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To cite this article: Elizabeth McDermott, Liam Cahill, Ronita Nath, Billy Reid, Jason Schaub, Willem J. Stander & Ashley Taylor (02 Nov 2025): Understanding protective and risk factors in preventing suicide among LGBTQ+ youth in the UK, International Journal of Mental Health, DOI: [10.1080/00207411.2025.2575422](https://doi.org/10.1080/00207411.2025.2575422)

To link to this article: <https://doi.org/10.1080/00207411.2025.2575422>



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Published online: 02 Nov 2025.



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Understanding protective and risk factors in preventing suicide among LGBTQ+ youth in the UK

Elizabeth McDermott^a , Liam Cahill^b , Ronita Nath^c , Billy Reid^d,
Jason Schaub^e , Willem J. Stander^f  and Ashley Taylor^c 

^aHealth Services Management Centre, School of Social Policy & Society, University of Birmingham, Birmingham, UK; ^bNTU Psychology, School of Social Sciences, Nottingham Trent University, Nottingham, UK; ^cThe Trevor Project, USA; ^dSchool of Social Policy & Society, University of Birmingham, Birmingham, UK; ^eSchool for Social Policy Studies, University of Bristol, Bristol, UK; ^fSchool of Psychology, School of Social Policy & Society, University of Birmingham, Birmingham, UK

ABSTRACT

LGBTQ+ youth are more likely to attempt suicide in comparison to their cisgender, heterosexual peers. Despite a UK national suicide prevention strategy, there have been minimal efforts to address this mental health inequality. Our aim was to provide evidence to guide suicide prevention strategies by examining risk and protective factors. Our LGBTQ+ youth advisory group were involved in all aspects of the study. We conducted an online self-complete, cross-sectional questionnaire. Participants were recruited via social media. The resulting sample ($N=9,666$) comprised UK LGBTQ+ youth aged 13–24 years old. Logistic regression analysis was used to assess associations between our predictor variables and our mental health outcomes. Random forest classification modeling was used to rank predictors. We found a positive LGBTQ+ school environment and social support and acceptance were significant protective factors; victimization and discrimination and food insecurity were significant risk factors. The most important ranked predictor variables of suicidality were having a trusted adult, experience of LGBTQ+ victimization, food insecurity, conversion therapy, and all school variables. This is the first large-scale UK study to examine protective and risk factors for LGBTQ+ youth suicide. Results suggest key to prevention is providing LGBTQ+ affirming and safe environments and relationships in school, at home, and in communities, alongside measures to address food insecurity.

KEYWORDS

LGBTQ+; youth; suicide prevention; mental health

Introduction

The World Health Organization (WHO) has prioritized suicide as a critical public health problem and it is the third leading cause of death for young people aged 15–29 (WHO, 2021). In the UK, an estimated 10.6% of females

CONTACT Elizabeth McDermott  e.mcdermott.1@bham.ac.uk  Health Services Management Centre, School of Social Policy & Society, University of Birmingham, Birmingham, UK.

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and 4.3% males aged 14- to 17-year-old have reported an attempted suicide (Patalay & Fitzsimons, 2020). There are no prevalence rates for more diverse genders in the UK. WHO (2025) also highlights that LGBTQ+ young people are more at risk of suicidal thoughts and attempts than their cisgender and heterosexual peers. There is a substantial body of international research demonstrating this elevated prevalence (di Giacomo et al., 2018; Marshal et al., 2011; Williams et al., 2021). For example, in a 2016 pooled analysis of 12 UK population surveys, people under the age of 35 who identified as lesbian, gay, and bisexual were twice as likely to report symptoms of poor mental health compared with heterosexual peers (Semlyen et al., 2016). In addition, transgender young people are more likely to experience suicidal behaviors and poorer mental health than cisgender youth (Christensen et al., 2025; McDermott et al., 2018). There are some differences between these groups; di Giancomo et al.'s meta-analyses of estimated risk of suicide attempts found that trans youth were six times, bisexual youth five times, and lesbian and gay youth four times more likely than cis-heterosexual peers to attempt suicide (di Giacomo et al., 2018).¹

This disparity in suicidality is explained through Minority Stress Theory (Meyer, 2003). This perspective suggests that LGBTQ+ individuals, due to their minority status, face unique stressors that stem from LGBTQ+ prejudice, discrimination, and societal stigma, leading to increased stress levels and poorer mental health outcomes. In de Lange et al. (2022) meta-analysis, there was a clear association between different types of minority stressors and suicidal ideation and suicide attempts among LGBT adolescents and young adults. Several systematic reviews confirm there are multiple LGBTQ+ specific risk and protective factors that interact to impact the suicidality of LGBTQ+ youth (Gorse, 2022; Hatchel et al., 2021; Mereish et al., 2025; Wallace et al., 2024; Wang et al., 2023; Williams et al., 2021). A recent systematic review found that key risk factors include: adverse childhood experiences, internalized queerphobia, minority stress, interpersonal violence, bullying, familial conflict, and anti-LGBTQ+ policies/legislation. Key protective factors include self-affirming strategies, adult/peer support, at-school safety, access to inclusive healthcare, family connectedness, positive coming out experiences, gender-affirming services, and LGBTQ+ inclusive policies and legislation (Wallace et al., 2024).

LGBTQ+ associated victimization, bullying, and harassment are repeatedly found to predict LGBTQ+ youth suicidality (Bochicchio et al., 2021; de Lange et al., 2022; Gorse, 2022; Marzetti et al., 2022; McDermott et al., 2018; Wang et al., 2023; Williams et al., 2021). In addition, Bochicchio et al.'s (2021) systematic review found that gender-based victimization and bullying were factors associated with suicidal behaviors in gender diverse youth. Significantly, in terms of suicide ideation and attempts, LGBTQ+

young people can experience this hostility across all aspects of their lives, such as family, school, among peers, and online (McDermott et al., 2018).

Systematic reviews consistently show that LGBTQ+ youth relationships with others can pose both a risk and protective influence on suicidality (de Lange et al., 2022; Real & Russell, 2025; Wallace et al., 2024). Negative reactions from family and peers contribute to increased risk (de Lange et al., 2022), and this is juxtaposed with evidence that youth who are accepted in the family are less depressed and suicidal (Real & Russell, 2025). Similarly, Bochiccio et al.'s (2021) systematic review found that lack of parental support was associated with suicidal behaviors in gender diverse youth. Social support and acceptance are protective factors against suicidal behaviors (Poštuvan et al., 2019), particularly LGBTQ+ affirming, trusting relationships outside the family (Mereish et al., 2025), including teacher and trusted adult support (Wang et al., 2023) and peer support (Rivas-Koehl et al., 2022). Having a community that is safe both inside school (Marraccini et al., 2022) and outside (Real & Russell, 2025; Wallace et al., 2024) is crucial to preventing suicidality in LGBTQ+ young people.

Furthermore, systematic reviews indicate that LGBTQ+ students in schools with more LGBTQ+ positive school climates are at a lower risk of suicidality compared to students in less positive school climates (Ancheta et al., 2021; Gorse, 2022; Marraccini et al., 2022; McDermott et al., 2024). A study across 13 European countries found that sexual and gender minority (SGM) inclusive sex education, teacher inclusiveness, and a positive representation of SGM issues in classrooms were associated with lower odds of suicidal ideation (Ioverno et al., 2025). Negative representation was associated with increased odds of suicidal ideation (Ioverno et al., 2025). Creating an LGBTQ+ inclusive school can create a more supportive and affirming educational environment for LGBTQ+ young people to feel safe and prevents suicidal feelings, thoughts and attempts (Ioverno et al., 2025; McDermott et al., 2023; Wang et al., 2023).

Overall, the literature suggests that negative and hostile social environments, inadequate support within their closest social network, and an absence of LGBTQ+ support in communities contribute to the development of suicidality in LGBTQ+ young people (Poštuvan et al., 2019). In contrast, accepting, affirming, and violence-free environments (home and school, especially) along with social support with both LGBTQ+ communities and non-LGBTQ+ people protect against suicidality.

The current study

The current UK Suicide Prevention Strategy (Department of Health & Social Care, 2023) does not identify LGBTQ+ young people as a priority group for targeted action at a national level. There have been no attempts

by UK governments, past or present, to address the elevated risk of suicide in LGBTQ+ young people. This is due to many factors, one of which is the absence of robust evidence to inform efforts to prevent suicide.

The evidence base on risk and protective factors for LGBTQ+ youth suicidality is overwhelmingly from the United States, and based on the secondary cross-sectional analyses of existing datasets (Wallace et al., 2024). There are very few longitudinal studies (for an exception, see Real & Russell, 2025) and a dearth of developmentally driven analyses (Hatchel et al., 2021). In the UK, there is a small body of research that has investigated the risk factors associated with elevated suicidality in LGBTQ+ young people (Gnan et al., 2019; Marzetti et al., 2022; McDermott et al., 2018; Rimes et al., 2019; Rivers et al., 2018), and only Rivers et al. (2018) examined protective factors in their small-scale ($n=17$) qualitative study. This means we currently lack UK-based research on protective factors for LGBTQ+ youth that are necessary to support suicide prevention interventions. Part of the reason there is so little research is that datasets on young people's mental health often do not include measures of sexual orientation or gender diversity (Marzetti et al., 2024; McDermott et al., 2021). Large-scale surveys may not include other relevant measures to LGBTQ+ youth, such as conversion therapy or discrimination based on sexuality/gender diversity. We aimed to generate a large dataset that included appropriate measures and produce robust evidence, missing in the UK, to inform suicide prevention strategies. Therefore, our research was exploratory and guided by two core research questions: (1) What are the risk and protective factors for LGBTQ+ youth suicidality in the UK?; (2) What factors are most strongly associated with suicidality among LGBTQ+ youth in the UK?

Method

The study was conducted in partnership with The Trevor Project, a US based LGBTQ+ youth suicide prevention organization.

LGBTQ+ youth involvement

We designed and conducted this study with the assistance of LGBTQ+ young people at McPin Foundation <https://mcpin.org/> (UK Charity) to ensure the robustness and relevance of our findings. We met regularly with 5–7 LGBTQ+ young people online at key points of the research study. They helped to design the survey (questions and navigation), recruitment materials, the direction of the analyses, the production of the final report, and they were also crucial in deciding how the results were reported on the website <https://www.thetrevorproject.org/survey-international/uk/2024/en/>.

Participants and procedure

The study utilized a quantitative cross-sectional design to collect data through an online survey platform (Qualtrics) between April 11, 2023 and May 18, 2023. A community convenience sampling strategy was employed to recruit LGBTQ+ young people aged 13–25 years old living in the UK. Participants were recruited via targeted advertisements on social media platforms Meta (Instagram, Facebook, Messenger) and TikTok. The eligibility criteria required respondents to define as being LGBTQ+ (i.e., a sexual orientation other than heterosexual, a gender identity other than cisgender, or both). Qualified respondents completed a secure online questionnaire that included a maximum of 77 questions. A response was valid if the participant correctly answered the browser check question (Q67) and responded that they had not completed the survey previously (Q77). We conducted data quality checks at regular intervals where our statistician ran sample analyses to check data for inconsistencies and bots.

Recruitment was monitored to ensure adequate sample sizes concerning age, region, ethnicity, gender identity, and sexual orientation. Quotas based on the UK census 2021 (ONS, 2021) were established for geography (4 UK nations: England 84%; Scotland 8%; Wales 5%; Northern Ireland 3%) and ethnicity (white 81.7%; Asian, Asian British, or Asian Welsh 9.3%; Black, Black British, Black Welsh, Caribbean, or African 4%; Mixed or multiple ethnic group 2.9%; Other ethnic group 2.1%). Free school meals (22.5%) (as a proxy for poverty) quotas were based on UK Gov survey of schools 2022 (Department of Education, 2025) and experience of care (1%) based on England Ofsted national statistics (Department of Education, 2022). Quotas were established for sex assigned at birth (female 65%; male 35%) because of the high numbers of female-assigned-at-birth participants in the first week of recruitment. Once quotas were reached, they were closed to recruitment.

A data cleaning protocol was employed. There were 37,893 respondents who consented to start the survey. Of those, 28,227 were excluded due to quota restrictions, eligibility, not answering the validity question, or taking the survey multiple times. The final sample comprised 9,666 LGBTQ+ youth residing in the UK. Participants were aged between 13 and 24 ($M_{\text{age}} = 17.00$, $SD_{\text{age}} = 2.93$). [Table 1](#) displays the demographic information for the sample.

Ethical approval

The study was approved by the Institutional Review Board in the United States and accepted by the University of Birmingham's Humanities and Social Sciences Ethics Committee. Participants were able to give their consent at the start of the survey after reading the participant information with a link to the website for further information. Parental consent was

Table 1. Demographic information for the sample.

Demographic question	Total
	<i>n</i> (%)
Country	
England	7,951 (82.3)
Scotland	945 (9.8)
Wales	499 (5.2)
Northern Ireland	271 (2.8)
Gender Identity	
Cisgender Woman	2,180 (22.9)
Non-Binary	1,991 (20.9)
Cisgender Man	1,500 (15.7)
Transgender Man	1,413 (14.8)
Questioning	1,165 (12.2)
Gender Fluid	720 (7.6)
Transgender Woman	567 (5.9)
Sexual Identity	
Bisexual	2,562 (26.5)
Lesbian	1,420 (14.7)
Gay	1,413 (14.6)
Queer	1,404 (14.5)
Pansexual	1,259 (13.0)
Asexual	966 (10.0)
Unsure	521 (5.4)
Straight	74 (.8)
Ethnicity	
White	7,950 (82.2)
Mixed/ Multiple Ethnic Groups	745 (7.7)
Asian/ Asian British	516 (5.3)
Arab/ Any other ethnic group	254 (2.6)
Black/ Black British/ Caribbean/ African	201 (2.1)
Disability	
No	5,051 (57.2)
Yes	3,773 (42.8)
Current Employment	
Not Employed	6,595 (68.2)
Employed (Part-Time)	2,035 (21.1)
Employed (Full-Time)	862 (8.9)
Prefer not to answer	174 (1.8)
Enrolment Status (School)	
Student at school	4,421 (45.7)
Student at college or sixth-form	2,322 (24.0)
Not a student	1,585 (16.4)
Student at university	1,245 (12.9)
Prefer not to answer	93 (.96)
Food Insecurity	
Yes	3,503 (37.8)
No	5,754 (62.2)
Precarious Housing	
Precarious	155 (1.7)
Safe	9,045 (98.3)
How well off is your family?	
Well-off	6,150 (66.1)
Not well-off	3,149 (33.9)
Free School Meals	
Yes	3,142 (36.1)
Never	5,558 (63.9)

Notes. The total number of responses may not equal the number of participants due to missing responses.

waived to ensure that youth could respond even if their family were not aware of their LGBTQ+ identity (Henrickson et al., 2020). All participants consented to take part in the survey.

Measures

Mental health

Questions on considering and attempting suicide and self-harm were taken from the Centers for Disease Control and Prevention's Youth Risk Behavior Survey (Johns et al., 2020). Self-harm was measured with two items. The first asked *Have you ever tried to harm yourself in some way? This may include any behavior that you purposely use to cause yourself physical or emotional discomfort, for example: using drugs, cutting, risky sexual practices, starving yourself, or other behaviors* with yes/no/prefer not to answer response options. The second asked *When was the last time that you self-harmed?*—with 6 response options last week/month/3 months/last year/over a year/prefer not to answer.

Suicidal thoughts was measured using two items: (1) *Have you ever considered attempting suicide?*; (2) *During the past 12 months, did you ever consider attempting suicide?* Both had Yes/no/prefer not to answer response options. Suicide attempts was measured via two items: (1) *Have you ever attempted suicide?* Yes/no/prefer not to answer response options; (2) *During the past 12 months, how many times did you actually attempt suicide?*—with six response options 0/1/2-3/4-5/6 or more/prefer not to answer.

Questions regarding depression were taken from the two-item Patient Health Questionnaire (PHQ-2) (Kroenke et al., 2003). Anxiety was measured using the two-item Generalized Anxiety Disorder (GAD-2) (Kroenke et al., 2007). Internal consistency for both depression ($\omega = 0.81$, 95% CI: 0.80, 0.81) and anxiety ($\omega = 0.83$, 95% CI: 0.82, 0.84) in our study was good.

Demographic

Demographic questions about race and ethnicity were taken from the UK Office for National Statistics (ONS, 2025). Gender was measured via three questions: identity, sex assigned at birth, and transgender identification (Johns et al., 2019). The item asking about sexual orientation was *What label best describes your sexual orientation?*—with eight response options.

Risk and protective factors

All non-demographic variables were coded so that higher values consistently reflected more protective, supportive, or affirming circumstances. All variables were dichotomized.

Social support and acceptance. *Community acceptance* was measured by asking participants how accepting their local community was toward LGBTQ+ people. Responses were dichotomized as “Not Accepting” (i.e., somewhat or

very unaccepting) versus “Accepting” (i.e., somewhat or very accepting). *Trusted adult status* was determined by whether participants reported having at least one trusted adult (“No” vs. “Yes”).

Support received for mental health was assessed by asking participants whether they had sought help in the past year and, if so, whether they received it. Responses were coded as “Did not ask or asked but did not receive” and “Received.” Access to *LGBTQ+ affirming spaces* was determined by whether participants reported having access to at least one affirming space (“No” vs. “Yes”). *Family help-seeking* was based on whether participants felt able to ask family members for support with mental health concerns (“No” vs. “Yes”).

Discrimination and victimisation. *LGBTQ+ discrimination in the past year* was coded as “Yes” if participants reported discrimination based on sexual orientation or gender identity and “No” otherwise. The same process was used to create the *LGBTQ+ victimization in the past year* variable.

Conversion therapy was assessed by asking participants whether they had been subjected to, threatened with, or neither subjected nor threatened with conversion therapy. Participants were coded as “Subjected or Threatened” vs. “Not Threatened or Subjected.”

Socioeconomic status and stability. *Food insecurity* was measured using two items assessing how often participants went without food. Those who answered “sometimes” or “always” to either item were coded as “Yes” (food insecure), and those who answered “never” to both were coded as “No.”

Family financial status was assessed using a subjective measure of family wealth. Participants who rated their family as “not at all well off” or “not particularly well off” were coded as “Not Well Off,” and those selecting higher categories were coded as “Well Off” (Quon & McGrath, 2014).

Housing security: Participants living in foster care, emergency accommodation, hotels, shelters, or other temporary settings were coded as “Precarious,” while those in more stable housing (e.g., parental home, student accommodation) were coded as “Safe” (Baams et al., 2019).

School environment. *Positive LGBTQ+ content* at school (Kosciw et al., 2022) was coded as “Yes” if participants reported being taught positive content about LGBTQ+ people, and “No” otherwise. The same process was used to create the *Negative LGBTQ+ content* variable. *Genders & Sexualities Alliance (GSA) presence at school* was coded as “Yes” if participants reported that their school had a GSA, versus “No or Unsure.” *Free school meals* were coded as “Yes” if participants had ever received free school meals, and “Never” if they had not.

Statistical analysis

All analyses were conducted in *R*. For research question one, our modeling approach involved constructing a probit structural equation model using *lavaan* to account for the shared covariances between our outcome variables. Bias-corrected 95% bootstrapped confidence intervals at 1,000 resamples were used. All associations controlled for the influence of other variables within the model. We calculated average marginal effects (AMEs) for each binary predictor variable to facilitate interpretation; AMEs indicate how a change in the predictor variable (from 0 to 1) affects the predicted probability of the outcome, while holding other predictor variables constant.

For our second research question, we used random forest classification models to identify the most important predictor variables for each binary mental health outcome. A separate model was run for each binary outcome, using 500 trees per model. Predictor variable importance was determined using Gini importance, indicating how much each variable reduced classification error across the forest. As random forest models do not support missing data, only complete cases were included. To examine school-related influences, we ran parallel models: one on the full sample with complete data ($n=4,490$) and one on school-enrolled participants ($n=1,741$). School-specific models included the same predictor variables as the general models, plus additional school-related variables.

Before running our analysis, we first assessed multicollinearity between our predictor variables, given their theoretical inter-relatedness. We calculated a value inflation factor (VIF) for each model and also for a model that contained all predictor variables simultaneously. Both models displayed no issues with multicollinearity ($VIF < 1.5$).

Results

Overall, in the last twelve months, 58.8% of our sample reported suicidal ideation, while 19% attempted suicide. Similarly, 61% of our sample reported self-harming in the previous twelve months. Concerning depression and anxiety, 69.3% screened positive for clinically significant anxiety and 62.0% for depression.

Risk and protective factors for suicidality

Table 2 outlines which variables had significant associations with each mental health outcome variable.

Table 2. Associations between the predictor variables and mental health outcomes among LGBTQ+ youth.

Predictor Measure	Suicidal Ideation		Suicide Attempts		Self-Harm		Anxiety		Depression	
	<i>b</i>	<i>p</i>	<i>b</i>	<i>p</i>	<i>b</i>	<i>p</i>	<i>b</i>	<i>p</i>	<i>b</i>	<i>p</i>
	[95% CI]		[95% CI]		[95% CI]		[95% CI]		[95% CI]	
Social Support and Acceptance (<i>n</i> = 6,886)										
Community Acceptance (Not Accepting; Accepting)	−0.34	<0.001	−0.34	<0.001	−0.25	<0.001	−0.28	<0.001	−0.37	<0.001
Trusted Adult (No; Yes)	[−0.41, −0.27]		[−0.41, −0.26]		[−0.32, −0.18]		[−0.35, −0.21]		[−0.44, −0.30]	
	−0.65	<0.001	−0.55	<0.001	−0.69	<0.001	−0.44	<0.001	−0.63	<0.001
	[−0.73, −0.56]		[−0.63, −0.46]		[−0.79, −0.62]		[−0.52, −0.35]		[−0.72, −0.55]	
Received Support (Did not ask or asked but did not receive; received)	0.29	<0.001	0.17	<0.001	0.33	<0.001	0.26	<0.001	0.17	<0.001
	[0.21, 0.36]		[0.09, 0.26]		[0.25, 0.40]		[0.18, 0.33]		[0.10, 0.24]	
LGBTQ+ Affirming Spaces (No; Yes)	−0.07	0.102	−0.13	0.012	−0.12	0.014	−0.13	0.009	−0.20	<0.001
	[−0.16, 0.01]		[−0.23, −0.03]		[−0.21, −0.03]		[−0.22, −0.03]		[−0.29, −0.11]	
Family Help-Seeking (No; Yes)	0.06	0.136	0.10	0.016	0.00	0.972	0.17	<0.001	−0.01	0.695
	[−0.02, 0.13]		[0.02, 0.19]		[−0.07, 0.08]		[0.09, 0.25]		[−0.09, 0.07]	
Discrimination and Victimization (<i>n</i> = 5,582)										
LGBTQ+ Discrimination Past Year (Yes; No)	−0.17	<0.001	−0.21	<0.001	−0.23	<0.001	−0.29	<0.001	−0.19	<0.001
	[−0.25, −0.08]		[−0.33, −0.10]		[−0.33, −0.16]		[−0.38, −0.20]		[−0.27, −0.11]	
LGBTQ+ Victimization Past Year (Yes; No)	−0.40	<0.001	−0.47	<0.001	−0.30	<0.001	−0.30	<0.001	−0.31	<0.001
	[−0.47, −0.33]		[−0.55, −0.39]		[−0.38, −0.23]		[−0.37, −0.22]		[−0.39, −0.24]	
Conversion Therapy (Subjected or Threatened; Not Threatened or Subjected)	−0.39	<0.001	−0.66	<0.001	−0.32	<0.001	−0.35	<0.001	−0.42	<0.001
	[−0.48, −0.29]		[−0.74, −0.56]		[−0.41, −0.22]		[−0.45, −0.25]		[−0.51, −0.31]	
Socioeconomic Status and Stability (<i>n</i> = 7,177)										
Food Insecurity (Yes; No)	−0.49	<0.001	−0.56	<0.001	−0.47	<0.001	−0.47	<0.001	−0.59	<0.001
	[−0.56, −0.42]		[−0.63, −0.48]		[−0.53, −0.40]		[−0.54, −0.40]		[−0.65, −0.52]	
How well off is your family (Not Well off; Well off)	−0.08	0.030	−0.08	0.049	0.02	0.568	−0.09	0.017	−0.10	0.006
	[−0.14, −0.01]		[−0.16, −0.00]		[−0.05, 0.09]		[−0.17, −0.02]		[−0.17, −0.02]	
Housing security (Precarious; Safe)	−0.32	0.014	−0.62	<0.001	−0.30	0.021	−0.04	0.749	−0.19	0.154
	[−0.61, −0.09]		[−0.88, −0.37]		[−0.56, −0.07]		[−0.32, 0.23]		[−0.46, 0.06]	
School Environment (<i>n</i> = 2,936)										
Positive LGBTQ+ Content taught at school (No; Yes)	−0.14	0.005	−0.10	0.059	−0.16	0.001	−0.17	0.001	−0.20	<0.001
	[−0.23, −0.04]		[−0.21, 0.00]		[−0.26, −0.07]		[−0.27, −0.07]		[−0.29, −0.09]	

(Continued)

Table 2. Continued.

Predictor Measure	Suicidal Ideation		Suicide Attempts		Self-Harm		Anxiety		Depression	
	<i>b</i>	<i>p</i>	<i>b</i>	<i>p</i>	<i>b</i>	<i>p</i>	<i>b</i>	<i>p</i>	<i>b</i>	<i>p</i>
	[95% CI]		[95% CI]		[95% CI]		[95% CI]		[95% CI]	
Negative LGBTQ+ Content taught at school (Yes; No)	−0.40 [−0.53, −0.27]	<0.001	−0.51 [−0.62, −0.37]	<0.001	−0.30 [−0.44, −0.18]	<0.001	−0.29 [−0.42, −0.17]	<0.001	−0.30 [−0.43, −0.18]	<0.001
GSA at school (No or Unsure; Yes)	−0.06 [−0.17, 0.03]	0.214	−0.10 [−0.20, 0.00]	0.045	−0.10 [−0.19, 0.00]	0.045	−0.07 [−0.16, 0.04]	0.173	−0.10 [−0.20, −0.01]	0.040
Free School Meals (Yes; Never)	−0.28 [−0.38, −0.18]	<0.001	−0.27 [−0.37, −0.17]	<0.001	−0.22 [−0.32, −0.12]	<0.001	−0.19 [−0.28, −0.08]	<0.001	−0.20 [−0.30, −0.10]	<0.001

Notes. Coefficients represent unstandardized regression estimates (*b*) with 95% confidence intervals (in square brackets) and associated *p*-values, estimated on the probit scale.

Social support and acceptance

Community acceptance was a consistent protective factor. Being part of an accepting community was associated with a 12% lower probability of suicidal ideation (9.3–13.5%), 11% for suicide attempts (8.9–13.2%), 8% for self-harm (6.1–10.5%), 10% for anxiety (7.6–12.4%), and 11% for depression (9.0–12.6%).

Having at least one trusted adult showed similarly robust protective associations: suicidal ideation was 23% lower (20.4–25.4% lower), 19% for suicide attempts (16.5–21.4%), 25% for self-harm (22.5–27.5%), 16% for anxiety (13.2–19.1%), and 20% for depression (18.0–22.4%).

By contrast, receiving support after asking for help was associated with higher risk: 9% higher probability of suicidal ideation (6.5–11.5%), 5% for suicide attempts (2.7–8.2%), 10% for self-harm (7.6–12.5%), 9% for anxiety (6.1–11.8%), and 5% for depression (2.5–6.7%).

LGBTQ+ affirming spaces were modestly protective: 4% lower probability of suicide attempts (1.0–7.2%), 4% for self-harm (0.9–6.7%), 5% for anxiety (1.3–7.9%), and 6% for depression (3.2–8.3%). There was no significant association with suicidal ideation.

Help-seeking from family showed mixed associations. It was not significantly related to suicidal ideation, self-harm, or depression. However, it was associated with a 3% higher likelihood of suicide attempts (0.7–6.1%) and 6% higher anxiety (3.2–9.2%).

Discrimination and victimisation

LGBTQ+ discrimination in the past year was associated with worse mental health: 5% higher probability of suicidal ideation (2.4–7.5%), 5% for suicide attempts (2.6–7.4%), 8% for self-harm (5.3–10.6%), 9% for anxiety (6.5–11.7%), and 6% for depression (3.4–8.4%).

Victimization related to LGBTQ+ identity in the past year was also associated with greater risk: 13% higher probability of suicidal ideation (11.4–15.5%), 13% for suicide attempts (11.3–14.9%), 11% for self-harm (8.2–13.2%), 10% for anxiety (7.8–12.8%), and 11% for depression (8.5–12.9%).

Exposure to or threat of conversion therapy was also linked to poorer outcomes: 14% higher probability of suicidal ideation (10.5–16.5%), 21% for suicide attempts (18.1–22.6%), 12% for self-harm (8.1–14.6%), 13% for anxiety (9.3–15.7%), and 15% for depression (11.5–17.8%).

Socioeconomic status and stability

Food insecurity emerged as strongly associated with poor mental health: 16% higher probability of suicidal ideation (14.1–17.9%), 14% for suicide

attempts (12.7–15.6%), 16% for self-harm (14.1–18.0%), 18% for anxiety (15.1–19.8%), and 20% for depression (18.0–21.8%).

Perceived family financial security showed small protective effects. However, given that the confidence intervals approach zero, we suggest interpreting these associations cautiously. Participants who reported that their family was well off had a 2% lower probability of suicidal ideation (0.2–4.4%), 2% for suicide attempts (0.1–3.6%), 3% for anxiety (0.7–5.9%), and 3% for depression (0.8–5.3%). There was no significant association with self-harm.

Only 1.7% of participants reported precarious housing and results should be interpreted cautiously. Precarious housing was associated with a 11% higher probability of suicidal ideation (3.2–19.0%), 19% for suicide attempts (12.1–24.0%), and 11% for self-harm (2.4–18.6%). No statistically significant associations were found for anxiety or depression.

School environment. Exposure to positive LGBTQ+ content at school was also a protective factor: 5% lower probability of suicidal ideation (1.2–7.3%), 6% for self-harm (2.4–8.9%), 6% for anxiety (3.2–9.8%), and 7% for depression (3.2–9.8%). The association with suicide attempts was not statistically significant.

By contrast, exposure to negative LGBTQ+ content at school was consistently associated with increased risk: 14% higher probability of suicidal ideation (9.8–17.9%), 17% for suicide attempts (13.2–20.6%), 11% for self-harm (6.7%–15.4%), 11% for anxiety (6.4–15.1%), and 11% for depression (6.6–14.9%).

The presence of a LGBTQ+ club (GSA) at school had small protective effects for suicidal attempts, self-harm, and depression. Apart from depression, which had a modest 4% reduced probability (0.2–6.8%), the 95% CIs for the remaining variables contained zero, so we opted not to report these values.

Eligibility for free school meals, used as a proxy for household poverty, was consistently associated with increased risk. Participants eligible for free school meals had a 10% higher probability of suicidal ideation (6.3–12.4%), 9% for suicide attempts (5.5–11.4%), 8% for self-harm (4.5–11.0%), 7% for anxiety (3.0–9.8%), and 7% for depression (3.6–10.1%).

For our second research question, we ranked the importance of each predictor variable for each mental health outcome ([Figure 1](#)). Having a trusted adult, experiencing LGBTQ+ victimization, and food insecurity were consistently important predictor variables across all mental health outcomes especially for suicidal ideation, suicide attempts, and self-harm over the past 12 months. For suicide attempts, conversion therapy was also



Figure 1. Relative importance of predictor variables for mental health outcomes among LGBTQ+ youth.

Notes. Higher values indicate a greater contribution to the model’s classification accuracy and, therefore, greater relative importance.

a salient predictor variable. Food insecurity emerged as the dominant predictor for depression, in addition to having a trusted adult, LGBTQ+ victimization and community acceptance. For anxiety, no single variable showed a clear dominant importance score. Instead, multiple predictor variables contributed more evenly to the model’s performance.

Figure 2 displays the relative importance of this expanded set of predictor variables that includes school variables. The trends shown for each outcome variable were similar to the general sample (e.g., food insecurity being an especially salient predictor). The four school predictor variables (Positive and Negative LGBTQ+ Content, GSA at school, and free school meals) all had similar Gini importance scores and all were relatively important predictor variables for each mental health outcome.

Discussion

This study aimed to provide evidence that is currently missing to guide the development of UK suicide prevention strategies for LGBTQ+ youth. Across our results, victimization due to being LGBTQ+ was associated with an increased likelihood of youth attempting or thinking about suicide. Notably, experiences of conversion therapy were associated with an increased probability of suicide attempts. These results concur with

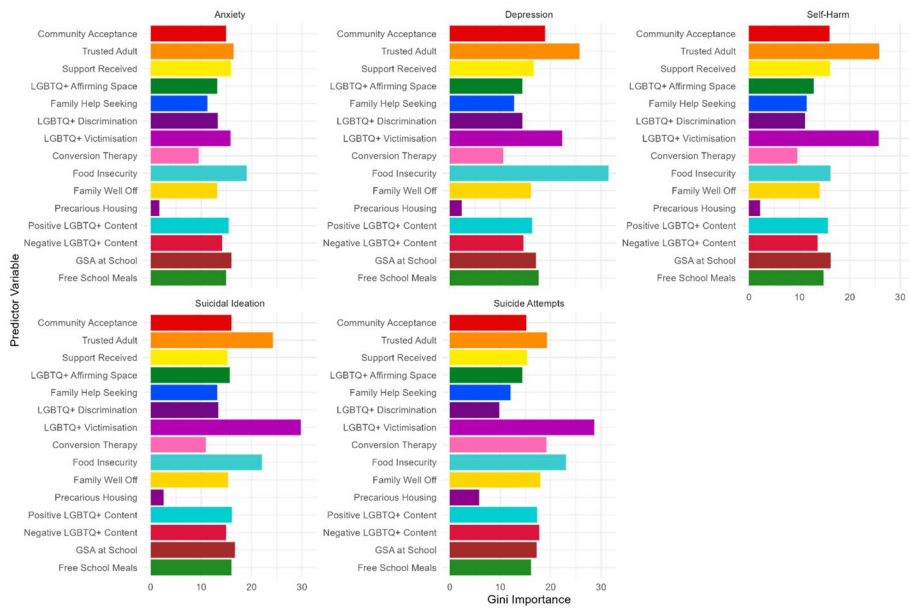


Figure 2. Relative importance of predictor variables for mental health outcomes among school-going LGBTQ+ youth.

Notes. Higher values indicate a greater contribution to the model's classification accuracy and, therefore, greater relative importance.

international evidence that exposure to hostility for being gender or sexually diverse elevates the risk of suicide (Williams et al., 2021).

Community acceptance was a strong protective factor against poor mental health, and having at least one trusted adult was the highest-ranked protective factor for suicidality. This highlights the importance of social relationships and support for LGBTQ+ youth, especially if they are in a non-affirming environment at school and home. Our results showed that the school environment posed both risk and protective factors. Positive LGBTQ+ content was associated with a lower probability of suicidality, and the converse was true of exposure to negative LGBTQ+ content. All four school variables were ranked high in importance concerning suicidality (positive and negative school content, GSA, free school meals). This correlates with international evidence where an LGBTQ+ inclusive school climate lowers the probability of suicidality (Ioverno et al., 2025).

We found that food insecurity was a strongly associated with all mental health outcomes. Research indicates that worldwide, food insecurity is associated with youth suicidality (Stear et al., 2024). The impact of social disadvantage on mental health is evident in the UK, where evidence from longitudinal cohort studies demonstrate that socioeconomic inequality (White et al., 2023) and general social adversity (Amos et al., 2020) are linked to suicide attempts in sexual minority youth. When we ranked all predictor variables, we found that experiences of LGBTQ+ victimization,

conversion therapy (for suicide attempts only), having at least one trusted adult, food insecurity, and all school variables were ranked most important when classifying suicide attempts and ideation. It is reasonable to expect that these results would be differentiated by LGBTQ+ identity, age and intersectional experiences of discrimination across age, race, gender, sexuality, disability, socioeconomic status.

Our study also found that receiving support after seeking help was associated with higher risk across all mental health outcomes. One potential explanation is reverse causality: youth experiencing more acute distress may be both more likely to seek and receive support, but also at greater baseline risk. Alternatively, the type or quality of support received may not have been affirming or effective, which could exacerbate distress. Future research should explore these nuances.

These results present clear opportunities for targeted suicide prevention strategies that focus, for example, on food insecurity and social adversity, which might contribute to improvements. The UK Department for Education has recently increased the number of children eligible to receive free school meals (Department of Education, 2025). Although this measure was not designed as a suicide prevention policy, it may contribute to improving the mental health of LGBTQ+ youth. However, in the UK, legal protections against discrimination on the basis of sexual orientation and gender recognition have been weakened. The recent UK Supreme Court ruling that excludes trans women from the category of ‘woman’ for the purposes of the Equality Act 2010 suggests a deterioration of legal protections for those who are gender diverse. In addition, Conversion Therapy has yet to be outlawed, there is still no equality in hate crime law, and there are no current efforts to improve school climate for LGBTQ+ pupils. Efforts to prevent suicide could include a legal ban on Conversion Therapy, parity in hate crime law and national policies that improve LGBTQ+ inclusivity in schools.

Overall, our results suggest that strategies to prevent LGBTQ+ youth suicide must focus on protective factors that operate at a national, community and individual level to create environments that accept and affirm LGBTQ+ identities in order that young people can feel valued and safe to be who they want to be.

Limitations

This is a cross-sectional study and therefore cannot point to causality. The social media community recruitment may produce a bias toward youth who can participate online; those without digital access and a safe space to complete the survey may have been excluded from participating. We

aimed to produce a diverse sample across age, region, ethnicity, gender and sexual orientation and monitored the sample and instituted quotas. However, we did not meet targets for all ethnic and gender groups. Our sample was skewed to those who identified as White, and our sample underrepresented transgender women. In addition, there may be a self-report bias or an under-reporting of suicidality that impacted on the study results. Finally, several measures, including our outcome variables, were dichotomized for parsimony. We acknowledge that dichotomizing discrete or continuous variables can entail information loss.

Conclusion

The legal, political, and social environment in the UK is one that may make preventing the suicide of LGBTQ+ young people challenging. The International Lesbian, Gay, Bisexual, Trans, and Intersex Association's (Europe) Rainbow Map ranks the legal and policy landscape for LGBTQ+ people across Europe. The latest rankings reveal the UK has dropped to an all-time low position of 22 out of 49 (ILGA-Europe, 2025). The next UK suicide prevention strategy needs to take into account the risk and protective factors demonstrated by this study and, hence, take seriously LGBTQ+ young people's mental health and future lives.

Note

1. In this article, we use the term "suicidality" to include both ideation and attempts and supply greater specificity when appropriate.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Funding

This paper was prepared using data from The Trevor Project's 2024 UK Survey on the Mental Health of LGBTQ+ Young People. This work is the result of a collaborative endeavour between the Authors and The Trevor Project.

ORCID

Elizabeth McDermott  <http://orcid.org/0000-0002-1960-9639>

Liam Cahill  <http://orcid.org/0000-0002-7897-0862>

Ronita Nath  <http://orcid.org/0000-0002-3630-7915>

Jason Schaub  <http://orcid.org/0000-0002-6878-2366>

Willem J. Stander  <http://orcid.org/0000-0002-3664-4647>

Ashley Taylor  <http://orcid.org/0000-0003-4609-9360>

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