source. And she was like, "I had top surgery," and I'm like, "Oh, no. I'm actually a woman after all this." And then she said, "So I don't think trans children should get healthcare." … That's one person out of a very, very, very, very, very small percent of people who transitioned, because I asked on Reddit for like a school project and it became this big, massive thing. Like these are all the big important statistics you need to know, and it was like very, incredibly very small.'* [N2 S2]

The experiences of, and anticipation of, discrimination takes a toll on the participants, supporting work that explores Minority Stress Theory, and the impact of stress caused by discrimination based on being a member of a minority group on health (Adelson et al., 2021; Hendricks & Testa, 2012; McGowan et al., 2021; Meyer, 2003), discussed further in the Discussion.

3.3 'Where do we start' – prioritising change.

Many priorities for change were consistent across different youth groups and sessions. Starting small, a lot of changes suggested by LGBTQ + young people centred upon the school environment and education system:

'I guess just more education on certain groups and equality. Things like racism, homophobia, stuff like that needs way more light and education for everyone, so they can understand what it actually is and why it's not right to just maybe make fun of them.' [N1 S3].

Specifically, the PSHE (Personal Social Health and Economic education) curriculum was pulled out numerous times as in need of overhaul to be more inclusive to address inequalities in sexual health, to ensure different relationship styles and sexual practices are normalized: '*Teach them about same-sex relationships and that that's something that can actually happen and that it's a normal thing. As well as different-sex relationships as well. Just in general, just don't be shitty people trying to hide all the "touchy" subjects*' [N1 S3].

Whilst young people prioritised addressing education and health care barriers they also wanted to see larger structural changes to address the inequalities in health experienced specifically by LGBTQ + youth. However, participants argued strongly that, because so many things needed to change, highlighting specific priorities felt overwhelming. This meant that they struggled to articulate where to begin, especially when they lacked trust in people in positions of power and felt that '*bigotry is all around us*' [N2 S1]. LGBTQ + young people felt disillusioned by people in positions of power, and denoted that a key barrier preventing change was that of not being listened to:

'if you're not listened to you can't speak up about health or mental health in departments like that too … Like, I've made complaints about CAMHS and everything like that, you know, and nothing happened, they're still as

bad as ever, but nothing really ever changes with that because people aren't listened to.' [N2 S2]

Participants thus raised a lack of agency to enact change, which was both frustrating and emotionally draining for them.

Participants demonstrated awareness of the structural disadvantage and 'unfairness' they faced, describing the need for systemic change and the almost insurmountable work that is required to get there as impacting their disillusionment: '*Yeah, like the ball was in the basement, we've got to the floor now, but there's still – we need to get up to the attic. We need to get up there'* [N2 S3]. The LGBTQ + participants evidenced a greater depth of understanding of how health and education systems operate than was present in the wider project that this data draws from (Fairbrother et al., 2022), their narratives often illustrating a lack of trust in education and health services and the need for support outside of these formal settings. Nevertheless, they recognised that support was linked to wider systemic inequality and bias, rather than just the individual responsibility of those they work with:

'*I mean, most teachers that I've encountered have been really supportive of me transitioning and everything. And if they aren't they've stayed professional, they haven't put their own views across, but it's sort of more just like the system itself and the young people that it influences'* [N2 S1].

Moreover, they reinforced that, while funding is desperately needed to improve support services for LGBTQ + youth, it is not enough to simply address the inequality they face at a funding and policy level. Instead, LGBTQ + young people wanted ongoing, iterative institutional change across the whole system to prevent cycles of inequality and inadequate treatment: '*if there were more health workers and more money towards paying them, well then you wouldn't have the same nurses dealing with 16-hour shifts every single day, like there'd be more people, so more people can take the stress of it … '* [N2 S3]. Nevertheless, in reference to social progress, one young person expressed that progress has been made but that it so far has been too slow, and others feared how long sustained systemic change would take: *'Does it have to be realistic?'* [N2 S3]. This led to apathy, disillusionment and lack of hope for change. Across focus group sessions, young people emphasised that politicians are detached from society and particularly detached from the lived experience of young people. However, their thoughts varied with context in terms of feeling that this was a product of lack of understanding and awareness, versus a deliberate devaluing of younger LGBTQ + people's attitudes and experiences: '*All of them like, "We want to help the country," and they just don't. They sort of get in power and say, "Oh, we're going to make this country a better place for everybody," and they get in and they're just like, "Here's a load of laws that isolate and stop different minorities'* [N2 S2]. Thus, forcefully, the young people recognised the need to tear down and dismantle existing power structures and redistribute wealth to address interlinking systems of inequality:

P3: It should be a percentage. You shouldn't be I'll take 5 from each of you, it should be like I'm going to take 5% of your money. I don't think necessarily we should make the rich people less money … 'this is the minimum amount that this person's allowed to have'.

P1: Yeah, or big corporations like Google, Facebook, Instagram, like all those social media are like – even Amazon are.

[N2 S3]

4. Discussion

4.1. Minority Stress Theory and the effects of stigma and discrimination on LGBTQ + youth: way beyond crisis

The LGBTQ + young people in our study felt discrimination and its impacts in pretty much every aspect of their lives and in most physical and virtual spaces they interact with. They lacked support and protection in places where children and young people should feel safe, supported and cared for, most notably institutional settings such as schools and healthcare. We know the current context in the UK is that of worsening inequalities, increasing poverty and widening income gaps that requires urgent and multi-level systematic changes (Bambra et al., 2021; Pickett et al., 2021) which LGBTQ + young people were cognisant of. Drawing from a rich history of work within psychology and social science fields, our analysis supports the significance of Minority Stress Theory (Meyer, 2003) as a conceptual framework for understanding health disparities in LGBTQ + populations, and suggests that individuals being subjected to unique distal and proximal stressors when navigating the world as members of a minority group, in turn, increases vulnerability to those negative physical and psychosocial health outcomes (Hendricks & Testa, 2012). Adelson et al. (2021) outline that interlinked forms of structural, interpersonal, and individual stigma are determinants of minority stress which compromise the psychosocial health of people from sexual and gender minority populations. Minority stress has been shown to have both physical and mental health outcomes (McGowan et al., 2021). Stress and anxiety related to 'coming out' or maintaining concealment are also examples of Minority Stressors when navigating the world, cyclically disadvantaging LGBTQ + youth (Meyer, 2003). In our study, the impact (and fear of) different forms of discrimination led to behavioural changes to ensure safety (such as staying home or being outside only in isolated spaces). A constant underlying sense of anxiety and stress is palpable in the transcripts, supporting research that has emphasised the significance and severity of chronic stigma-related stress experienced by LGBTQ + communities, and that such stress accumulates and compounds (Harkness et al., 2022; Williams, 2021).

Meanwhile, intersectionality looks to the impact of multiple intersecting identities of individuals and groups and how they can compound each other (Crenshaw, 1989; Agénor, 2020; Medina-Martínez et al., 2021). While there were differences in how participants articulated and understood the links between different inequalities in health, intersections in axes of oppression are reflected in the transcripts of our study. Young people made reference to the marginalization of certain sexual and gender identities intersecting with other domains of disadvantage in health (namely racism, age-related inequalities, geographical inequalities, socio-economic inequalities, ableism, and the impact of inhabiting multiple identities within the LGBTQ+ 'umbrella'). Regional and place-based inequalities were important to participants and they described the disadvantage they face, and are likely to face, as a result of where they live, as compounded by being LGBTQ+. Arguably young people, therefore, exhibited an intersectional understanding of health inequalities, reflecting on experiences of discrimination that they have faced as a result of intersecting identities, as well as others they know and/or have heard about (experiences of racism, transphobia and homophobia described by one participant, for example), all adding to and compounding the impacts of minority stress. See Bambra (2022) for further discussion on intersectionality and the impact of place on health and health inequalities.

Age was another distinct pillar in how participants described their experiences of inequality and young people's lack of autonomy was clear. When discussing their own gender and sexualities, they reflected the belief conveyed upon them by adults that 'it will pass' or 'it's just a phase'. Thus, young people felt undermined and unsupported. There remains a tendency for young people's emotions to be 'temporalised', reproducing traditional power dynamics between the 'mature and rational adult' and the 'over-sensitive, emotional adolescent' (McDermott et al., 2019; Burman, 2016). We know that childhood and adolescence are a critical point in determining later life health outcomes (acknowledged in national government policy, see Griffin et al., 2021; 2022 for example) and that childhood is a particularly important time for addressing the impacts of inequalities in health (Marmot Review, 2010; 2020). We also know that experiences in early life have a lasting effect on adult health both directly and through influencing adult health

behaviours (Pickett et al., 2021). Yet, the young people in this study saw growing health inequalities and felt that their concerns were often dismissed due to their age, that they were deliberately not educated about certain topics in schools, not consulted on things that mattered to them, felt belittled when expressing emotions about the difficulties they face, and were given very little autonomy to make changes in their lives or to seek help in relation to health. This aspect of intersecting inequalities illustrates the importance of rights-based and child-centred policies and practice which have ethical care at their core (Lundy et al., 2021).

4.2. Health inequalities as socially determined, intersectional, complex, systemic & structural: so what can be done about it?

Minority Stress Theory situates psycho-social stressors experienced everyday by marginalized people within wider structural frameworks of discrimination and stigma, highlighting the significance of mental and physical health responses to structural inequality, discrimination and bias. The examples offered by our participants demonstrate an understanding of the ways in which structural inequality affects individual experiences of mental ill-health. From our findings it is clear that the LGBTQ + young people recognised health inequalities across different axes, which can interlink and exacerbate each other. Participants had a sophisticated, nuanced and critical understanding of the impact of structural inequality on their lives, perhaps borne out of a need to navigate such barriers on a daily basis. Yet, they struggled to articulate what changes they wanted to see. Further, it appeared hard for them to envisage change when they lacked trust in people with the power to enact such change. Indeed, there was a clear narrative both in this sample and the wider study (Fairbrother et al., 2022) that health inequalities are worsening for young people and growing disillusionment in decision makers (particularly national government) was expressed as a need for structural change and the dismantling of unjust power systems.

In relation to formal healthcare settings, participants of the wider research project that this paper draws from have highlighted the negative impacts of limitations of child and adolescent mental health services (CAMHS), particularly increasing waiting times, on the young people who try to engage with them (Holding et al., 2022). Our participants argued that CAMHS are not serving LGBTQ + young people appropriately, despite their increased risk of mental health problems (Carlile, 2020; Jaspal et al., 2022; McDermott, et al., 2021; Westwood et al., 2020). Further, adults in positions of authority acting in discriminatory ways compounded mental and emotional distress. Negative experiences of help-seeking or attempts to stand up for themselves led to apathy ('what's the point'), which risks reducing further engagement with healthcare settings. Quotes about professional gatekeeping and pressures to appear a certain way in order to access life-saving treatment further illustrate potential impacts of discrimination in healthcare settings, exacerbating inequalities faced by participants. These findings supports research highlighted earlier that LGBTQ + communities are more likely to avoid engagement with primary healthcare settings due to experiences, or expectations, of stigma (Carlile et al., 2020; Stonewall, 2018; TransActual, 2021). This is particularly concerning when we consider the increased risk of multiple physical and mental health morbidities for LGBTQ + communities (Adelson et al., 2021; Higgins et al., 2021; Fish et al., 2020; Williams et al., 2021). This concern is further intensified by missed appointments and increasing healthcare waiting lists as a result of the COVID-19 pandemic, which appear to have also disproportionately also affected LGBTQ + communities (Hawke et al., 2021; Stevens et al., 2021). When we also consider findings that suggest young people have and will continue to be disproportionately affected by the longer-term impacts of the COVID-19 pandemic (Pickett et al., 2021; Scott et al., 2021), the picture becomes ever worrying for LGBTQ + youth. Our findings support other research that suggests LGBTQ + young people are likely to have been uniquely disadvantaged by the pandemic-related lockdowns compared to their cis-heterosexual peers due to reduced access to support services and networks, and many LGBTQ + young people feeling trapped in unsupportive households (Fish, 2020; Krueger et al., 2021; McGowan et al., 2021; Paceley et al., 2021). Thus, at a time of health & wellbeing crises in multiple directions (increasing inequalities, increasing poverty and socio-economic inequality, cost of living concerns, increasing waiting times for child and adolescent mental health support, increasing geographical inequalities including in access to, and waiting lists for, gender focused services, and a growing climate emergency and continued impacts of the COVID-19 pandemic) the situation seems way beyond a crisis for LGBTQ + youth in the North East. These concerns were very much felt by our participants, which caused stress and worries about their futures, compounded by feeling powerless to enact change.

4.3. Changing spaces for LGBTQ + young people

The young people in our study articulated a number of practical suggestions for institutional contexts to improve health and wellbeing for LGBTQ + youth. For brevity, we focus here on healthcare and education settings as the two arenas most discussed, but suggestions potentially can (and should) be extrapolated to other settings. Recommendations were made around adequate training and education of healthcare staff, supporting the work of Carlile et al. (2020) and Litvin et al. (2021) who stress the need for in-depth, nuanced staff training on gender identity and gender dysphoria for all professionals working with children and young people in healthcare settings. This would require investment in an already strained UK healthcare system but is vital in order to counter the impacts of health inequality and discriminatory experiences upon the mental and physical health of LGBTQ + populations. Young people in our study also described inappropriate pathologizing of LGBTQ + identities from healthcare professionals as being a particular concern, as well as a lack of understanding of neurodivergence, and the stressors this placed upon LGBTQ + young people and their mental health (see also Strauss et al., 2021). Our research supports the findings of TransActual (2021) where 70% of 700 trans people surveyed reported being impacted by transphobia in healthcare settings; reporting both a lack of understanding as well as active discrimination and even refusal of treatment (14%) in G.P. settings as a result of being trans. The same survey also highlighted experiences of racism and ableism when accessing transition-related treatment.

Participants particularly highlighted the damaging impact of long waiting times for both mental health and specialist gender health services. For context, it is estimated that the UK wait time to start CAMHS treatment is 13 weeks (however, geographical disparities means in some places average waiting times are much longer) (Bell, 2022). Gender Dysphoria Clinics, as of May 2022, were offering first appointments for referrals made in January 2018 (GIC, 2022). The Gender Identity Development Service (for under 18s) as of September 2022 were offering first appointments to CYP referred in 2019 (GIDS, 2022). A recent USbased study (34759 young people between 13 and 24) illustrated the importance of hormone therapy for trans and nonbinary youth seeking such support, with the results showing significantly decreased rates of depression, suicidal thoughts and suicide attempts among transgender and non-binary young people who have undergone gender affirming hormone therapy (Green et al., 2021, pp. 1–7). Our participants described the need for tailored mental health support for LGBTQ + youth and the significant impact that access to timely and appropriate gender services could have, but that the situation in England is that of long waiting times for treatment that is not necessarily adequate, accessible, or appropriate.

The school environment and culture played a large role in participant experiences of discrimination. There were clear differences in young people's experiences of the school environment, with participants comparing their experiences throughout focus group sessions. Key differences included: the extent to which teachers were supportive of LGBTQ + students; whether there were school-wide policies that center inclusion in relation to LGBTQ + students; occurrence and responses to

bullying; and inconsistencies and inadequacies in PSHE (Personal Social Health and Economic education), most prominently within sex education. While some schools were deemed 'better' than others in these areas, particularly further education colleges where greater autonomy was celebrated, there were issues in all educational institutions discussed. In a UK based study, Phipps and Blackall (2021, p. 2) discuss how '*cultural cisgenderism and cisnormativity*' become embedded in school cultures, warning that exclusionary practices and attitudes from teachers and pupils towards trans young people are worsened when accommodations are only made when trans young people are visible or they are requested, mirroring our participant accounts. Drawing upon Gower et al. (2018) and Marmot Review (2010), our findings suggest that all professionals working with LGBTQ + youth must understand and learn to recognise the multiplicity and complexity of LGBTQ + experiences, as a non-homogenous group, and must target the overall supportiveness and culture of environments in which they work. For Marmot Review (2010) 'whole school' approach is required to address cis-heteronormative school environments and to tackle discrimination and victimization in schools. Our findings illustrate that inclusion must be central to policy and practice in all schools (and other institutions working with young people), with nuanced understanding of the discrimination faced by LGBTQ + youth and practical and well-informed training and intervention to support all young people.

For our participants, their LGBTQ + youth groups provided a space of sanctuary from the stressors of their lives. They saw these spaces as vital for their health, viewing them as a protective factor against worsening mental health, particularly reflecting on how difficult the loss of their group was due to pandemic lockdowns. It was also noted that the support provided by other youth groups would not be adequate in supporting and providing the vital space for the specific needs of LGBTQ + youth (particularly raised around support in navigating institutional processes for gender services and mental health support). However, LGBTQ + focused youth groups and services are limited and are unequally accessible or available, with some participants needing to travel from neighboring towns/cities to attend groups. Moreover, some participants needed an adult to take them. VCSE organisations, increasingly relied upon by vulnerable, marginalized and disadvantaged communities as state services are strained through austerity measures, are unequally distributed through England (Booth, 2021) with more affluent areas better served in many cases (Corry, 2020). Broadly, they cluster in larger cities, meaning more geographically isolated young people may be further disadvantaged (Booth, 2021; Holding et al., 2022). There are also limitations on membership that individual youth groups can support due to capacity. Therefore, participants in our study strongly recommended greater funding to increase numbers and capacity of LGBTQ + focused youth work/groups to increase the support, knowledge, empowerment and safety they offer to LGBTQ + youth. Yet, other important protective factors acknowledged by LGBTQ + young people pointed to larger societal changes that participants wanted to see. Participants expressed the need for tackling stigma and the impacts of discrimination at all levels of society, tackling multiple and often interlinked oppressive ideas and practices that affect minority populations, targeting growing poverty and geographical inequalities, and creating more opportunities for LGBTQ + young people. Therefore, whilst LGBTQ + youth spaces are quite obviously a vital lifeline, they are not enough and not a panacea, and the systemic problems that participants raised must also be addressed.

There is an urgent need for young people, particularly young people with marginalized identities, to be part of policy and practice decisions that impact them, recognised also within the broader study upon which this analysis is based (Fairbrother et al., 2022). Aligning with McGowan et al. (2021), Pickett et al. (2021), Lundy et al. (2021) and Westwood et al. (2020), we advocate the need for a rights-based approach to health inequalities, one which recognises the principles of social justice to ensure meaningful, change-orientated policy and practice, and which supports inclusion health in order to mitigate the harms experienced as a result of inequity. Stigma and it's health impacts must be targeted at a clinical as well as public health intervention level (Hatzenbuehler & Pachankis, 2016) and we propose that challenging the failings highlighted by the young people in our study, including targeting discrimination against LGBTQ + identities, must be seen as a public health priority.

Finally, we support calls for further research examining health inequalities faced by LGBTQ + youth, particularly social justice research which can unpack the nuanced and differential experiences within the LGBTQ + community (McDermott, Gabb, et al., 2021). McDermott, Gabb, et al. (2021) contend that limiting research that explores the socio-political, socio-ecological and psycho-social determinants of health leads to de-politicised descriptions of LGBTQ + health inequality that do not recognise power and the unjust social relations that produce such inequities. Meanwhile, others note that limited routine evidence gathering may be driven (at least in part) by institutional homophobia and transphobia, which must be acknowledged and challenged (McGowan et al., 2021). Evidently, more research is needed to address gaps in our understanding of increasing inequalities faced by LGBTQ + young people, particularly in light of emergent 'polycrisis' such as residual COVID-19 impacts, cost of living, Brexit, and growing discontent with those in public office (Phillips, 2021).

4.4. Strengths and limitations

We used 'pre-acquainted' focus groups rather than artificially constructed groups. Doing so can be positioned as a limitation but also a strength. On one hand, familiarity may inhibit disclosure, particularly if there are any pre-existing power dynamics within the group (Kidd & Parshall, 2000) and may impact upon levels of conformity and confrontation (Leask et al., 2001). Meanwhile, others argue that this is dependent upon the scope of the research question and that a shared experience or a common frame of reference can help reflect discussions that some groups may have in regular, everyday life as well as elucidate collective identities (Barbour, 2018). Our youth groups were already formed and ongoing. Nevertheless, particularly in the second group, there were many members who were new to the group and had not met each other yet. In part this was due to the time period where data collection took place – face-to-face youth group sessions had just been re-established following a prolonged period of sessions moving online due to COVID-19 (during which time the youth worker expressed attendance was lower). Therefore, the familiarity between young people varied. It was clear, however, that with each session the young people grew more comfortable with the researchers and each other, reflecting on how much they enjoyed the sessions.

Youth workers were able to prompt based on knowing the young people and were able to give added context to conversations due to their familiarity with the young people and the areas in which they lived. In between periods of heightened pandemic restrictions, the lead researcher [N.G.] was able to go and visit the young people before the sessions started, to explain in person what the research would involve and to get to know the groups. She was involved in activities within the session and young people could ask her questions. We believe this helped to promote comfort and flow once the sessions started (supported by the reflections of the youth worker present). The second group recruited was in September 2021 so focus groups were able to take place in person. We believe that due to the difficulty of internet connections for many of the young people, the awkwardness of turn taking and interruptions in online settings, as well as sound problems in recordings, the data gathered in the second group was in some ways richer. However, break out rooms worked well in both contexts, allowing all young people the option to speak and to share their views without interruption.

We specifically set out to capture the views of young people from particularly disadvantaged areas. We did so using the Index of Multiple Deprivation (IMD). However, due to the limited number of youth groups available that offer tailored support to LGBTQ + young people, several young people travelled quite far for the sessions. We therefore collected

IMD data for each participant based on their home postcodes. This activity showed us that group 1 were predominantly living in areas in the lowest quintile of multiple deprivation, whereas group 2 were more mixed (though still with a greater representation of the lowest quintile than others).

The distance that some young people needed to travel to the young groups may have affected the generalisability of our sample of LGBTQ + youth, as most participants relied on supportive family members (as noted by the youth workers), to bring them to the session (though some older participants did not disclose their membership to family members). Further, working with already established youth groups also limited the amount of purposive sampling that was possible to capture the diversity of experience of LGBTQ + youth, particularly greater diversity in participant ethnicity. Youth workers confirmed that the representation in the focus groups was reflective of the general membership of the groups at the time. Nevertheless, along with McDermott, Gabb, et al. (2021), we strongly recommend a more purposive exploration of inequality through an intersectional lens; recognizing that LGBTQ + experiences of health inequalities are not homogenous, and exploring the experiences of children and young people with multiple marginalized identities as an important area of further research.

5. Conclusion

The young people in our study were acutely aware of the disadvantages in health and wellbeing faced by LGBTQ + young people and attributed them to a lack of awareness, a need for education, a lack of commitment to inclusion and access, negative and bigoted attitudes, and active discrimination. Participants made links between different forms of oppression and discrimination, recognizing that barriers and discrimination that they have experienced, or fear experiencing, are made worse by intersecting forms of oppression, disadvantage and inequality. Intersecting inequalities were recognised also within the broader study that this analysis draws from, particularly in relation to socio-economic inequalities (Fairbrother et al., 2022), but within this group discrimination, the impact of stigma, and inaccessibility were more pertinent and heightened. They particularly stressed that the increasing needs for mental health support for young people, particularly marginalized young people, are not being met, or are being met inappropriately and creating damaging impacts (for example, avoiding/not seeking formal healthcare).

In response to the ever-growing health inequality crisis for LGBTQ + young people, particularly those facing multiple forms of disadvantage, and the huge gaps in research, much more research is needed to fully understand the crisis that is the health inequalities faced by LGBTQ + youth in England. Our findings highlight the need for nuanced understandings of health impacts of minority stress that do not pathologise or have individual focus, but which instead interrogate the social determinants of health inequalities in more depth for LGBTQ + young people, which tackles structural inequalities. Despite recognition of the health and social inequalities faced by LGBTQ + communities (Government Equalities Office, 2018), there has, to date, been little by way of UK government response (Griffin et al., 2022; Phillips, 2021) which must be addressed.

Our findings also highlight the need for further investment in community-based support and spaces for LGBTQ + youth, such as LGBTQ + youth groups, recognizing the vital work that they do, particularly in the absence of appropriate, timely, equally distributed and effective interventions at national government and institutional levels to address the ever-growing inequalities in health in England. Finally, we reiterate the urgent need for young people, particularly young people with marginalized identities, to be part of policy and practice decisions that impact them (Fairbrother et al., 2022).

Finally, as participants linked health inequalities faced by LGBTQ + people to a lack of education and growing misinformation, referencing an increase in transphobia in media and political discourses in recent years, stigma and its health impacts must be targeted at a clinical as well as public health intervention level. We therefore urge that challenging the failings highlighted by the young people in our study, including actively targeting discrimination against LGBTQ + identities, must be seen as a public health priority.

Author contributions

NG: Conceptualisation, methodology, data collection, data analysis, visualization, writing – original draft, writing - review & editing. MC: Conceptualisation, methodology, data collection, data analysis, writing - review & editing. PK: Data analysis, writing - review & editing. EH: Conceptualisation, methodology, data collection, data analysis, writing - review & editing. NW: Conceptualisation, methodology, data collection, data analysis, writing - review & editing. HF: Conceptualisation, methodology, data collection, writing - review & editing. CDR: Conceptualisation, methodology, data collection, writing - review & editing. CS: Conceptualisation, methodology, writing - review & editing. SS: Conceptualisation, methodology, data analysis, visualization, writing - review & editing.

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