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Mental health staff perceptions and practice regarding self-harm, suicidality and help-seeking in LGBTQ youth: Findings from a cross-sectional survey in the UK

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## Introduction

People who identify as lesbian, gay, bisexual, transgender or queer (LGBTQ) experience significant mental health inequalities compared with the heterosexual and cisgender population. Worldwide evidence consistently demonstrates that people who identify as LGBTQ experience significant levels of mental distress (Haas et al., 2011). Young people who identify as LGBTQ have been identified as a high risk group for suicide and self-harm and were identified as a specific group that warranted attention in the National Suicide Prevention Strategy in England (Department of Health, 2017). However, little is known about the link between sexual orientation, gender identity and mental distress culminating in suicidality and self-harm in LGBTQ youth.

In a systematic review of evidence King et al. (2008) found a two-fold increase in suicide attempts in LGB people compared to heterosexual populations. Analysis of the United Kingdom (UK) *Adult Psychiatric Morbidity Survey 2007*, a nationally representative sample, found non-heterosexuality was associated with increased prevalence of suicidal thoughts, acts and self-harm (Chakraborty, McManus, Brugha, Bebbington, & King, 2011). Evidence also indicates that LGBTQ people under 25 are more at risk than adults. In a pooled analysis of 12 population surveys in the UK, the authors found adults who identified as LGB and 'other' were twice as likely to report symptoms of poor mental health, and that younger LGB people were more at risk of suicide and self-harm than those over 25 years old (Semlyen, King, Varney, & Hagger-Johnson, 2016). Similarly in the US, transgender youth have been found to have higher rates of depression, suicidality and self-harm, and eating disorders when compared with their peers (Connolly et al., 2016).

The reasons for this disparity are multi-factorial however, a significant factor is homophobia, biphobia and transphobia (Haas et al., 2011). In addition to facing stigma related prejudice that impacts on an individual in the form of minority stress (Meyer, 2003), people identifying as LGBTQ may feel, for example, that they need to hide their sexual identity when using health services and this in turn compounds the feelings of isolation. There is evidence that adults who identify as LGBTQ face barriers to health care as a result of stigma. Stigma can comprise of three aspects: individual, interpersonal and institutional. On an individual basis, people identifying as LGBTQ may expect prejudice (perhaps from previous experience or the pervasive heteronormative cultures in which they exist) and therefore may feel they need to hide or deny their sexual identity/orientation. Maycock P (2009) found that participants in their study had deliberately concealed their sexual identity and were mistrustful of healthcare providers, which in turn led to poor uptake of mainstream mental health services. In addition, there is evidence of interpersonal/institutional stigma. Heck, Sell, and Gorin (2006) and McCann and Sharek (2014) found that people who

identified as LGBTQ reported a range of negative responses from staff including embarrassment, hostility, suspicion, pity, condescension, ostracism and even refusal of treatment.

A similar picture emerges when young people who identify as LGBTQ are considered. Research from USA suggests that LGBT youth have a significantly higher rate of mental health services use compared to heterosexual counterparts (McGuire & Russell 2007, Williams & Chapman, 2011, 2012). Despite higher use, there is also significantly higher unmet mental health need compared to heterosexual young people (Marshall et al., 2011). A small number of studies demonstrate that LGBTQ youth find it difficult to ask for help for their mental distress (E. McDermott, 2015; Elizabeth McDermott & Roen, 2016). In a systematic review of evidence, Brown, Rice, Rickwood, and Parker (2016) found that LGBTQ young people commonly reported fear of harassment due to their sexual identity, and fear of being misunderstood as barriers to accessing mental health support. Mental health services, like all health care services, are attempting to become more socially inclusive.

Globally there has been a transformation from institutionalised care setting to a more rights-based empowerment and recovery orientated model. Marginalised groups including LGBTQ people are acknowledged in the UK policy on healthcare: NHS Five Years Forward View on Mental health (Mental Health Taskforce, (2016) and indeed one of the recommendations is that inequalities in mental health care are tackled. However, there are specific historical challenges for mental health services given that up until recently homosexuality had been conflated with mental illness and was considered a sexual deviation. Homosexuality was “treated” in psychiatric institutions up to and including the 1970s (Dickinson, 2015) and was only removed as a term from the World Health Organisation International Classification of Disease in 1977. However, gender identity dysphoria (GID) (discord between biological gender and one’s own identification ) has been seen as a “mental disorder” and is in fact still a disorder in the Diagnostic Statistical Manual version V (2013). However, there has been a marked change in how GID is described. Rather than being diagnosed on the basis of identity being in conflict with birth gender, the emphasis is now on the distress caused by this difference rather than the difference itself. This recognises that gender identity that’s different to birth identity is not in of itself pathological (F. Beek, Cohen-Kettenis, & Kreukels, 2016)

Little is known about how staff who work in health services perceive the needs of LGBTQ people. The studies that do exist have tended to focus on staff attitudes towards homosexuality and other minority sexual identities. In a literature review of nurses’ attitudes, Dorsen (2012) found evidence of negative attitudes towards LGBTQ people in all 17 studies included in the review. Of the 17

studies, only two examined attitudes of mental health nurses in particular (and none addressed attitudes to gender identify) (Smith, 1995; Hou et al, 2006).

Smith (1993) surveyed 250 randomly selected psychiatric nurses and found moderate to severe negative attitudes using the Index of Attitudes to Homosexuality Questionnaire (ATHQ). A more recent study was conducted in Taiwan by Hou et al. (2006). They were interested in the correlation between attitudes and intention to care. They surveyed 133 psychiatric nurses working in medical centres, teaching hospitals and psychiatric facilities using ATHQ, as well as a questionnaire on knowledge about homosexuality and a single item on intention to care (0 was no intention at all, and 100 was full intention). They found that education at Bachelors and above level was associated with more positive attitudes and a higher intention to care. In addition, those who had experience of working with LGBT people or had friends or family members who were LGBT were also more likely to have positive attitudes.

There has been even less attention paid to mental health staff views on gender identify and transgender issues. One study (Ali, Fleisher, & Erickson, 2016) administered the Genderism and Transphobia Scale (GTS) to psychiatrists (N=142) and found that, in general, they had more favourable attitudes towards transgender people than general population comparisons. Child and Adolescent psychiatrists had more favourable attitudes than general psychiatrists (but they also reported more recent contact with this group). There is a general consensus that issues of sex and sexuality are not adequately addressed in professional training.

In order to start to address this lack of knowledge and to inform suicide prevention policy, the Department of Health Policy Research Programme commissioned a research study related to LGBTQ youth suicide and self-harm and helping seeking behaviour (Queer Futures: [www.queerfutures.co.uk](http://www.queerfutures.co.uk)). This comprised of three distinct but interconnected studies: a qualitative study interviewing LGBTQ youth to gain their perspectives and lived experience; and two online surveys: one aimed at mental health staff, and the other at LGBTQ youth.

This paper reports on the findings from the mental staff survey. This is the first such study to examine perceptions and practice related to working with LGBTQ youth suicide, self-harm and help-seeking in mental health care settings.

## **Method**

**Design:** A cross-sectional design was employed administering a specifically developed online survey to mental health staff at one time point.

**Sample** mental health staff were invited to take part in the survey in three NHS Trusts in the UK

Survey Development: The survey items were developed by the research team based on themes that had emerged in the qualitative interviews for phase 1 in the study. Using interview transcripts, we drew upon the participants' experiences of seeking help from mental health services. We wanted to examine whether staff views concurred with the young peoples' experiences of routine care, as well as how staff viewed the intersection between mental distress (suicidality and self-harm), age, sexual orientation and gender identity. The survey was created in Qualtrics™ (online survey platform). A draft of the survey was piloted by a group of senior mental health nurses for accessibility in the NHS as well as for feedback regarding the content.

Procedure: The survey was distributed at 3 NHS Trusts in England in three regions: North West, London, and Yorkshire to mental Health staff. The electronic link was forwarded to the local collaborator at each NHS Trust site. The local collaborators were asked to distribute the link via Trust communications systems (including weekly news bulletins and via email lists to specific services such as child and adolescent and early intervention teams). The communications were scripted with standard text (provided by the research team) that explained the aims and rationale for the survey, and invited people to participate by clicking on a link that took them directly to the survey platform. Once they clicked on the link they could access the full information sheet and could indicate their consent.

#### Ethics and Governance

The Queer Futures study as a whole received favourable opinion at Liverpool Research Ethics Committee (REC) on 2<sup>nd</sup> April 2014 ref: 14/NW/0125 which included this study. We sought local Trust permissions via Research and Development (R&D) departments at each site to undertake the survey in 2015. R&D approval was received from the lead NHS Trust and site specific forms were completed for each additional site. Once confirmation of approval from each site was received, data collection commenced. The first page of the survey provided details in the form of a participant information sheet. We obtained consent via the first question (which confirmed agreement to participate). Copies of the survey are available from the lead author by request.

#### Data protection

We did not collect names or other identifiable information (including the name of the organisation). All data from the survey was retained in a Qualtrics™ account (which was specific to the Queer Futures researcher at Lancaster University, and is password protected). Qualtrics™ abides by EU regulations on data security. For the purposes of analysis, the data was downloaded to a Lancaster

University secure server and saved as an SPSS (version 22) file in the drive of the researcher (password protected).

## Analysis

Questionnaire data was inputted into Statistical Package for Social Sciences (SPSS) version 22.0 (2013) and frequencies and responses were examined, with certain variables (age, gender identity, sexual orientation, suicidality) being re-categorised to enable more robust analysis. Statistical analysis was then performed. Chi Square ( $\chi^2$ ) tests were conducted to determine associations between variables. Probability criteria were set to  $p < 0.05$  for inclusion.

## Results

### Demographics of the sample

A total of 113 participants gave consent and answered at least question one (how old are you). Responses per item declined until the final question, which was answered by 83 participants (73%). Participants were distributed evenly across all age groups in the mental health service staff questionnaire: 26.5% (n=30) of participants were 30 years old or under, 47.8% (n=54) were between 31 and 50, and 25.7% (n=29) were aged 51 and over. In terms of gender and sexuality, 96.5% (n=109) of the sample identified as cis gender (identify with gender assigned at birth i.e. male/female), with only 3.5% (n=4) identified as “gender diverse” (do not identify with with gender assigned at birth e.g. transgender, genderqueer). In terms of their own sexual identity, 41.7% (n=45) of the sample identified with a sexual identity other than heterosexual. Most of the sample (96.3%; n=105) were from a white ethnic background, with almost 90% (89.9%, n=98) identifying as White British. Nearly half (41.7%) identified as a sexual identity other than heterosexual.

Despite the fact that we did not use targeted sampling, and that participation was on an “opt in” basis, the sample did contain a range of professions and work place settings in mental health care. Over one quarter of participants were registered mental health nurses (27.6%, n=29), and 15.2% (n=16) were healthcare/nursing assistants. There were a range of work locations with community mental health teams (23.1%, n=24), acute inpatient wards (9.6%, n=10), crisis assessment services (7.7%, n=8), early intervention teams (5.8%, n=6), Child and Adolescent Mental Health Services (CAMHS) (2.9%, n=3), assertive outreach teams (1.9%, n=2), forensic inpatient units (1.9%, n=2), and home based treatment (1.9%, n=2) each represented. Almost half the sample reported “other setting” that was within the NHS mental health service.

Whilst two thirds of the sample had received training for self-harm (60%) or suicide prevention (59.4%, n=60), only one third (35.4%, n=35) had received training on LGBT awareness.

## **Staff knowledge and Understanding**

Participants were asked about their views on the reasons for high levels of distress experienced by LGBT youth. The most frequently chosen response was '[they] feel isolated by their sexual orientation/ gender identity' (n=70; 72.2%). The next most frequent response was 'experiencing more bullying' (chosen by 16.5%). Only one participant (1% of those who responded to that question) indicated that they believed these young people experience increased emotional distress because 'it is attention seeking behaviour'.

Participants were also asked about what they believed to be the main cause of young people self-harming. The vast majority (n=90; 93%) chose the main reason was 'it is a way of coping with difficult feelings'. 6.2% (n=6) said that it was a stress reliever, while only one participant (1%) indicated that 'it is a way of attention seeking'. None of the participants chose the other two options- 'It is a sign of a personality disorder' and 'It is because they feel suicidal'.

The participants were presented with a list of barriers to seeking help from mental health services and were asked to rate how significant each one was (these were barriers that the young people had given us in the qualitative interviews) (table 1). When presented with a list of potential barriers to LGBTQ youth asking for help from mental health services, the participants were asked to click as many as they thought relevant. The most frequently selected was 'Lack of information about mental health services' (n=85, 94%,). Fear of not being understood; the stigma of mental health diagnoses; and fear of judgement were also selected by the vast majority of participants (n=84, 93%;). There were no significant differences found between these responses and participants' own sexual orientation, age, or reception of training (self-harm, suicide prevention, and LGBT awareness).

Insert Figure 1

## **Barriers to Disclosure of Sexual Identity**

Participants were asked about perceived barriers that young people might experience in disclosing self-harm and suicidal feelings to mental health staff (table 2). Fear of parental/ carer/ family involvement was selected by the majority of participants (93.3%, n=83), while fear of being misunderstood was also selected by over 90% (90.1%, n=81) of participants. There was no

significant difference in terms of sexual orientation, age and training in terms of participants' responses to this item.

Insert figure 2

### **Staff practice and training**

Using a three point likert scale (agree, disagree and neither agree nor disagree), participants were asked about discussing sexual orientation and gender identity at work (table 3). Generally, there was consensus in responses but one question divided the participants. When responding to the statement 'I routinely discuss issues of sexual orientation and gender identity with all clients that I work with', a third (33.3%) of participants agreed, 37% disagreed, and the remainder (30%) neither agreed nor disagreed. Other items revealed a lack of confidence and skill that could affect discussions such as 'I often don't know how to talk about issues of sexual orientation and gender identity' (31% agreed), 'I worry that asking about sexual orientation and gender identity might embarrass the people I work with' (44% agreed).

Insert figure 3

### **Impact of prior training on responses**

Those who had received training with a focus on LGBT awareness were significantly more likely to state that they routinely discussed issues of sexual orientation/ gender identity with all clients that they worked with ( $\chi^2=8.782$ ,  $df=2$ ,  $p <0.05$ ). Those who had prior training were more likely to disagree with the negatively worded statement: 'I often don't know how to talk about issues of sexual orientation and gender identity' ( $\chi^2=9.028$ ,  $df=2$ ,  $p <0.05$ ).

### **Views of working with young people who self-harm**

Figure 4 presents the attitudes to working with young people who are LGBT, self-harming or suicidal. The statement that provided the greatest consensus of agreement was 'I am confident in my ability to work effectively with young people who self-harm' (69%,  $n=58$ ), followed by 'I feel I have the skills and understanding to work with LGBT young people with emotional distress' (66.7%,  $n=56$ ). Two thirds of the participants agreed with the statement 'I find it frustrating when young people don't take up my advice about self-harm' (66.7%,  $n=56$ ). Half of the participants



(50% n=42) felt that they didn't have access to adequate skills training that supported their work with LGBT youth who are self-harming or having suicidal feelings, and almost half (45.2%; n=38) did not feel that they had adequate support and supervision for this work.

Insert figure 4

### **Impact of Prior Training on Responses**

There were significant differences between responses that related to participants' ability to support young people and their prior training experiences. Those who had received self-harm training were significantly more likely to agree that they felt confident in their ability to work effectively with young people who self-harm ( $\chi^2=6.059$ ,  $df=2$ ,  $p <0.05$ ). Those participants that had self-harm training were significantly less likely to find it frustrating when young people did not take their advice about self-harm ( $\chi^2=7.295$ ,  $df=2$ ,  $p <0.05$ ). Those that had received LGBT awareness training were significantly more likely to feel that their organisation was supporting them to work with LGBT youth, while those that had not received this training were less likely to feel supported ( $\chi^2=14.401$ ,  $df=2$ ,  $p <0.001$ ). Those who had received LGBT awareness training were significantly more likely to report that they had access to adequate skills training that supported their work with self-harming or suicidal LGBT youth than those who had not received training ( $\chi^2=21.911$ ,  $df=2$ ,  $p <0.001$ ).

### **Engaging LGBT youth in mental health services**

When asked about the best way to engage LGBT youth in mental health services, the most frequent response (31.3%, n=26) selected was 'mandatory awareness training for staff'. The next was 'more proactive discussions facilitated by staff about sexual orientation and gender identity and mental health' (18.1%, n=15), followed by 'guidelines for practice with LGBT youth who self-harm or feel suicidal' (15.7%, n=13), 'outreach work targeting LGBT youth groups' (13.3%, n=11), 'having information about LGBT issues and support groups displayed' (10.8%, n=9) and 'an online support service targeted to LGBT young people' (10.8%, n=9). There were no significant differences in participant understandings of how to engage LGBT youth.

### **Discussion**

People who identify as LGBTQ experience health inequalities and in particular experience significant mental health problems. It is hypothesised that universal heteronormative cultures, homo bi- and transphobia contribute to minority distress (Meyer, 2003), as well as reluctance to seek help

from care providers (McDermott & Roen, 2016). People who identify as LGBTQ have reported negative attitudes in mental health services, but less is known about the views of staff themselves. To date, there have only been two studies that have examined mental health nurse views on LGBT adults; one in USA (Dorsen, 2012) and one in Taiwan (Hou et al., 2006). This paper represents the first survey in the United Kingdom (UK) to explore mental health staff views of working with self-harm and suicide specifically in relation to LGBTQ youth.

In our sample, mental health service staff appeared to have a good level of knowledge about LGBTQ youth and self-harm and suicide. For example, the majority believed that LGBT youth experienced more emotional distress because they felt isolated by their sexual orientation/ gender identity. In addition, most recognised that self-harm is a way of coping with difficult feelings (as opposed to “attention seeking”). They recognised that there were many barriers to overcome to access their services. They were also aware of a number of reasons that prevented LGBTQ young people from disclosing their self-harm and suicidal feelings to mental health staff.

In terms of confidence in discussing and raising sexual orientation and gender identity in their work, the responses were mixed. It seemed that those who had received prior training were more likely to report that they routinely discussed issues of sexual orientation and gender with LGBTQ youth. They were also more likely to agree that they felt confident in their ability to work effectively with young people and less likely to find it frustrating when young people did not take their advice about self-harm. In addition to feeling more confident in their own practice, those who had accessed training were also likely to feel more supported by their organisation in their work and that they had access to skills training to perform their roles.

However, despite this encouraging relationship between specific training and its impact on practice, half of the respondents did not believe that they had access to adequate skills training or access to supervision to support their work with LGBT youth who are self-harming or having suicidal feelings.

The respondents recognised the importance of training and the most common response to how best to engage LGBT youth in mental health services was ‘mandatory LGBT awareness training for staff’. In the study by Hou et al. (2006) of mental nurses in Taiwan they also found that personal knowledge of LGBT issues through friends and family predicted more positive attitudes. In our sample, non-heterosexuals were over-represented (at 40%) so it is possible that this personal connection to the topic that this may have had some influence on both interest in the topic and awareness of the issues.

The strengths of the study are that the content of the survey was generated from interviews with LGBTQ youth who had experience of mental distress and help-seeking. We were able to collect data from three NHS organisations in three regions of England (the North West, Yorkshire and Humber, and London), and were able to recruit participants from diverse clinical and professional backgrounds. This is the first survey of its kind to be undertaken with mental health staff in relation to this specific topic of LGBTQ youth, suicide and self-harm and help-seeking in England. This study is limited by the seemingly low response rate. We have no way of estimating the actual response rate because whilst we can estimate the overall population, we don't know who actually saw the emails or other communications and subsequently chose to take part or not. This survey was based on a very specific topic, and with "opt-in" surveys such as this, we are likely to have attracted people with an interest in LGBTQ issues. Indeed, nearly half of the participants identified as "non-heterosexual" which is significantly higher than in general population estimates. The National Survey on Sex and Lifestyle (NATSAL-3) (Mercer et al.) reported 1% identified as 1% lesbian/gay; 1.4% bi-sexual and 0.3% "other". Therefore, this may limit how representative the findings are to mental health staff in general.

Despite the limitations, the findings of the study indicate that training has a positive impact on how staff view working with LGBTQ youth and mental distress that manifests as self-harm and/or suicidality. It is important that nurses can access appropriate training in order to be able to address this inequality in access to mental health care. In addition, services should consider how welcoming they are to people from marginalised sexual and gender identities. The Royal College of Nursing and NHS England have provided toolkits to support suicide prevention work with LGB and trans young people

## **Conclusion**

LGBTQ youth are at high risk for suicide and self-harm, yet experience multiple barriers to seeking help. In this survey, mental health professionals demonstrated a good understanding of the reasons for self-harm and suicidal behaviours as well as the specific barriers that LGBTQ youth experience in asking for help. However only a third reported routinely discussing LGBTQ issues. There was an indication that prior LGBTQ awareness training was associated with routine discussions.

## **Relevance for Clinical Practice**

Mental health staff highlighted areas where they felt uncomfortable discussing aspects of gender and sexuality in the context of mental health care. Mental health staff should have access to LGBTQ awareness training and services should consider ways in which to outreach to marginalised groups who have elevated mental health needs. Creating ways of ensuring that mental health

services are welcoming and helpful places will be an important component in addressing this manifest health inequality.

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