THE TREVOR PROJECT

Project SPARK Interim Report:

A Longitudinal Study of Protective and Risk Factors in LGBTQ+ Youth Mental Health (2023-2025)

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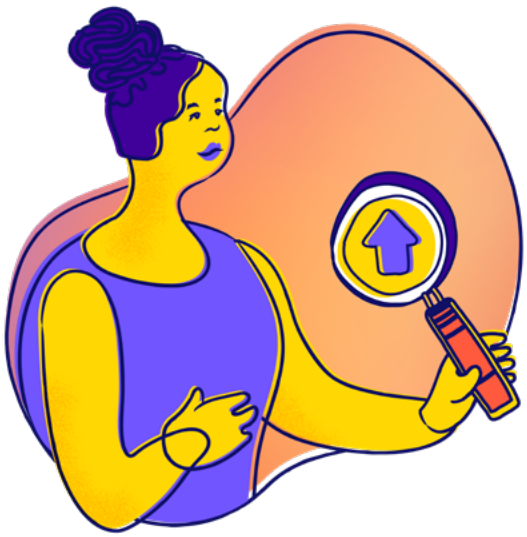
Executive Summary

Project SPARK (***S**tudying **P**rotective **A**nd **R**is**K** factors: A Longitudinal Mental Health and Experiences Study among LGBTQ+ Young People*) is a longitudinal study, currently planned for five waves, following 1,689 LGBTQ+ youth (ages 13–24) across the United States (U.S.). The analyses in this report draw on data collected every six months between September 2023 to March 2025.

This report presents interim findings over one study year, based on data from the first three waves (Waves 1 through 3) tracking the mental health, well-being, and lived experiences of LGBTQ+ youth. The sample is diverse across race/ethnicity (68% youth of color), sexual orientation (23% bisexual, 15% pansexual, 11% queer, 8% asexual), and gender identity (53% transgender, nonbinary, or gender-questioning). The study's primary goal is to understand how risk and protective factors – including family support, access to mental health care and transgender health care, and experiences of discrimination – shape the mental health trajectories of LGBTQ+ youth over time.

Key Findings

- **Worsening Mental Health Indicators:** Mental health distress increased markedly in the first year of data collection. The proportion reporting recent anxiety symptoms rose from 57% at baseline to 68% at Wave 3; depressive symptoms climbed from 48% to 54%; and suicidal ideation grew from 41% to 47%. While past-year suicide attempts declined from 11% to 7%, this rate remains higher than national estimates for cisgender heterosexual peers. Transgender, nonbinary, and gender-questioning youth and participants ages 13 to 17 reported the poorest mental health outcomes and represented the highest risk for suicide.
- **Persistent Minority Stress:** Experiences of victimization and discrimination remained widespread. At both baseline and one year later, about one-third of participants reported being physically harassed or threatened because of their sexual orientation, and approximately two-fifths of transgender and nonbinary respondents said they were physically harassed or threatened because of their gender identity. Sexual-orientation discrimination was high and held steady at roughly 55% across the year, while gender-identity discrimination among transgender and nonbinary respondents remained higher, with approximately two-thirds experiencing discrimination both at baseline and a year later. Economic insecurity was common. At baseline, 14% of participants said they were unable to meet basic needs such as food, housing,



Executive Summary

or clothing; by the one-year follow-up, 21% had faced this hardship during the preceding year. Houselessness showed a similar pattern: 21% reported ever being unhoused at baseline, and 10% reported experiencing houselessness at some point in the year that followed.

- **Conversion Therapy Exposure:** Exposure to conversion therapy – attempts to change a person's sexual orientation or gender identity – remains a significant and harmful experience for LGBTQ+ youth. Across the first year of the study, reports of conversion therapy harm rose sharply: conversion therapy threats increased from 11% at baseline to 22% after one year, while actual exposure climbed from 9% to 15%.
- **Barriers to Care:** While 80% of youth who wanted mental health care were able to access it at baseline, this dropped to 60% the following year. The top barriers included affordability, fear of not being taken seriously, and fear of involuntary hospitalization. Access to transgender health care improved for some transgender and nonbinary youth, but significant disparities by age and identity persisted.
- **Protective Factors and Affirming Environments:** Over the course of the year, more LGBTQ+ youth reported feeling supported at school, with school affirmation of LGBTQ+ identities increasing from 53% at baseline to 58% one year later. However, LGBTQ+ affirmation at home remained unchanged at 51%, indicating that many LGBTQ+ young people continued to lack support in their home environments.
- **Help-Seeking and Support Networks:** One year after baseline, LGBTQ+ youth reported significantly higher rates of seeking help during suicidal crises. The proportion of LGBTQ+ youth turning to a mental health professional during suicidal crises doubled from 32% at baseline to 64% one year later. Seeking support from friends also rose substantially, from 45% to 73%. Despite improving from 27% at baseline to 20% a year later, the number of young people (1 in 5) who sought help from no one during suicidal crises remains a concerning gap.
- **Longitudinal Associations:** Longitudinal analyses over the first year demonstrated that risk factors such as discrimination, unmet basic needs, and physical threats significantly increased the likelihood of anxiety, depression, and suicidal ideation; houselessness predicted an increased likelihood of anxiety and suicidal ideation, and exposure to conversion therapy predicted increased likelihood of depression and suicidal ideation. On the other hand, protective factors including helpful mental health care, family and friend support, affirming home environments, and access to transgender health care were associated with reductions in these mental health symptoms and suicide risk.

Executive Summary

These results highlight the urgent and ongoing mental health crisis facing LGBTQ+ youth in the U.S., particularly those who are transgender, nonbinary, or questioning; younger; or marginalized by the multiple effects of anti-LGBTQ+ sentiment and racism or economic challenges. The study period overlapped with a surge in anti-LGBTQ+ legislation and rhetoric, which likely contributed to worsening mental health and increased barriers to necessary care. At the same time, the data underscore the powerful protective effects of family support, affirming environments, and access to culturally competent mental health and transgender health care.

The findings are critical for families, educators, health care providers, policymakers, and community organizations seeking to support LGBTQ+ youth. They emphasize the need for targeted interventions to reduce mental health concerns and suicide risk, expand access to mental health care and transgender health care, and foster supportive environments at home, in schools, and in communities.

As the study continues, future analyses will explore long-term trends, causal relationships, and intersectional experiences in greater depth. We recognize these data are being collected during a period of significant sociopolitical change and heightened attention on LGBTQ+ issues; subsequent analysis will explore how such events may have an enduring impact on the health and wellness of LGBTQ+ young people. These ongoing data collection efforts will be vital for informing evidence-based policy, resource allocation, and the design of interventions to improve the lives and well-being of LGBTQ+ youth nationwide.

— The Trevor Project

Background

Study Rationale

LGBTQ+ young people experience significant mental health disparities, including higher rates of poor mental health and suicidal thoughts and behaviors, compared to their cisgender heterosexual peers (Centers for Disease Control and Prevention [CDC], 2023). However, much of the existing research relies on data collected at a single point in time (Real & Russell, 2025), limiting our understanding of how these challenges evolve throughout adolescence and early adulthood. Gaps are especially stark for transgender, nonbinary and gender-questioning youth, whose developmental trajectories and needs for mental health support and related services remain under-examined, and for youth whose sexual or gender minority status intersects with other salient identities such as race/ethnicity, culture, and religion (Russell & Fish, 2016). Understanding mental health in this intersectional context is essential, because stressors and supports often operate differently across dimensions of gender, race/ethnicity, and class.

This longitudinal study, Project SPARK, addresses these gaps by examining how the experiences and mental health of a diverse sample of LGBTQ+ young people change over time. Long-term data are essential for developing targeted, evidence-based interventions and policies, and ensuring that resources and supports effectively reach the young people who need them most. Ultimately, these findings can inform educators, policymakers, health care providers, and community leaders, guiding efforts to build more supportive environments for LGBTQ+ youth.

Throughout this report, the acronym **"TGNB"** is used to refer to participants who are transgender, nonbinary, or gender-questioning.

Study Design Overview

Project SPARK (***S****tudying* ***P****rotective* ***A****nd* ***R****is****K*** *factors: A Longitudinal Mental Health and Experiences Study among LGBTQ+ Young People*) is a longitudinal study that tracks 1,689 LGBTQ+ young people ages 13 to 24 from across the U.S., surveying them every six months over a span of at least two years. Participants complete comprehensive online surveys that explore their mental health, experiences of discrimination and victimization, family and peer support, access to mental health and transgender health care, and their overall well-being. This report presents interim findings over one study year, based on data from Waves 1 (often referred to in this report as the baseline) through 3.

Background

Methodology

Participant recruitment and eligibility: The study recruited U.S. residents ages 13 to 24 who self-identified as LGBTQ+ through paid social media advertisements. This occurred online during two recruitment windows: September 13 – December 12, 2023 and January 8 – February 17, 2024. Quota limits kept the baseline sample diverse by race/ethnicity and sex assigned at birth; once a quota filled, additional entries from that stratum were closed. To be enrolled, respondents had to (1) provide electronic consent, (2) pass an honesty screen, and (3) submit unique email and phone information. Weekly reviews resolved possible duplicates or malicious responders, yielding a final analytic cohort of 1,689 participants.

Survey administration: To ensure accessibility and safety, data collection occurred via secure, confidential online surveys that included a maximum of 139 questions. All participant information was collected following strict ethical guidelines approved by an Institutional Review Board (IRB). Baseline and Wave 2 questionnaires were administered in the survey platform Qualtrics; Wave 3 was administered in the survey platform REDCap. Surveys were available in English and waves opened at six-month intervals.

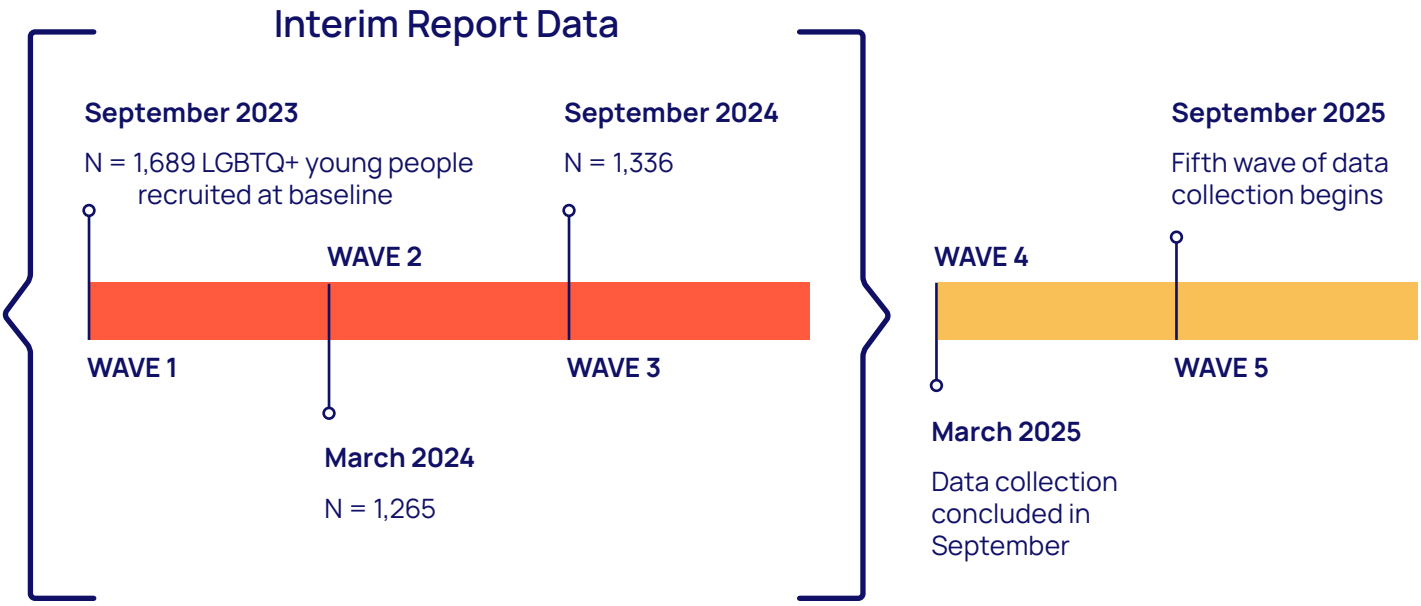
Data analysis: This interim report presents descriptive statistics and generalized linear mixed models. For descriptive results that present one-year follow-up data, we combined the 6-month recall windows used in the Wave 2 and 3 surveys, so that a "yes" response in either wave was indicative of exposure during the full 12-month follow-up. Generalized linear mixed models used data from all three available waves, controlling for the different recall window at baseline (i.e., 12 months), in order to examine the association of risk and protective factors on observed changes in anxiety, depression, suicidal ideation, and suicide attempts. Models additionally controlled for age, sexual orientation, gender identity, and race/ethnicity. Because suicide attempts were relatively rare events during the first year of the study, statistical models examining changes in suicide attempts over time did not reliably converge and are not included in this report; we still report descriptive percentages for suicide attempts.

Unless otherwise noted, all analyses are statistically significant at $p<0.05$, meaning results as extreme as those observed would be expected less than 5% of the time if there were no true difference (i.e., under the null hypothesis). Due to rounding, some presented percentages may not precisely add up to reported totals.

Background

Waves and Timeline

The following timeline summarizes the study's progress:



Key Domains Measured

To understand how well-being changed for LGBTQ+ young people over time, we tracked key areas spanning mental health, risk factors, and sources of support. Below is a summary of each domain assessed in Waves 1 to 3.

Mental Health Outcomes

1. **Suicidal ideation:** Assessed with the Depressive Symptom Index–Suicidality Subscale (DSI-SS) (Joiner et al., 2002), which measures the frequency, intensity, and controllability of suicidal thoughts over the past two weeks.
2. **Attempted suicide:** Reports of past-year suicide attempts, based on items from the CDC's Youth Risk Behavior Survey (YRBS; CDC, 2023).
3. **Anxiety:** Anxiety symptoms captured using the Generalized Anxiety Disorder 2-item (GAD-2) screener (Plummer et al., 2016), which measures how often participants felt nervous or unable to control worrying over the past two weeks.
4. **Depression:** Depressive symptoms captured using the Patient Health Questionnaire 2-item (PHQ-2) screener (Richardson et al., 2010), which measures how often participants experienced low mood or loss of interest or pleasure over the past two weeks.

Risk Factors

1. **Victimization:** Experiences of being physically threatened or abused based on one's sexual orientation or gender identity.
2. **Discrimination:** Experiences of being treated unfairly or excluded based on one's sexual orientation or gender identity.
3. **Conversion therapy:** Threats of or actual attempts to change one's sexual orientation or gender identity, reported separately. These include experiences with health care professionals and religious or spiritual leaders.
4. **Economic security:** Unstable housing and difficulty meeting basic needs like food, housing, and clothing.

Key Domains Measured

Protective Factors

1. **Access to mental health care:** Ability to obtain counseling or therapy when needed, perceived helpfulness of mental health care, and experiences with mental health-related hospitalization, as well as common barriers that prevent them from accessing desired care.
2. **Access to transgender care:** Ability of TGNB youth to access the care and resources they wanted to support their gender identity – including clothing and binders, puberty blockers, hormones, surgeries, and/or updated identity documents.
3. **Family support and supportive environments:** Levels of acceptance and affirmation from family, peers, schools, and the broader community.
4. **Gender euphoria:** Degree of affirmation and comfort TGNB youth feel in expressing their gender and being seen as their gender, based on their agreement with statements from the Trans Youth CAN! Gender Positivity Scale (Bauer et al, 2021).
5. **Help-seeking behaviors:** Support sought by participants who seriously considered suicide in the past year — including from friends, family members, professionals, and crisis services.

Results

Demographics

Baseline Characteristics

Age: At the start of the study, 41% of participants were ages 13 to 17 and 59% were ages 18 to 24; the median age was 18. By Wave 3, the median age had risen to 20.

Race/ethnicity: Participants were racially and ethnically diverse; most (68%) were LGBTQ+ young people of color. Participants identified as White (32%), Multiracial (25%), Black or African American (17%), Hispanic/Latinx (15%), Asian American or Pacific Islander (8%), Indigenous (2%), and Middle Eastern or North African (1%).

Sexual orientation: At baseline, participants reported a range of sexual orientations, with a plurality identifying as bisexual (23%). The remainder of participants identified as lesbian (20%), gay (19%), pansexual (15%), queer (11%), asexual (8%), and heterosexual (1%). Three percent of participants indicated they were not sure of their sexual orientation. The majority of participants (74%) reported the same sexual orientation at Wave 3 as they did at baseline; this change was not statistically significant.

Gender identity: Nearly half of participants (48%) were cisgender – 21% cisgender boys/men and 27% cisgender girls/women. Nonbinary youth made up 30% of the sample, transgender youth made up 18% (11% transgender boys/men, 7% transgender girls/women), and 5% were questioning their gender identity. The majority of participants (83%) reported the same gender identity at Wave 3 as they did at baseline; this change was not statistically significant.

Results

Demographics

Baseline Characteristics

By Age

- **41%** 13 to 17
- **59%** 18 to 24

By Race/Ethnicity

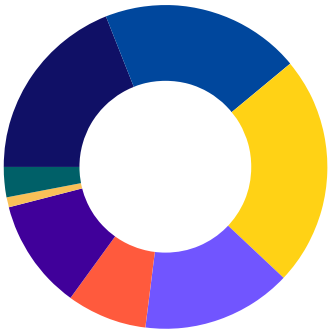
- **1%** Middle Eastern/ Northern African
- **2%** Native/Indigenous
- **8%** Asian American/ Pacific Islander
- **17%** Black/ African American
- **15%** Hispanic/Latinx
- **32%** White
- **25%** Multiracial

By Gender Identity

- **27%** Cisgender Girl/Woman
- **21%** Cisgender Boy/Man
- **30%** Nonbinary
- **7%** Transgender Girl/Woman
- **11%** Transgender Boy/Man
- **5%** Gender Questioning

By Sexual Orientation

- **19%** Gay
- **20%** Lesbian
- **23%** Bisexual
- **15%** Pansexual
- **8%** Asexual
- **11%** Queer
- **1%** Heterosexual
- **3%** Questioning



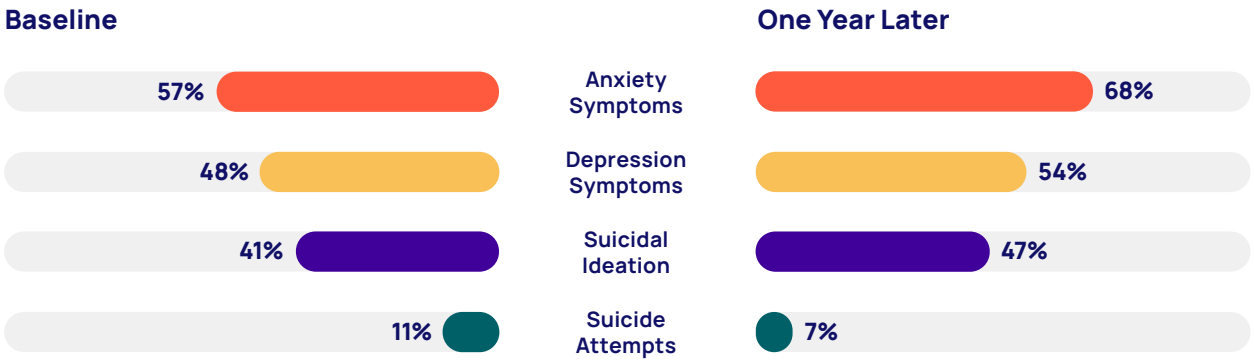
Results

Changes in Mental Health Outcomes Over Time

At baseline, 57% of participants reported recent symptoms of anxiety, and one year later, this increased to 68%. Similarly, 48% of participants reported recent symptoms of depression at baseline, and one year later, this increased to 54%. Increases in suicidal ideation were also observed, with 41% of participants reporting suicidal ideation at baseline and 47% one year later. At the start of the study, over one in ten (11%) participants reported having attempted suicide in the past year; during the subsequent year, 7% of participants reported a suicide attempt.

Mental Health Indicators and Suicide Risk over a One Year Period:

LGBTQ+ young people experienced increases in anxiety, depression, and suicide ideation.



Results

Demographic Differences in Outcomes

Anxiety: Participants ages 13-17 at baseline were more likely to report recent symptoms of anxiety (61%) than those 18-24 (53%). White participants were more likely to report recent symptoms of anxiety (63%) than young people of color (54%). There were significant differences by sexual orientation as well, with 44% of gay or lesbian participants reporting recent symptoms of anxiety, compared to 61% of bisexual, 66% of pansexual, and 73% of queer respondents. TGNB participants were more likely to report recent symptoms of anxiety (70%) than cisgender participants (42%).

Depression: Participants ages 13-17 at baseline were more likely to report recent symptoms of depression (52%) than those ages 18-24 (45%). There were significant differences by sexual orientation: 37% of gay or lesbian participants reported recent symptoms of depression, compared to 50% of bisexual, 56% of queer, and 60% of pansexual respondents. TGNB participants were more likely to report recent symptoms of depression (58%) than cisgender participants (36%). There were no significant differences in depressive symptoms by race/ethnicity.

Suicidal ideation: Participants ages 13-17 at baseline were more likely to report suicidal ideation (49%) than those ages 18-24 (37%). Gay and lesbian participants reported the lowest rates of suicidal ideation (31%) compared to 46% of bisexual, 49% of queer, and 50% of pansexual respondents. TGNB participants were more likely to have suicidal ideation (53%) than cisgender participants (28%). There were no significant differences in suicidal ideation by race/ethnicity.

Suicide attempts: Participants ages 13-17 at baseline were more likely to report a suicide attempt in the past year (16%) than those ages 18-24 (8%). In terms of sexual orientation, gay and lesbian participants reported the lowest rates of attempting suicide in the past year (7%) compared to 13% of bisexual, 15% of queer, and 16% of pansexual respondents. TGNB participants were more likely to have attempted suicide in the past year (16%) than cisgender participants (6%). There were no significant differences in suicide attempts by race/ethnicity.

Results

Suicide Ideation and Attempts at Baseline, by Gender Identity:

At baseline, TGNB participants considered and attempted suicide more than cisgender participants.

Most of these associations persisted a year later, with a few notable exceptions. One year later, baseline age was no longer associated with differences in recent depressive symptoms. Race/ethnicity, which showed no association with recent depressive symptoms or suicidal ideation at baseline, became associated with these outcomes one year later: 59% of White participants reported recent symptoms of depression compared to 50% of participants of color, and 53% of White participants reported suicidal ideation compared to 44% of young people of color. Although rates for depression and suicidal ideation increased for all participants regardless of race/ethnicity over the past year, this increase was greater for White participants.

Changes in Suicidal Ideation over Time, by Race/Ethnicity:

Rates of suicidal ideation increased for all participants, with White participants experiencing the largest increase in suicidal ideation.

Results

Changes in Risk Factors Over Time

Risk factors are experiences that can negatively affect the health and well-being of LGBTQ+ young people. In this section, we track key risk exposures reported over the first year of the study, including victimization, discrimination, exposure to or threats of conversion therapy, and economic insecurity (such as houselessness or not being able to meet basic needs).

Victimization

Baseline characteristics: At baseline, 31% of the sample reported being physically threatened because of their sexual orientation in the last year. This differed across age; youth ages 13-17 were more likely to report an experience of being physically threatened (36%) than those who were 18-24 (27%). There were differences across sexual orientation as well, with gay (41%) and lesbian (34%) respondents reporting the highest rates. Reports of threats based on sexual orientation by gender were highest among cisgender boys/men (38%), gender-questioning individuals (32%), and transgender girls/women (31%). There were also differences by race/ethnicity, with Indigenous/Native (48%) and Black/African American (37%) participants reporting the most sexual orientation-based victimization.

Among TGNB participants, 43% reported being physically threatened because of their gender identity in the last year. There were differences by sexual orientation and gender identity: queer (51%), gay (46%) and bisexual (46%) respondents reported higher rates than other sexual orientation groups. Transgender girls/women (57%) and transgender boys/men (56%) reported the highest rates overall. Gender identity-based victimization did not differ by age or race/ethnicity.

Changes over time: In the year following the start of the study, 32% of participants reported being physically threatened because of their sexual orientation in the past year, and 42% of TGNB participants reported being physically threatened because of their gender identity. Neither of these rates were statistically different from the rates reported at baseline.

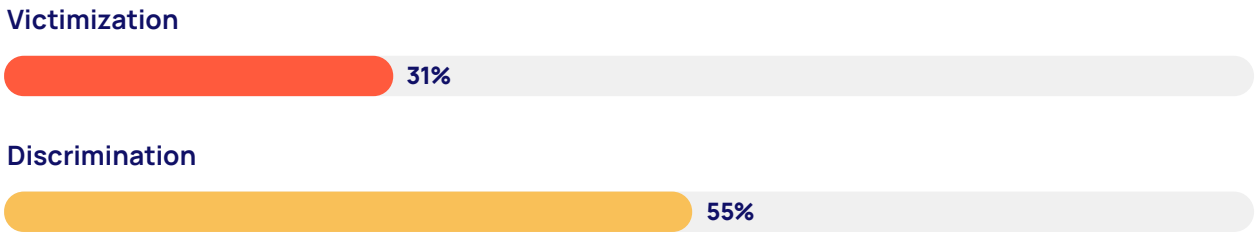
Results

Discrimination

Baseline characteristics: At baseline, 55% of the sample reported being discriminated against because of their sexual orientation in the last year. Participants ages 13-17 were more likely to report an experience of discrimination based on sexual orientation than those ages 18-24 (63% vs. 50%). There were differences across sexual orientation, with gay (75%) and lesbian (68%) participants reporting the highest rates compared to other sexual orientation groups. By gender identity, cisgender boys/men (73%) and cisgender girls/women (58%) reported the highest rates of discrimination on the basis of sexual orientation. By race/ethnicity, Black/African American (72%) and Indigenous/Native (65%) participants were most likely to report being discriminated against because of their sexual orientation compared to any other race/ethnicity.

Experiences of Victimization and Discrimination Due to Sexual Orientation at Baseline:

LGBTQ+ young people reported high rates of sexual orientation-based victimization and discrimination.

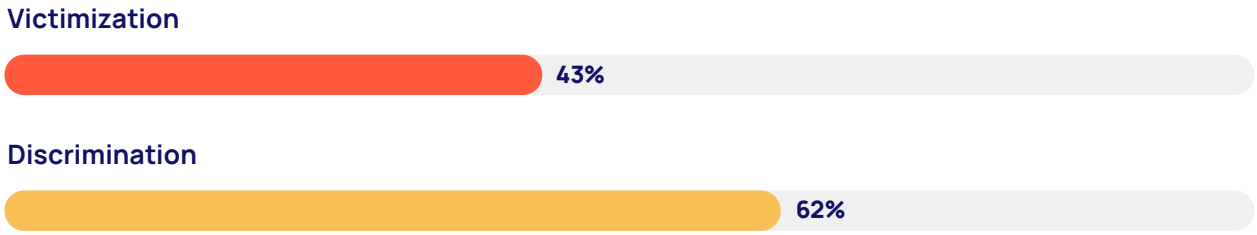


Results

Among TGNB participants, 62% reported discrimination based on gender identity in the last year at baseline. Rates varied by gender identity, with transgender boys/men (73%) and transgender girls/women (69%) reporting the highest rates of discrimination. There were also differences by sexual orientation, with queer (75%) and asexual (73%) respondents being more likely to report an experience of discrimination based on gender identity. There were no differences by age or race/ethnicity.

Experiences of Victimization and Discrimination Due to Gender Identity at Baseline:

TGNB young people reported high rates of gender identity-based victimization and discrimination.



Changes over time: One year after baseline, 54% of participants reported experiencing discrimination based on their sexual orientation, and 67% of TGNB participants reported experiencing discrimination based on gender identity. Neither rate, however, was statistically different from that reported at the beginning of the study.

Results

Conversion Therapy

Baseline characteristics: Conversion therapy refers to any threat or attempt to change a young person's sexual orientation or gender identity. At baseline, 11% of respondents reported ever being **threatened** with conversion therapy, and 9% reported ever being **subjected** to conversion therapy. Threats differed by age: LGBTQ+ young people ages 13-17 (12%) were more likely to report ever being **threatened** with conversion therapy than those ages 18-24 (10%). Conversely, LGBTQ+ young people ages 18-24 (10%) were more likely to report ever being **subjected** to conversion therapy than those ages 13-17 (6%). Threats of conversion therapy also differed by race/ethnicity: Middle Eastern/North African (19%) and Hispanic/Latinx (16%) participants reported the highest **threat** levels. Actual conversion therapy exposure was greatest among Indigenous/Native (15%) and Black/African American (13%) participants. By sexual orientation, gay (13%) and lesbian (16%) respondents were more likely than their peers to report ever being **threatened** with conversion therapy; gay (24%) and lesbian (21%) participants were also most likely to report being **subjected** to conversion therapy in the past. There were no differences by gender identity.

Changes over time: One year after baseline, 22% of participants reported having ever been threatened with conversion therapy – double the baseline figure (11%). Reports of ever having been subjected to conversion therapy rose too, from 9% at baseline to 15% a year later.

Experiences with Conversion Therapy over One Year:

A high number of LGBTQ+ youth were threatened with or exposed to conversion therapy at baseline and in the past year.

Results

Economic Security

Economic security — defined here as houselessness and difficulty meeting basic needs such as food, housing, or clothing — showed the following patterns.

Houselessness

Baseline characteristics: At baseline, 21% of the sample reported currently being houseless or having experienced houselessness in the past. This differed across age, with those 18-24 (25%) being more likely to report houselessness either currently or in the past than those who were 13-17 (17%). There were also differences across race/ethnicity, with Hispanic/Latinx (27%) and Black/African American (25%) respondents being more likely to report this than any other race/ethnicity. There were no differences by sexual orientation or gender identity.

Changes over time: One year after baseline, 10% of participants reported an experience of houselessness in the past 12 months. This rate was notably higher for those who reported a history of houselessness at baseline compared to those who had not (29% vs. 5%).

Unmet basic needs

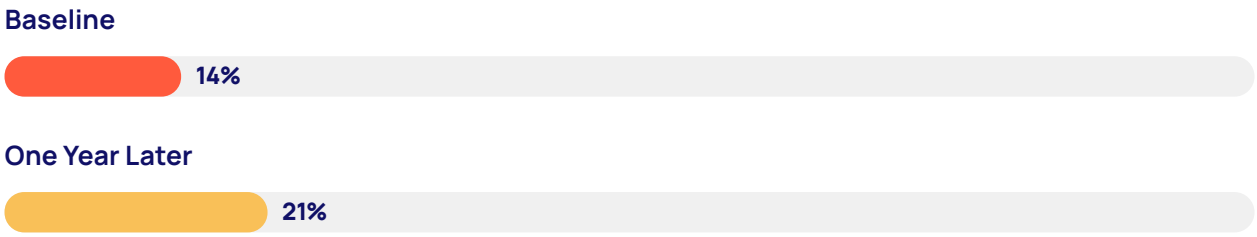
Baseline characteristics: At baseline, 14% of participants reported that they could not meet their basic needs. This differed across age: participants ages 18-24 (17%) were more likely to report being unable to meet their basic needs than those who were 13-17 (10%). There were differences across sexual orientation as well, with pansexual (23%) and questioning (22%) participants being more likely to report being unable to meet basic needs than other sexual orientation groups. Differences also emerged by race/ethnicity: Indigenous/Native (29%) and multiracial (19%) participants were the most likely to report being unable to meet basic needs. By gender identity, TGNB respondents (18%) were more likely to report being unable to meet their basic needs than cisgender respondents (9%); transgender boys/men (19%) and nonbinary (18%) respondents were more likely to report being unable to meet basic needs than participants of other gender identities.

Results

Changes over time: More than one in five (21%) participants reported being unable to meet their basic needs at some point during the year after baseline, a statistically significant increase compared to the 14% who reported being unable to meet their basic needs when the study began.

Unmet Basic Needs in the Past Year Among LGBTQ+ Young People:

LGBTQ+ young people experienced an increase in unmet basic needs in the past year.



Results

Changes in Protective Factors Over Time

Protective factors are the resources and supports that buffer minority stress and promote LGBTQ+ young people's well-being. In this section, we examine how key protective factors changed over the first year of Project SPARK, including access to mental health care; affirming environments (at home and in school); medical, legal, and social supports for gender transition (such as transgender health care and document updates); family support; and help-seeking behaviors.

Access to Mental Health Care

Access to Desired Mental Health Care

Baseline characteristics: At the start of the study, 81% of participants reported wanting mental health care in the past, and of those, 80% reported that they had been able to access the mental health care they desired. Access to desired mental health care varied by demographic groups. Across age groups, LGBTQ+ young people ages 13-17 reported lower rates of access (75%) compared to their 18-24-year-old peers (83%). By race/ethnicity, White (85%) youth reported higher rates of access to desired mental health care than youth of color (78%). More specifically, Black/African American (65%) and Native/Indigenous (67%) youth reported the lowest rates of access. Additionally, across gender identity, transgender and nonbinary youth (84%) and gender-questioning youth (80%) reported higher rates of access to desired mental health care compared to their cisgender peers (73%).

Changes over time: During the 12-month follow-up period, 60% of participants reported receiving the mental health care they wanted within the past year. Mental health care access still varied by gender identity, with 63% of transgender or nonbinary youth reporting access to desired mental health care, compared to 59% of gender-questioning youth and 56% of cisgender youth.

Results

Access to Desired Mental Health Care over One Year:

Fewer LGBTQ+ young people were able to access desired mental care over the past year.

Helpfulness of Received Mental Health Care

Baseline characteristics: Among those who were able to access the care they wanted in the past, 61% found the care helpful. Helpfulness differed by age: LGBTQ+ young people ages 13-17 reported a lower rate of helpful care (51%) than those ages 18-24 (67%).

Changes over time: During the 12-month follow-up period, 75% of LGBTQ+ young people reported that their mental health care had been helpful within the past year. Age differences persisted, with LGBTQ+ young people ages 13-17 reporting lower rates of helpful care (65%) compared to their 18-24-year-old peers (78%).

> “Being able to talk to someone objective about past trauma and about being trans is **an incredible weight lifted off my shoulders.**”

Results

> **“I feel hopeful for the first time in more than a decade.”**
> I feel like getting help with my mental health has made life worth living again. I feel like I can have a future now.

Mental Health-Related Hospitalization

Baseline characteristics: At baseline, 21% of LGBTQ+ youth reported any prior mental health-related hospitalization. More specifically, 10% reported experiencing involuntary hospitalization, 7% voluntary, and 4% both. Past hospitalization varied by sexual orientation, with queer (31%) and questioning (27%) youth reporting the highest rates of past hospitalization, and gay and lesbian (16%) youth reporting the lowest. Past mental health-related hospitalization also varied by gender identity, with cisgender youth (9%) reporting lower rates than their TGNB peers (28%).

Changes over time: During the 12-month follow-up period, 4% of LGBTQ+ young people reported being hospitalized involuntarily or voluntarily. Rates varied by gender identity: 2% among cisgender youth compared to 5% among TGNB youth. Rates of hospitalization were highest among those who were hospitalized prior to baseline (31%).

Results

Barriers to Care

Baseline characteristics: At the start of the study, the most common reasons for being unable to access desired mental health care in the past were:

1. Inability to afford it (43%),
2. Fear of not being taken seriously (35%),
3. Fear of involuntary hospitalization (32%),
4. Fear of talking about mental health with someone else (31%), and
5. Previous negative experiences with a therapist (30%).

Changes over time: One year later, three of the five most common barriers reported at baseline remained among the top reasons for not accessing care:

1. Inability to afford care (46%)
2. Fear of talking about mental health with someone else (36%),
3. Not wanting to have to get a parent/caregiver's permission (30%),
4. Fear of not being taken seriously (30%),
5. Fear that the care would not work (26%), and
6. Insurance not covering it (26%).

"They [mental health care professionals] just don't understand what it's like to be trans and they don't take the time to do proper research. I constantly have to educate them which is **exhausting and makes me not want to go.**"

Results

Access to Transgender Health Care

Access to Puberty Blockers

Baseline: Puberty blockers are medications that pause the physical changes of puberty. At baseline, 48% of TGNB youth had not taken puberty blockers and did not want them, while 49% had not taken them but wanted to. These rates differed by gender identity. While the vast majority of transgender boys/men (86%) and transgender girls/women (88%) reported they had not taken puberty blockers but wanted to do so, most nonbinary (57%) and gender-questioning (79%) young people expressed no interest in puberty blockers. Only 1% of all TGNB young people had taken puberty blockers in the past, and 2% were taking them currently.

Changes over time: Interest in and use of puberty blockers did not change over time, with 1% of TGNB participants reporting taking them at some point in the follow-up year, and 2% reporting taking them at the time of their follow-up survey.

> **"Gender affirming health care significantly improved my life.** It drastically improved my mental health, and reduced my suicidal ideation significantly. It also reduced my dysphoria extensively. Gender affirming health care is extremely important and helpful for non-cis/trans people!"

Results

Access to Hormones

Baseline: At baseline, 58% of TGNB participants wanted gender-affirming hormones – also referred to as hormone replacement therapy – which typically include testosterone or estrogen used to support gender-related physical changes. However, only 32% were able to access them. Among individuals who had taken hormones at some point in the past, 86% were on hormones at baseline. Access differed by age: participants ages 18-24 reported a higher rate of access (51%) compared to their younger 13-17-year-old peers (12%). Access also varied by sexual orientation, with heterosexual TGNB youth reporting the highest rate of access (60%), and asexual TGNB youth reporting the lowest (25%). Rates of access also differed by gender identity, with transgender boys/men (50%) having the highest, followed by transgender girls/women (37%), nonbinary young people (26%), and gender-questioning young people (7%).

Changes over time: At the 12-month follow-up period, 36% of TGNB youth who wanted hormones had access to them (this includes youth who already had access at baseline and those who newly gained it). Access still varied by age and sexual orientation at the 12-month mark: 12% for younger (13-17) TGNB youth versus 51% for older (18-24) TGNB youth; 60% for heterosexual TGNB youth versus 25% for asexual TGNB youth. The association between gender identity and hormone access did not change over time.

A year after baseline, 30% of TGNB individuals who did not initially have access to hormones were able to access them. Additionally, 99% of those who had access at baseline maintained access, with only 1% no longer reporting access at follow-up.

> “Being denied access to gender-affirming health care has been detrimental to my mental health and my overall well being and is one of the leading reasons why I considered suicide and turned to self harm. **Access to it would [be] life changing and potentially life saving.**”

Results

Access to Gender-Related Surgeries to Support Gender Transition

In the U.S., gender-related surgeries – when pursued – are undertaken after careful clinical evaluation and informed consent with qualified medical professionals, in line with applicable standards of care and laws. Availability and eligibility vary by age, state, and insurance. As with all findings in this report, these results are based on a convenience (non-probability) sample and are not nationally representative population estimates.

Baseline: At baseline, 45% of TGNB youth reported not having gender-related surgery and not wanting it. However, 51% wanted surgery but had not had it, and 4% had already undergone gender-related surgery. Those who had gender-related surgery were an average of 21.3 years old. These rates differed by gender identity. Most transgender boys/men (87%) and transgender girls/women (85%) had not received gender-related surgery but wanted it, while most nonbinary (51%) and gender-questioning (79%) young people expressed no interest in surgery.

Changes over time: One year post-baseline, 2% of TGNB participants (n = 11, average age = 20.9 years old) reported having had gender-related surgery in the past year. There was no significant change in the percentage of participants who wanted surgery but did not have it, or those who were not interested in surgery.

Access to Tools Related to Gender Expression or Transition

Baseline: TGNB youth were asked whether they were able to access tools – such as clothing, binders, or shapewear – that support their gender expression or transition. At baseline, 85% of TGNB youth expressed interest in tools supporting gender transition, and 59% of these TGNB youth were able to obtain the tools they wanted. Of these TGNB youth, 62% could access a few tools and 38% reported being able to access most tools they wanted. Among TGNB youth who wanted tools to support their gender expression or transition, access varied by age: those ages 13-17 reported lower rates of access (47%) than their older peers, ages 18-24 (68%). Access also varied by sexual orientation, with queer TGNB youth reporting the highest rate of access (71%) and TGNB youth questioning their sexual orientation reporting the lowest (44%). Among those

Results

who wanted tools to support their gender expression, access varied by gender identity. Transgender boys/men (84%) were the most likely to have access to at least some of the tools they wanted, followed by nonbinary young people (54%), transgender girls/women (51%), and gender-questioning young people (40%).

Changes over time: Over the 12-month follow-up period, 65% of TGNB youth reported being able to access tools they desired related to their gender expression or transition. Access again varied by age (52% for younger TGNB youth ages 13-17 vs. 72% for older youth ages 18-24) and sexual orientation (78% among heterosexual TGNB youth vs. 53% among TGNB questioning their sexual orientation). Though the pattern of access remained the same by gender identity one year later, there were notable increases in the rates of access for nonbinary young people (60%), transgender girls/women (59%), and gender-questioning young people (45%). Among those without access at baseline, 59% obtained the tools within a year; 98% of those who already had access maintained it, with only 2% losing access.

> **“It [transgender health care] has given me some sense of control over my body that I never felt before.** It’s been freeing in a way that I wasn’t sure I’d ever get to feel or experience.”

Results

Ability to Change Identification Documents

Baseline: At baseline, 68% of TGNB participants reported wanting to change their identification documents (e.g., driver's license, passport) to match their gender identity. Of those, 49% were able to do so, while 52% lived in states where they were unable to change their official documents. Changing an identification document, when desired, varied by age: 18-24-year-old participants (60%) were more likely to update their documents than their younger 13-17-year-old peers (36%). Transgender boys/men (60%) and transgender girls/women (51%) were more likely to change their documents than nonbinary (42%) or gender-questioning (27%) young people.

Changes over time: After 12 months, the proportion of TGNB young people wanting document changes remained 68%. Among those wanting changes, 53% had updated their documents by that point, an increase of 4% over the year. Ability to change documents still varied: young TGNB youth (35%) were less able to update their documents than their older peers (63%). By race/ethnicity, youth of color (47%) were less able to update their documents than their White (57%) peers. Further, by sexual orientation, pansexual TGNB youth (46%) reported the lowest rate of being able to update identity documents, and heterosexual TGNB youth (79%) reporting the highest. There was no significant change in access by gender identity.

Affirming Spaces

Access to Affirming Schools

Baseline: At baseline, 53% of participants in school reported that their school was LGBTQ+-affirming. This varied by age, with those ages 13-17 (48%) reporting lower rates of affirming school environments compared to their 18-24-year-old counterparts (60%). Affirming school environments also varied by sexual orientation, with gay youth (43%) reporting the lowest rate, and queer youth (67%) reporting the highest. Finally, rates varied by gender identity: cisgender youth reported the lowest affirmation (42%) compared to TGNB youth (60%).

Results

Access to an LGBTQ+-Affirming School

Changes over time: One year later, 58% of students reported that their school was LGBTQ+-affirming. Age differences persisted (51% for 13-17-year-olds vs. 63% for 18-24-year-olds). Affirming school environments also varied by sexual orientation, with questioning youth (46%) reporting the lowest rate, and heterosexual TGNB youth (70%) the highest. By gender identity, cisgender youth (51%) reported the lowest rate, followed by TGNB youth (63%).

> "In some places in school I'm affirmed like specific teachers' offices or classes, **but some teachers are transphobic and I feel unsafe around them.**"

Access to Affirming Home Environments

Baseline: At baseline, 51% said their home was LGBTQ+-affirming. Rates were lower for youth ages 13-17 (42%) than for those ages 18-24 (56%). Affirming home environments also varied by sexual orientation, with questioning youth (37%) reporting the lowest rate, and gay (55%) and lesbian youth (58%) reporting the highest. Finally, it varied by gender identity, with cisgender youth (53%) reporting a higher rate than TGNB youth (50%).

Results

Access to an LGBTQ+-Affirming Home

Changes over time: In the 12-month follow-up period, there was no significant change in the percentage of youth who reported that their home was LGBTQ+-affirming. Despite this lack of overall change, differences by race/ethnicity emerged, with youth of color (47%) reporting lower rates than their White (60%) peers.

> **Acceptance.** There is no feeling worse than not being taken seriously/accepted.

Types of Support Received by Family

LGBTQ+ youth answered 12 questions about specific family supportive actions (e.g., "Supported your gender expression," "Talked with you respectfully about your LGBTQ+ identity"). Responses were on a 4-point scale (0 = no family members engaged in the action and 4 = all of the family members engaged in the action). Scores were summed to create a total score of supportive actions taken by the family.

Results

Baseline: At baseline – when youth reported whether family members had ever engaged in each action – the mean number of family supportive actions (on a 4-point scale) was 1.92 (standard deviation [SD] = 0.66, range: 1-4), reflecting that "some" of their family members had been supportive. The mean number of supportive actions by family members differed by demographic variables. LGBTQ+ youth ages 13-17 reported experiencing fewer supportive actions (M = 1.86) than their 18-24-year-old peers (M = 1.95). Supportive family actions also varied by race/ethnicity, with White youth reporting less support (M = 1.85) than their peers of color (M = 1.95). Additionally, these actions varied by gender identity, with TGNB youth reporting less support (M = 1.78, SD = 0.61) than cisgender youth (M = 2.11, SD = 0.68). By sexual orientation, gay and lesbian youth reported receiving the most support (M = 2.07, SD = 0.63) and asexual youth reporting the least (M = 1.71, SD =0.62).

Changes over time: One year later – based on support received during the past 12 months – the mean number of family supportive actions was not significantly different to that at baseline at 1.87 (SD = 0.69, range: 1-4). The mean number of supportive actions by family members in the past year still differed by demographic variables. By gender identity, TGNB youth reported fewer supportive actions (M = 1.75, SD =0.64) than cisgender youth (M = 2.06, SD = 0.72). By sexual orientation, gay and lesbian youth reported the most support (M = 2.03, SD = 0.69) and asexual youth reported the least (M = 1.63, SD =0.67).

Gender Euphoria

Baseline characteristics: Gender euphoria captures how affirmed and comfortable young people feel in expressing their gender and being recognized for who they are. Following the Trans Youth CAN! Guide (Bauer et al., 2021), each participant's score was calculated as the average of 11 items rated 1–5, yielding a 1–5 scale in which higher values indicate greater gender positivity. At baseline, the full sample of LGBTQ+ young people reported a mean gender positivity score of 3.17 (SD = 0.83). LGBTQ+ young people ages 18-24 reported higher mean gender positivity scores compared to those ages 13-17 (M = 3.26, SD = 0.84 vs. M = 3.00, SD = 0.79). There were differences by sexual orientation as well. Heterosexual transgender young people reported the highest mean gender positivity scores (M = 3.38, SD = 0.92) while asexual young people (of all gender identities) reported the lowest mean gender positivity scores (M = 2.98, SD = 0.76).

Results

Gender positivity scores also varied by race/ethnicity. Indigenous/Native LGBTQ+ young people reported the lowest mean gender positivity scores (M = 2.73, SD = 0.74) and Asian American/Pacific Islander young people reported the highest (M = 3.43, SD = 0.82).

There were differences across gender identity, as well: cisgender girls/women reported the highest mean gender positivity scores (M = 3.27, SD = 0.80) and transgender girls/women reported the lowest mean gender positivity scores (M = 2.94, SD = 0.94).

Changes over time: Across the one-year period, mean gender positivity increased by 0.15 points on average.

Help-seeking Behaviors

Baseline characteristics: At baseline, 27% of participants reported that in the past 12 months they had not sought help from anyone when experiencing suicidal thoughts. There were no differences in not seeking help by age, race/ethnicity, sexual orientation, or gender identity.

When support was sought for suicidal thoughts, the main sources of support were: a friend (45%), a mental health professional (32%), an intimate partner (31%), a phone helpline (23%), a parent or caregiver (16%), another relative (10%), a doctor or general practitioner (6%), and a religious leader (1%).

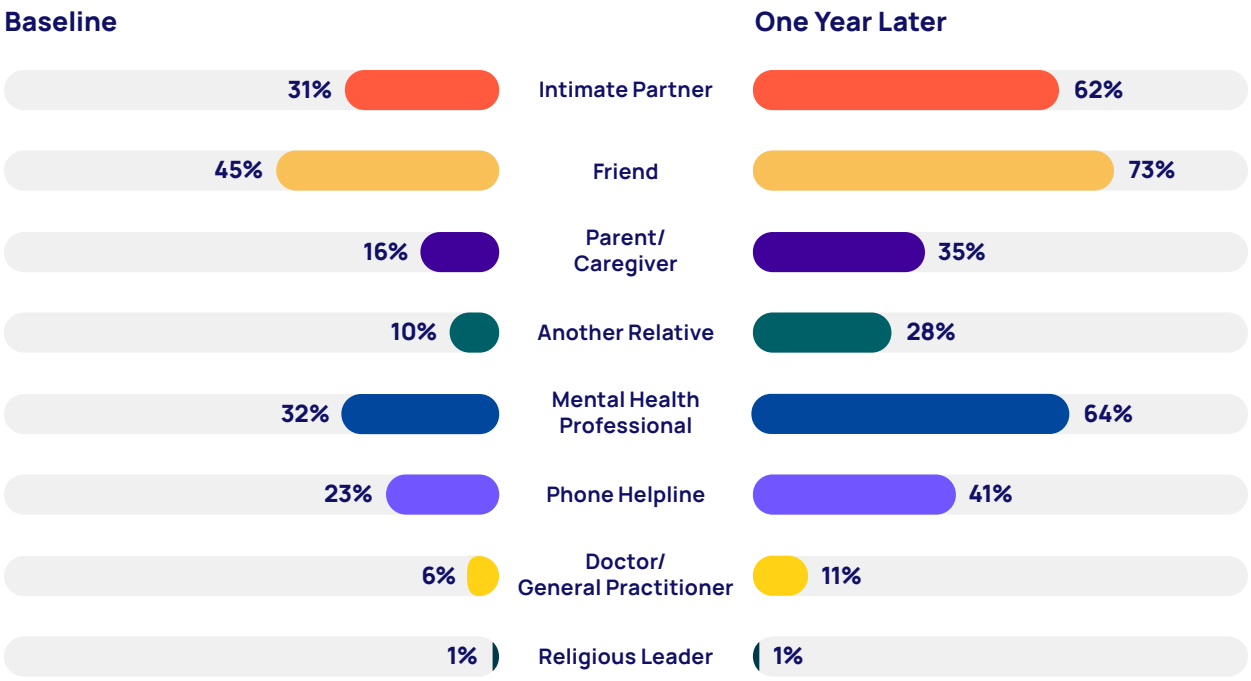
Help-seeking from a parent showed no demographic differences. Help-seeking from a friend differed by gender identity, with transgender girls/women reporting the highest rates of seeking help from friends (56%) and gender-questioning young people reporting the lowest (33%). Seeking help from a mental health professional differed by age: youth ages 18-24 reported higher rates of seeking help from a mental health professional when experiencing suicidal thoughts compared to their LGBTQ+ peers ages 13-17 (38% vs 27%, X=7.35). There were no differences across race/ethnicity, sexual orientation, or gender identity.

Results

Changes over time: Over the follow-up year, the proportion of LGBTQ+ youth who sought help from no one when experiencing suicidal thoughts fell from 27% to 20%. Help-seeking during suicidal thoughts in the past year rose across nearly every source: intimate partners (31 % → 62 %), friends (45 % → 73 %), parents (16 % → 35 %), other relatives (10 % → 28 %), mental health professionals (32 % → 64 %), phone helplines (23 % → 41 %), and doctors/ general practitioners (6 % → 11 %). There was no change in those who went to a religious leader for support when experiencing suicidal thoughts.

Changes in Where LGBTQ+ Young People Seek Help During Suicidal Crisis:

There was an increase in the rate at with LGBTQ+ young people sought help from nearly all sources when experiencing a crisis.



Results

Temporal Relationships

Both risk and protective factors were associated with changes in participants' likelihood of experiencing recent symptoms of anxiety and depression, as well as past-year suicide ideation. Over the course of the first year of the study, suicide attempts were too rare of an event to produce models that reliably converged. All models took into account the nested nature of the data, in which multiple observations from the same participant were taken over time. Models also controlled for age, sexual orientation, gender identity, and race/ethnicity.

Also, not described earlier, we examined the effects of high social support as a protective factor for the outcomes we look at below. Friend and family support were operationalized using an abridged version of the Multidimensional Scale of Perceived Social Support (MSPSS). Participants were categorized as having high support if they scored above 5 ("mildly agree" or higher) on the 1–7 response scale. Descriptive percentages at baseline and follow-up are not shown here because analyses focused on this dichotomized "high support" measure, which was used consistently across all models.

Results

Anxiety

Risk Factors

The following risk factors were independently associated with an increase in the likelihood of anxiety symptoms:

- Having been recently hospitalized due to a mental health condition (adjusted odds ratio [aOR]=1.54, 95% Confidence Interval [CI] = 1.05-2.23).
- Being unable to meet basic needs (aOR=2.51, 95% CI = 1.73 - 3.64).
- Having a history of houselessness (aOR=1.41, 95% CI = 1.10 - 1.81).
- Being discriminated against because of sexual orientation (aOR=1.48, 95% CI = 1.09 - 2.02).
- Being physically threatened because of gender identity (aOR=1.96, 95% CI = 1.42 - 2.72).

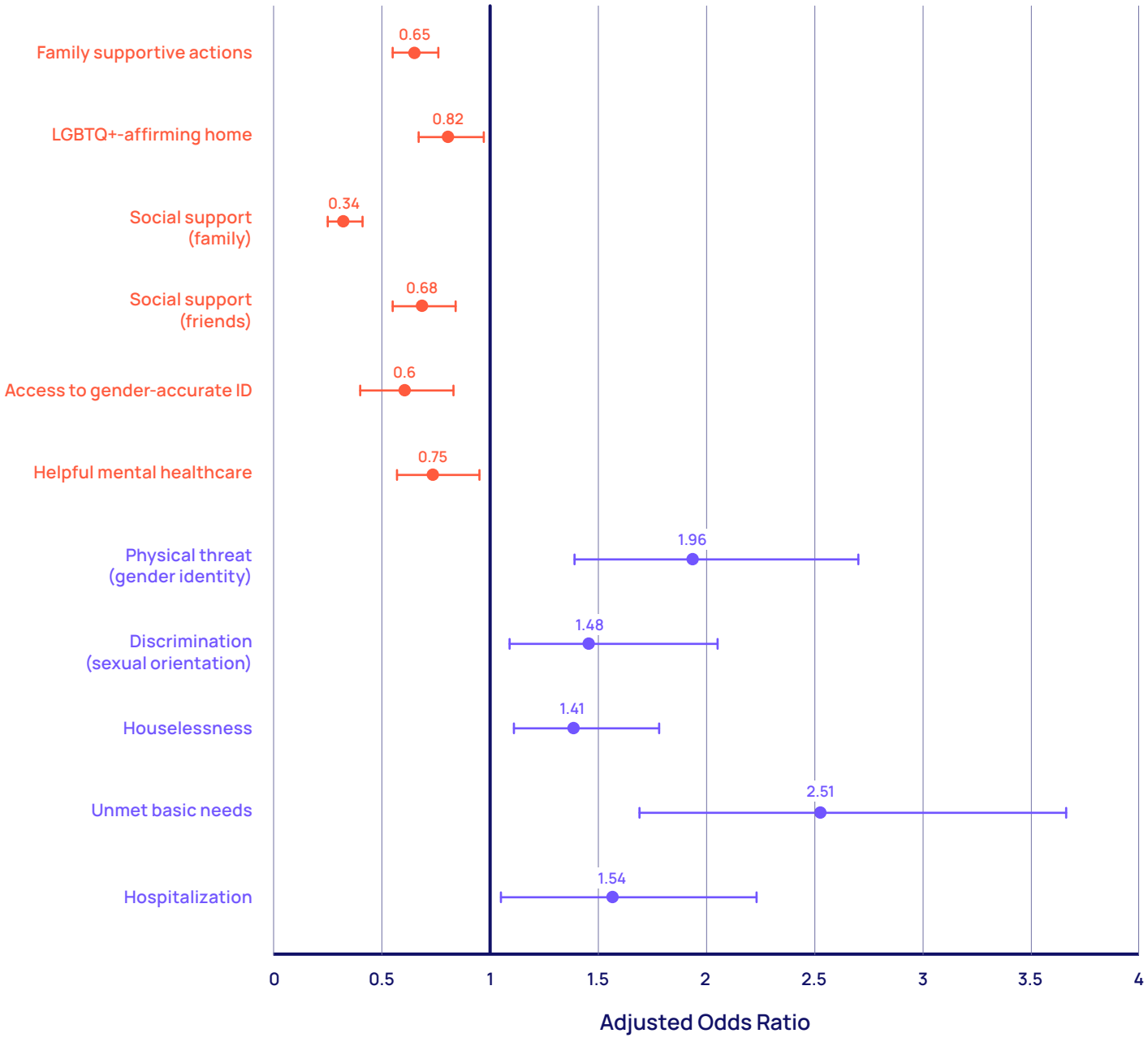
Protective Factors

The following factors were independently associated with a reduction in the likelihood of anxiety symptoms:

- Receiving mental health care that was found to be helpful (aOR=0.75, 95% CI = 0.58-0.97).
- For TGNB participants, having access to gender-accurate identification documents (aOR=0.60, 95% CI = 0.43-0.83).
- Receiving high support from friends (aOR=0.68, 95% CI = 0.55-0.84).
- Receiving high support from family (aOR=0.34, 95% CI = 0.28-0.41).
- Living in an LGBTQ+-affirming home (aOR=0.82, 95% CI = 0.68-0.98).
- Experiencing supportive actions from family (aOR=0.65, 95% CI = 0.55-0.76).

Results

Factors Associated with Changes in Anxiety among LGBTQ+ Young People



Results

Depression

Risk Factors

The following risk factors were independently associated with an increase in the likelihood of depressive symptoms:

- Being unable to meet basic needs (aOR=2.17, 95% CI = 1.52 - 3.12).
- Having ever been threatened with or subjected to conversion therapy (aOR=1.28, 95% CI = 1.01 - 1.55).
- Being discriminated against because of sexual orientation (aOR=1.37, 95% CI = 1.07-1.75).
- Being physically threatened because of sexual orientation (aOR=1.47, 95% CI = 1.13-1.90).
- Being physically threatened because of gender identity (aOR=1.61, 95% CI = 1.17-2.20).

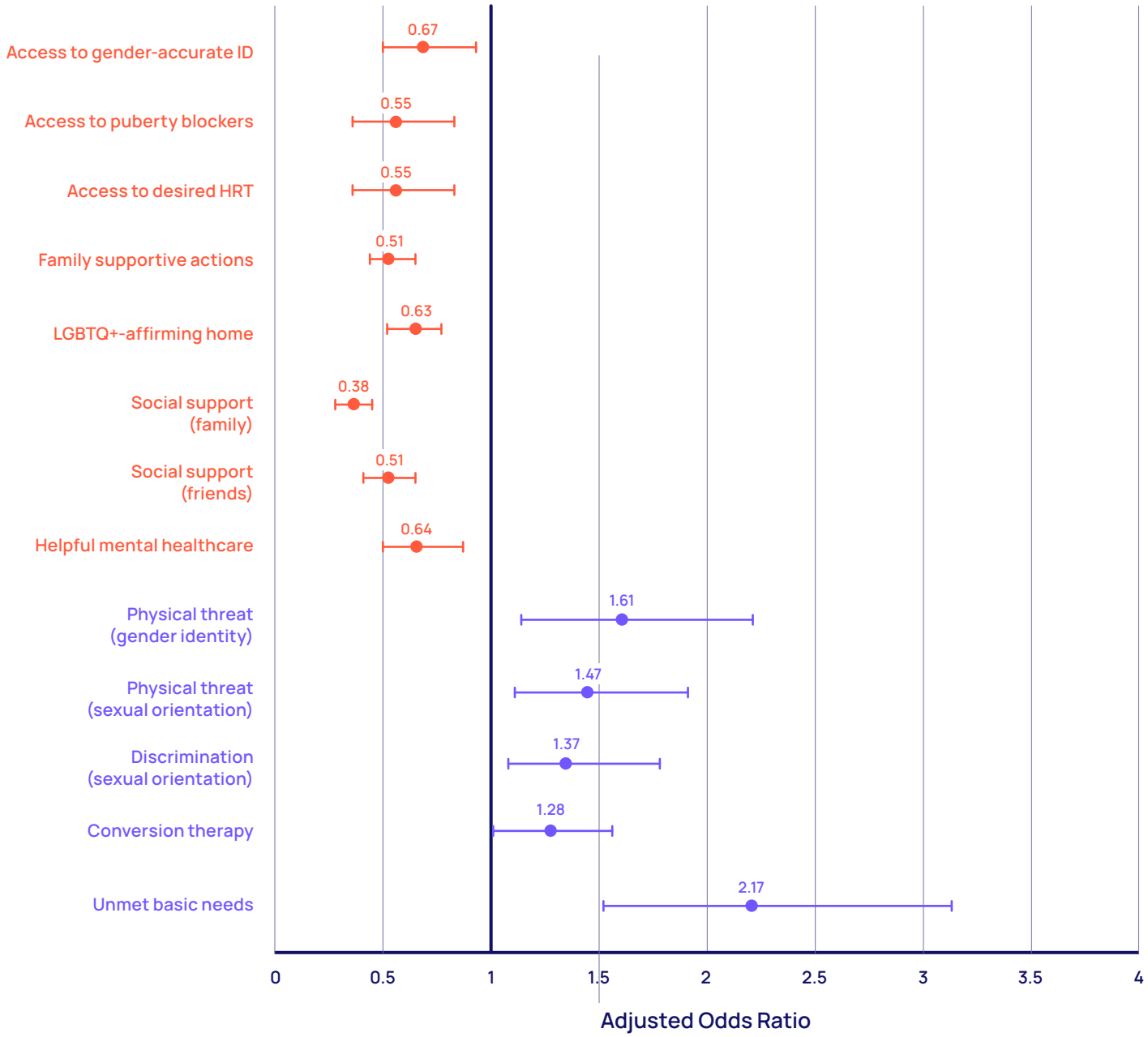
Protective Factors

The following factors were independently associated with a reduction in the likelihood of depressive symptoms:

- Receiving mental health care that was found to be helpful (aOR=0.64, 95% CI = 0.50-0.82).
- Receiving high support from friends (aOR=0.51, 95% CI = 0.41-0.62).
- Receiving high support from family (aOR=0.38, 95% CI = 0.31-0.46).
- Living in an LGBTQ+-affirming home (aOR=0.63, 95% CI = 0.52-0.74).
- Experiencing supportive actions from family (aOR=0.51, 95% CI = 0.44-0.60).
- For TGNB participants, having access to desired hormones (aOR=0.55, 95% CI = 0.38-0.80) and puberty blockers (aOR=0.55, 95% CI = 0.38-0.80).
- For TGNB participants, having access to gender-accurate identification documents (aOR=0.67, 95% CI = 0.50-0.90).

Results

Factors Associated with Changes in Depression among LGBTQ+ Young People



Results

Suicidal Ideation

Risk Factors

The following risk factors were independently associated with an increase in the likelihood of suicidal ideation:

- Being unable to meet basic needs (aOR=1.72, 95% CI = 1.18 -2.49).
- Having a history of houselessness (aOR=3.01, 95% CI = 2.21-4.08).
- Having ever been threatened with or subjected to conversion therapy (aOR=2.17, 95% CI = 1.76-2.67).
- Being discriminated against because of sexual orientation (aOR=1.35, 95% CI = 1.03-1.76).
- Being discriminated against because of gender identity (aOR=1.48, 95% CI = 1.07-2.05).
- Being physically threatened because of sexual orientation (aOR=2.10, 95% CI = 1.58 - 2.78).
- Being physically threatened because of gender identity (aOR=2.85, 95% CI = 2.03-4.00).

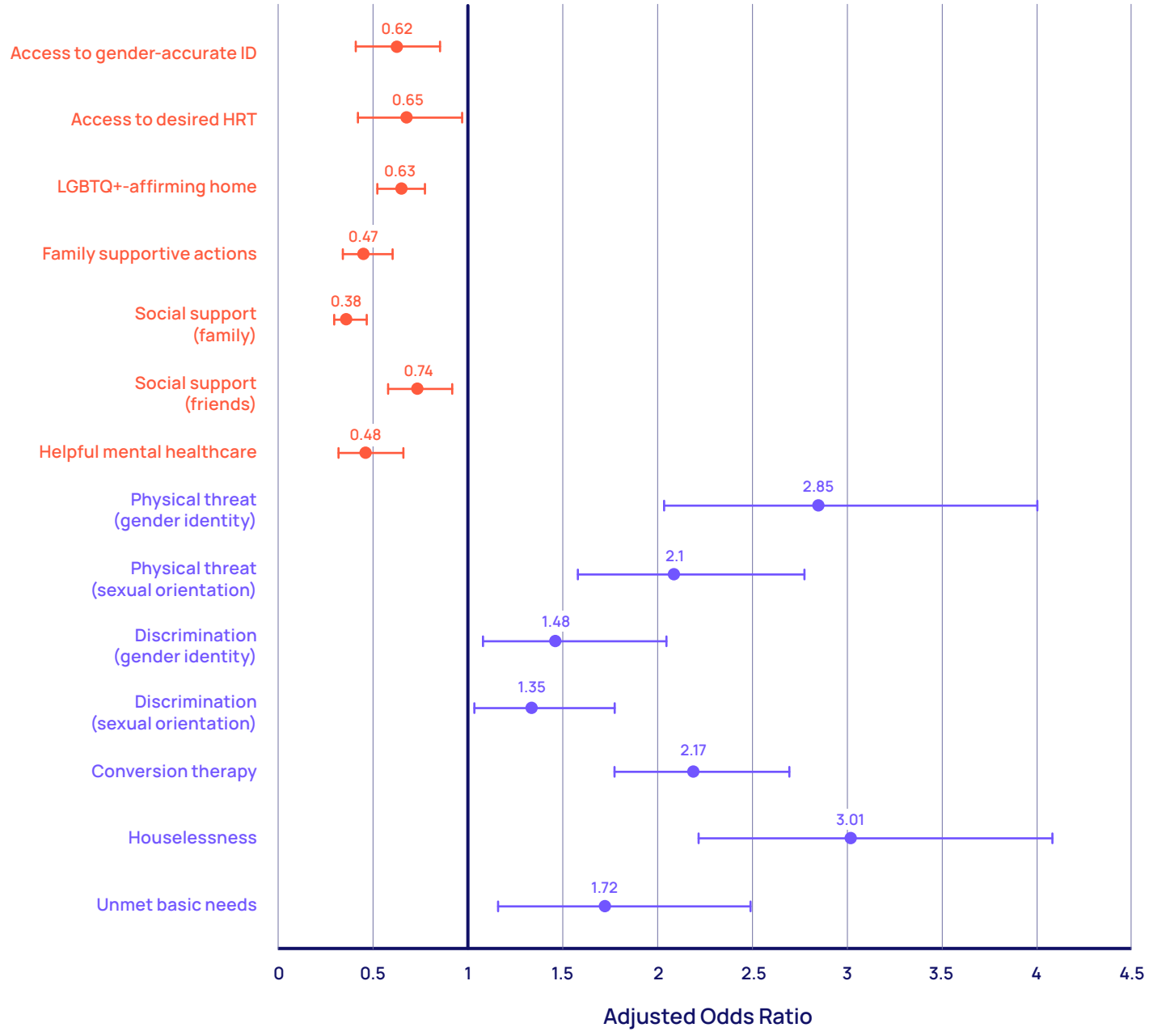
Protective Factors

The following factors were independently associated with a reduction in the likelihood of suicidal ideation:

- Receiving mental health care that was found to be helpful (aOR=0.48, 95% CI = 0.37-0.62).
- Receiving high support from friends (aOR=0.74, 95% CI = 0.59-0.92).
- Receiving high support from family (aOR=0.38, 95% CI = 0.33-0.46).
- Living in an LGBTQ+-affirming home (aOR=0.63, 95% CI = 0.52-0.74).
- Experiencing supportive actions from family (aOR=0.47, 95% CI = 0.39-0.56).
- For TGNB participants, having access to desired hormones (aOR=0.65, 95% CI = 0.44 - 0.97).
- For TGNB participants, having access to gender-accurate identification documents (aOR=0.62, 95% CI = 0.45-0.84).

Results

Factors Associated with Changes in Suicidal Ideation among LGBTQ+ Young People



Interpretations and Implications

This longitudinal study that followed 1,689 LGBTQ+ young people ages 13 to 24 in the U.S. from September 2023 to March 2025, captured three waves of data at six-month intervals. Findings highlight both alarming increases in mental health concerns and suicide risk, as well as critical insights into protective factors and systemic barriers faced by LGBTQ+ youth amid a shifting sociopolitical landscape.

Worsening Mental Health and Suicide Risk

Over the one-year period, symptoms of anxiety, depression, and suicidal ideation significantly increased among participants. Anxiety symptoms rose from 57% to 68%, depressive symptoms increased from 48% to 54%, and suicidal ideation rose from 41% to 47%. While suicide attempts declined slightly over the study period (11% to 7%), the overall prevalence remains concerningly high. These increases in mental health distress may reflect escalating social and political pressures facing LGBTQ+ young people, particularly during a period marked by increased legislative targeting of LGBTQ+ rights across the U.S. (Movement Advancement Project, 2025).

These trends may also be linked to broader economic uncertainty (Center on Budget and Policy Priorities, 2024) and a reduction in access to affirming spaces due to sociopolitical shifts following the 2024 presidential election. Prior research has shown that anti-LGBTQ+ policy rhetoric can contribute to significant psychological distress among LGBTQ+ youth (Hatzenbuehler et al., 2010; Russell & Fish, 2016).

Disparities Across Subgroups

Across mental health outcomes, TGNB youth and younger participants (ages 13-17) consistently reported higher levels of distress than their cisgender and older peers. For example, at baseline, TGNB youth were nearly twice as likely to report anxiety (70% vs. 42%) and suicidal ideation (53% vs. 28%) compared to cisgender peers, a pattern that persisted a year later. In addition, youth ages 13 to 17 were more likely than those ages 18 to 24 to report suicide attempts, depression, and anxiety at baseline – and continued to report higher rates of suicide attempts and anxiety one year later. Sexual orientation also played a role: gay and lesbian participants generally reported lower levels of mental health distress, while bisexual, pansexual, and queer youth experienced significantly higher rates.

Interpretations and Implications

These findings align with a substantial body of research showing that both TGNB young people and bisexual youth are at significantly greater risk for depression, anxiety, and suicidal thoughts and attempts compared to cisgender and gay/lesbian peers (Feinstein & Dyar, 2017; Liles et al., 2024; Veale et al., 2017). For TGNB youth, elevated risk is attributed to experiences of gender-based discrimination, victimization, and barriers to transgender health care (Nath et al., 2024), while bisexual youth face unique stressors such as erasure and invalidation from both heterosexual and gay/lesbian communities (Price et al., 2021). Younger LGBTQ+ adolescents are also particularly vulnerable, with studies indicating that mental health disparities emerge early and may be exacerbated by limited access to supportive environments and affirming resources (McDermott et al., 2021; Russell & Fish, 2016).

Notably, while race/ethnicity was not associated with depression or suicidal ideation at baseline, by Wave 3, White youth reported higher rates of both compared to youth of color.

Persistent Minority Stress

LGBTQ+ youth in this study experienced persistently high levels of violence and discrimination. Roughly one-third of participants reported harassment or threats because of their sexual orientation both at baseline (31%) and again one year later (32%), while about two-fifths reported gender-identity-based victimization at both time points (43% and 42%). Discrimination was even more pervasive: about 55% of participants experienced sexual-orientation discrimination at both baseline and one year later, while roughly two-thirds of TGNB respondents faced gender-identity discrimination at each time point (62% and 67%). These burdens were especially severe for TGNB youth and youth of color. Experiences of victimization and discrimination are well-established drivers of minority stress and mental health disparities in LGBTQ+ youth (Poteat et al. 2020, Russell & Fish, 2016). These findings mirror national survey data and reinforce the urgent need for systemic anti-bullying and anti-discrimination policies (Kosciw et al., 2020, 2022; Nath et al., 2024; The Trevor Project, 2023a).

Conversion therapy exposure in this cohort is deeply troubling. By Wave 3, almost one-quarter of participants (22%) had been threatened with conversion therapy and 15% had actually experienced it – 11 and 6 percentage-point increases, respectively, since baseline. LGBTQ+ young people of color reported

Interpretations and Implications

the highest levels of both threats and exposure. Given that every major medical and psychological association condemns conversion therapy (The Trevor Project, 2023b) and links it to severe mental health harm (Green et al., 2020), these rates demand urgent attention. The uptick may stem from the recent weakening or uneven enforcement of state and local bans, along with a resurgence of anti-LGBTQ+ rhetoric that may have emboldened some providers and faith-based groups to resume or expand these practices. Because the study relies on a non-probability sample, the exact percentages may not represent all LGBTQ+ youth; nonetheless, the pattern signals a serious and growing risk within this population.

Economic insecurity emerged as a growing concern over the study period. At baseline, 14% of participants reported lacking basic necessities, and 21% experienced such hardship during the subsequent year. Houselessness followed a similar pattern: 21% at baseline reported being unhoused currently or at some point in the past, and 10% reported an episode of houselessness during the follow-up year. Youth ages 18 to 24, TGNB participants, and youth of color reported higher rates than youth ages 13 to 17, cisgender participants, and White youth. Economic instability has been repeatedly shown to heighten suicide risk among LGBTQ+ youth (The Trevor Project, 2025). The uptick in economic insecurity likely reflects the combined impact of 2024–25 cost-of-living spikes (The Hope Center for Student Basic Needs, 2025) and anti-LGBTQ+ discrimination in housing and employment (Human Rights Watch, 2025). These pressures disproportionately affect TGNB youth and youth of color, while young adults ages 18 to 24 experience greater economic strain than 13 to 17 year-olds because they are often aging out of family homes and must secure other housing on their own.

Barriers and Progress in Access to Care

Access to mental health care remained a major challenge. While 81% of youth expressed a desire for mental health care at baseline, and 80% reported accessing it at some point, only 60% who wanted care received it during the subsequent year. Persistent demographic disparities were evident throughout the study period. Younger participants (ages 13–17), cisgender youth, and youth of color consistently reported lower rates of accessing desired mental health care. These disparities remained after a year, highlighting ongoing systemic inequities such as affordability issues, provider bias, and prior negative experiences as enduring barriers (Alencar Albuquerque et al., 2016; Dawes et al., 2023; Snow et al., 2019).

Interpretations and Implications

At follow-up, affordability remained the leading barrier and fear-based concerns were still common; additional obstacles (e.g., needing parent/caregiver permission and insurance denials) also featured prominently. Because follow-up measured recent experiences rather than lifetime exposure at baseline, these patterns indicate persistent — and in some cases intensifying — access problems.

Encouragingly, although a smaller share of LGBTQ+ youth obtained the mental health care they wanted within the past year than had ever accessed such care at baseline, the proportion who found that care helpful was higher. The proportion of youth who found mental health care helpful increased from 61% to 75% over the year. Helpful care is strongly associated with reduced depression, increased hope, and better coping (Craig et al., 2021). However, younger participants rated their care as less helpful than older peers, highlighting ongoing gaps in youth-centered, developmentally appropriate services.

Mental health-related hospitalizations also revealed disparities. Although only 4% of youth were hospitalized due to a mental health condition during the follow-up, those with prior mental health-related hospitalizations were much more likely to be hospitalized again, particularly TGNB youth. This points to gaps in post-hospitalization support, as well as the need for outpatient and preventative supports for youth with acute mental health needs.

For TGNB youth, access to medical, legal, and social supports for gender transition improved modestly over the year. Among those who initially lacked access, 59% obtained tools related to their gender expression or transition and 36% accessed hormones within one year. However, access varied widely by age, gender identity, and sexual orientation, with younger TGNB youth (ages 13-17) being much less likely to access hormones than older peers. These disparities reflect structural barriers (such as state laws and clinical policies), developmental factors (Durwood et al., 2021; Turban et al., 2020), and younger TGNB youth's greater reliance on parental support when accessing transgender health care.

Environmental and Identity-Based Supports as Protective Factors in LGBTQ+ Youth Outcomes

Only about half of the participants had access to LGBTQ+-affirming environments – both in school and at home. While school affirmation rose modestly from 53% at baseline to 58% a year later, home affirmation did not change. Family support emerged as a critical but uneven resource: youth reported an average of only 1.9 supportive family actions (on a scale of

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4-point scale) – closer to "some" than "most" – and this level barely changed over the study year. Support was lowest for younger adolescents and TGNB youth, both of whom remain at highest risk for poor mental health outcomes. The relative rarity of this support does not diminish its importance however, as each one-point of support on the family-support actions scale was associated with 53% lower odds of suicidal ideation over time. Even small increases in specific affirming behaviors (e.g., using chosen names, respectful conversation about identity) are linked to sharp drops in suicide risk (Ryan et al., 2010).

Gender euphoria also increased over the year. This suggests that, despite external stressors, some youth are experiencing greater self-acceptance and affirmation, possibly due to increased internal resilience or support from peers and online communities. Peer connections – especially friends – are a cornerstone of support. When experiencing suicidal thoughts, participants turned to friends more than any other source, and this reliance grew markedly over time, outpacing increases for parents. These findings underscore the value of moderated peer platforms such as TrevorSpace - safe, scalable communities in which youth support each other and generate their own content – which complement clinical care and can especially reach younger adolescents who are least likely to access professional services.

Over the study's first year, more LGBTQ+ youth reached out for support during suicidal crises, speaking of the rising need for support. Over the course of a year, contacts with mental health professionals doubled, and appeals to friends, partners, and family all jumped sharply. This pattern mirrors data from The Trevor Project's crisis lines where a 700% spike in crisis contacts was logged in the days after the 2024 election (Alfonseca, 2024). The finding signals that young people's desire for help is growing just as many LGBTQ+-affirming programs face cuts or bans, underscoring the urgency of protecting and expanding accessible, confidential services – especially for younger teens, who remain least likely to secure professional care.

Temporal Relationships and Causal Insights

Longitudinal analyses confirmed that risk factors – including discrimination, economic insecurity, violence, and conversion therapy – directly contributed to worsening mental health. Youth facing unmet basic needs, physical threats, or discrimination were significantly more likely to experience anxiety, depression, and suicidal ideation over time. Prior mental health-related hospitalization predicted higher levels of anxiety –

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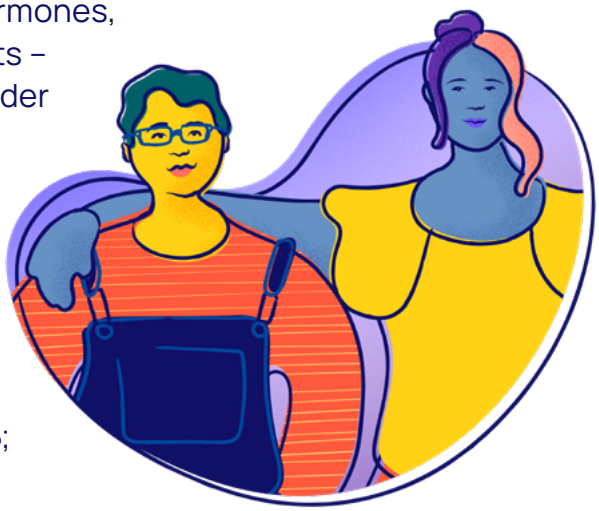
likely reflecting ongoing psychological distress, limited access to outpatient care, or fear of future hospitalization (Daughtrey et al., 2024).

Conversely, protective factors played a clear role in reducing mental health symptoms over time. Youth who received helpful mental health care were significantly less likely to experience anxiety, depression, or suicidal ideation. Access to medical, legal, and social supports for gender transition – including hormones, puberty blockers, and accurate identification documents – contributed to improved mental health among transgender and nonbinary youth, highlighting the potential harm created by legislation reducing access to transgender health care and accurate identification documents. Supportive family environments, accepting friends, and greater cumulative family support actions all reduced the likelihood of anxiety, depression, and suicidal ideation, echoing decades of research on the protective power of family acceptance (Nath et al., 2025; Ryan et al., 2010; Snapp et al., 2015).



Broader Context and Policy Implications

The worsening mental health trends documented here must be understood within the context of growing sociopolitical hostility toward LGBTQ+ youth, particularly transgender and nonbinary individuals. State-level legislative attacks, public policy debades, and media coverage have compounded internal experiences of marginalization, especially for youth at the intersection of multiple identities (Dhanani & Totton, 2023; Moran et al., 2025; Roche et al., 2024). Research has shown that inclusive state policies and school climates are protective, while exclusionary or hostile environments increase risk (Kosciw et al., 2022; Lee et al., 2024; Moran et al., 2025).

At the same time, the data offer hope: access to mental health care and transgender health care, supportive relationships, and affirming environments not only mitigate distress but promote resilience. These findings echo the minority stress model (Meyer, 2003), which emphasizes the dual impact of stressors and resilience-promoting factors on LGBTQ+ well-being.

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Limitations

Despite its strengths, this study has some important limitations. First, these findings represent an interim analysis and reflect only the first three waves of this longitudinal study; additional data from upcoming waves may alter observed trends and associations. Second, all measures rely on self-report, which can introduce recall bias or social-desirability effects, particularly around sensitive topics such as suicide or conversion therapy. Although validated screeners and standardized items help maximize reliability, objective linkage to administrative or clinical data would be needed to confirm hospitalization and treatment histories.

Attrition over time is another key limitation. Generalized linear mixed models (McCulloch & Searle, 2004) allow participants to contribute data even if they did not complete one or more follow-up surveys. These estimates are valid if the missing data can be explained by variables we observed – that is, the data are "missing at random" given measured factors such as age or baseline symptoms. However, if people who stopped participating differ from those who remained in ways we did not measure, the results could be biased. Also, the sample, though large and diverse, is not nationally representative; recruitment was primarily online, which may exclude youth without reliable internet access, limiting generalizability. For this reason, the point prevalences should not be generalized to LGBTQ+ young people broadly, but rather what is learned in terms of which factors are associated with mental health and suicide and how they change over time.

Finally, while the longitudinal design allows for examination of associations over time, causal inferences remain limited due to possible unmeasured confounding and the observational nature of the study. The broader sociopolitical context – including significant anti-LGBTQ+ legislation and rhetoric during the study period – likely influenced participants' experiences and mental health, but the study was not designed to isolate the effects of specific external events or policies. These limitations highlight the need for cautious interpretation and underscore the importance of continued data collection and analysis in future waves.

Recommendations and Next Steps

The patterns emerging from Waves 1-3 underscore the importance of policy, practice, and research initiatives that move beyond crisis response to structural prevention. States that already offer comprehensive nondiscrimination protections for LGBTQ+ people show measurably lower rates of depressive symptoms and safer school climates among LGBTQ+ adolescents, validating calls for federal and state action to codify such protections across education, housing, employment, and health care sectors (Moran et al., 2025). Parallel legislative priorities include explicit statutory bans on conversion therapy for minors. Economic-evaluation modeling indicates that conversion therapy practices not only double the odds of suicide attempts but also impose billions of dollars in avoidable humanistic and health-system costs in the U.S. each year (Forsythe et al., 2022).

Clinical access must keep pace with policy change. Prospective and cohort evidence continues to demonstrate that timely, guideline-concordant transgender health care – whether puberty blockers during early adolescence or gender-affirming hormone therapy in later adolescence and young adulthood – produces clinically meaningful reductions in moderate-to-severe depression and suicidal thoughts and attempts (Reisner et al., 2025; Turban et al., 2020). Ensuring that such care remains legally protected, financially affordable, and geographically accessible is therefore a suicide prevention imperative.

Schools remain a daily context in which this cohort lives, learns, and, too often, experiences victimization. Large statewide datasets show that the mere presence of a Gender Sexuality Alliance (GSA) corresponds with better school functioning, lower substance use, and improved mental health for all students, with the largest benefits among LGBTQ+ youth themselves (Baams & Russell, 2021). Investment in GSAs, LGBTQ+-inclusive curricula, and staff-wide training in trauma-informed, affirming practices should be integrated into every district's continuous improvement plan. Outside of school, culturally responsive mental health services must be scaled. Hybrid and fully web-based models are particularly well suited to rural areas and to youth who face stigma-related barriers to in-person care (Chaiton et al., 2023).

Family environments exert a particularly important influence. Long-term follow-ups show that specific parental acceptance behaviors in adolescence – such as using a youth's chosen name and pronouns – cut the odds of suicide attempts by more than half and promote higher self-esteem and general health (Ryan et al., 2010). Public health agencies should therefore prioritize dissemination of empirically tested family-acceptance curricula, with outreach tailored to families of color and faith-based communities.

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Economic insecurity and housing instability magnify all other risks. National survey data reveal that LGBTQ+ young people who experience houselessness or unstable housing have two to three times the odds of considering or attempting suicide compared with peers in stable housing (DeChants et al., 2021). Sustainable funding for LGBTQ+-inclusive rapid rehousing programs, drop-in centers, and basic needs stipends must accompany any mental health strategy, and mental health supports should be embedded directly into these programs to reduce access barriers.

Community level safety nets also matter. Twenty-four-hour crisis lines, chat, and text services staffed by LGBTQ+-affirming responders must be preserved as core public health infrastructure. In July 2025, federal officials ended the 988 Suicide & Crisis Lifeline's national "Press 3" pathway that routed LGBTQ+ youth to specially trained counselors – removing a dedicated option at the very moment need is rising. 988 is a tool in a broader suicide prevention system: round-the-clock call, text, and chat services must be adequately funded and staffed, with rigorous training, so responders can deliver best-practice care for high-risk populations. States and the federal government should restore and sustain specialized services for at-risk populations within 988. Given the clear growth in help-seeking in our data, ensuring that youth who reach out actually reach someone equipped to help is both urgent and achievable.

In addition to the recommendations outlined above, it is important to emphasize that this report represents interim findings in The Trevor Project's ongoing longitudinal study, with additional waves of data collection still to come. As the study progresses through additional waves, we will be able to track participants' experiences over a longer period, allowing for more robust analyses of how risk and protective factors change over time. This deeper understanding will be invaluable for informing policies and programs that can make a lasting difference in the lives of young people.

We want to reinforce the critical value of continued participation from our cohort. Consistent involvement from participants ensures that the study's findings are as accurate and meaningful as possible, capturing the full range of experiences and

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changes that occur over time. Every voice matters, and ongoing engagement will help ensure that the final report reflects the diversity and resilience of LGBTQ+ youth across the country. We encourage all participants to remain involved through the final waves, as their contributions will directly inform future resources, advocacy, and support for LGBTQ+ young people nationwide.

By staying engaged, participants are not only helping to advance scientific understanding but are also supporting a stronger, more informed movement for LGBTQ+ youth well-being. The Trevor Project is deeply grateful for the commitment and honesty of everyone involved, and we look forward to sharing more comprehensive and actionable insights once the study is complete.

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THE TREVOR PROJECT

The Trevor Project is the leading suicide prevention organization for lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQ+) young people.

We provide 24/7 crisis services for LGBTQ+ young people via a phone lifeline, text, and chat. We also operate innovative research, advocacy, public training, and peer support programs.

Crisis Services

Peer Support

Research

Advocacy

Education and Public Awareness