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ORIGINAL ARTICLE

Homelessness, Mental Health and Suicidality Among LGBTQ Youth Accessing Crisis Services

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Abstract

LGBTQ youth experience increased risks of homelessness, mental health disorder symptoms, and suicidality. Utilizing data from LGBTQ youth contacting a suicide crisis services organization, this study examined: (a) rates of homelessness among crisis services users, (b) the relationship between disclosure of LGBTQ identity to parents and parental rejection and homelessness, and (c) the relationship between homelessness and mental health disorder outcomes and suicidality. A nationwide sample of LGBTQ youth was recruited for a confidential online survey from an LGBTQ-focused crisis services hotline. Overall, nearly one-third of youth contacting the crisis services hotline had experienced lifetime homelessness, and those who had disclosed their LGBTQ identity to parents or experienced parental rejection because of LGBTQ status experienced higher rates of homelessness. Youth with homelessness experiences reported more symptoms of several mental health disorders and higher rates of suicidality. Suggestions for service providers are discussed.

Keywords LGBTQ youth · Homelessness · Suicidality · Mental health · Crisis services

Introduction

Lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth experience a disproportionate burden of negative health and mental health outcomes [1–3]. In particular, suicide among LGBTQ youth is a major public health crisis, with rates of suicide attempt or ideation 4 times higher than those of heterosexual and cisgender youth [4]. Some studies indicated as many as 40% of transgender individuals have attempted suicide in their life [5].

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Similarly, homelessness among LGBTQ youth specifically is a major public health concern, with estimated rates of past-year homelessness among LGBTQ youth as high as 30–45% [6, 7] and evidence of a clear link between homelessness and poorer mental health for these youth. For example, gender or sexual minority homeless youth experience depression (OR 2.18; CI 1.28, 3.71) [8, 9], depressive symptoms [10], posttraumatic stress disorder (PTSD) [9], and several domains of psychopathology (e.g., anxiety, aggression, internalizing and externalizing behaviors, and overall Youth Self Report scores) [11] at much higher rates than their cisgender and heterosexual homeless counterparts [8–12]. Using the Brief Symptom Inventory with homeless LGBTQ youth, Bidell [12] found that nearly two-thirds (64.3%) had clinically elevated Global Severity Index scores, suggesting greater overall mental health distress and symptoms and elevated scores in specific subdomains of depression, paranoid ideation, and psychoticism.

Unfortunately, a relationship also exists between LGBTQ youth homelessness and suicidality [9, 11], with rates of suicidal ideation among homeless LGBTQ youth 9–20% points higher than those of non-LGBTQ homeless youth [8, 9]. Disparities in suicidality between LGBTQ and non-LGBTQ homeless youth are particularly troubling given that rates of suicidality among homeless youth are already higher than

those of housed youth [13–15]. The relationship between experiences of homelessness and negative mental health outcomes among LGBTQ youth is complicated by the fact that LGBTQ youth often experience homelessness because of parental rejection or other home-based issues related to their sexual orientation or gender identity [16–18], and parental rejection and poor home environment have been associated with negative mental health outcomes for LGBTQ youth [19].

Crisis services for persons experiencing suicidality, including services specifically for LGBTQ populations, have become more commonly available during the past 60 years [20]. The crisis services organization involved in this research serves LGBTQ youth and has more than 50,000 crisis services contacts each year. Given the widespread access to mobile devices among homeless youth (e.g., cell phones) [21, 22] and the overrepresentation of LGBTQ youth in that population [6, 7], it is likely that LGBTQ-focused crisis services programs are serving a large contingent of young people experiencing homelessness; however, research has not examined the prevalence of homelessness among LGBTQ youth using crisis services.

In their efforts to address suicidality, it is unclear whether crisis services providers address issues of homelessness directly (e.g., assessing housing status or providing housing resources to those in need). At the same time, research has suggested an inability of homelessness service providers to adequately meet the needs of LGBTQ youth [23] and those experiencing suicidality [24]. As such, there is a need to better understand the needs of LGBTQ youth experiencing homelessness and using suicide crisis services. We addressed three research questions that have not been well described in the literature:

1. What are the characteristics of homelessness among LGBTQ youth accessing crisis services (e.g., frequency and type of homelessness experiences, demographic characteristics associated with experiences of homelessness)?
2. What is the relationship between parental rejection and disclosure to parents of LGBTQ identity and homelessness among LGBTQ youth using crisis services?
3. What is the relationship between homelessness and mental health outcomes, including suicidality, for LGBTQ youth using crisis services?

Methods

This university institutional review board-approved study relied on a national sample of youth (aged 12–24) obtained from an LGBTQ youth-focused suicide crisis prevention service provider during an 18-month period (September 2015 to April 2017). Services available through this provider include a 24/7 crisis phone line, daily chat or text crisis services staffed by trained counselors, and an online social networking platform and resource center (respondents were recruited through phone and chat or text crisis services only). After crisis contact with the organization, eligible individuals were transferred to an automated survey to complete a brief demographic screener (i.e., age, race and ethnicity, gender identity, sexual orientation, zip code). Eligible youth were those for whom a mandated child abuse report was not being made and who were not currently at immediate suicide risk (defined as intent and plan in the next 48 h). Eligible youth were then asked (via a prerecorded message) if they would consider participating in a study of the needs of LGBTQ youth, and if so, to provide contact information (email or phone number). Of all eligible crisis services contacts during the study recruitment period, 37% were referred to the demographic and contact information screener (see Fig. 1). Case-by-case reasons that eligible contacts were not referred to the survey were not collected by the service provider, but available data suggested the primary reasons were because the call, chat, or text was dropped or otherwise ended abruptly or because the counselor forgot to offer the screener. Of those referred, 96% completed the screener, and 31% of those youth agreed to be contacted for the study. Of those who agreed to be contacted, 32% were ineligible (because of missing crisis services data, age, or because they were duplicate contacts) and 9% provided incomplete or invalid contact data; the remaining 59% were contacted for study participation ($n = 2008$).

Demographic and contact data of participants who agreed to be contacted was provided to the study team by the crisis services organization. Upon contact, research assistants (RAs) identified the principal investigator's (PI) institution and research lab and stated that the youth had recently agreed to be contacted about a research study. To maintain confidentiality, the youth was required to identify the crisis services organization's name before proceeding. Fewer than 4% of youth contacted could not remember the name of the organization or were unsure about why they were being contacted; individuals who could not correctly cite the agency's name were told they could not participate and were thanked for their time.

Once identity was confirmed, RAs completed a rescreening to validate eligibility, reviewed an assent form with the participant, and requested verbal (for participants on the phone) or written (for chat, text, and email participants) consent. Slightly more than 4% declined to participate in the survey. After agreement, RAs completed a brief suicide risk assessment that followed the protocols of the crisis services provider, and those at imminent risk were immediately connected to a crisis counselor. All others were provided a link to participate in the survey measures. Participants received

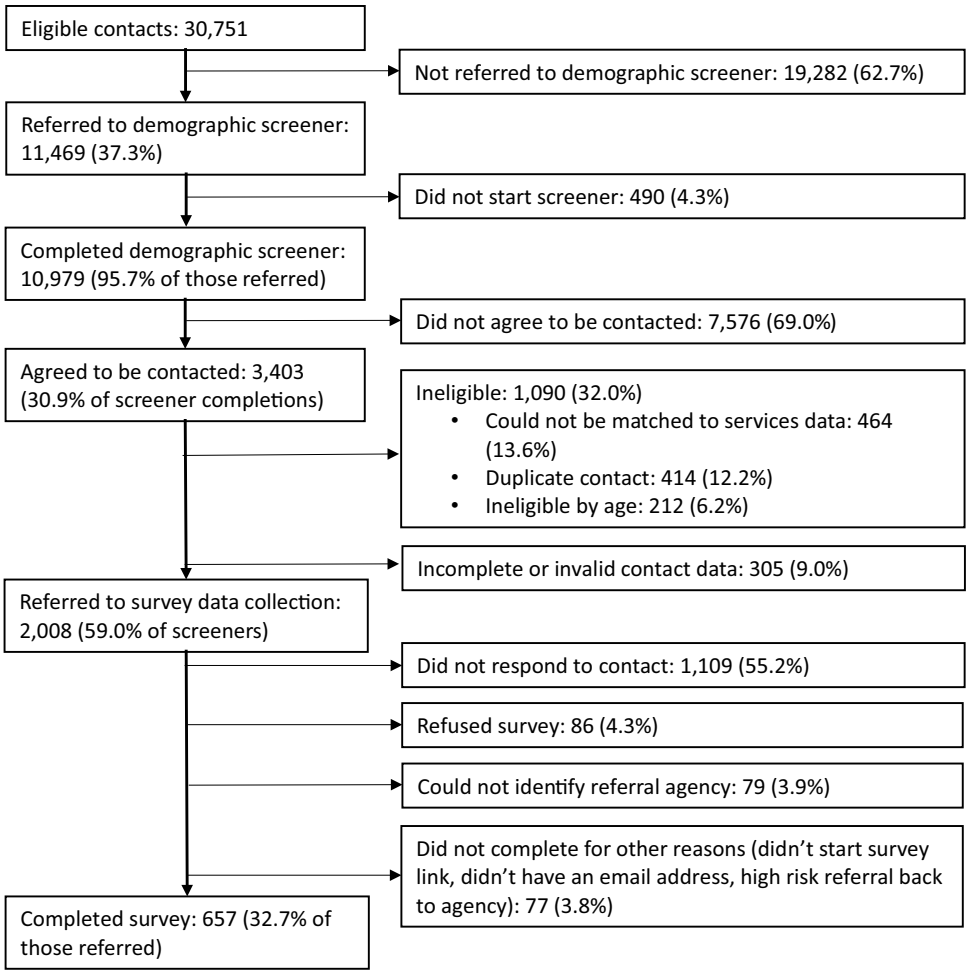

Fig. 1 Study recruitment

a $15 gift card incentive for participation. Overall, 33% of youth referred to the study completed the baseline survey ($n = 657$); the primary reason for not completing the survey was not responding to contact (55%).

Measures

Demographics

Demographic characteristics (age, race and ethnicity, gender identity, sexual orientation) were assessed with items created by the authors. The race and ethnicity item had six response options (Native American, American Indian, or Alaska Native; Asian or Pacific Islander; Black or African American; White; Latino or Hispanic; and race and ethnicity not listed here); respondents could choose all categories with which they identified. Youth who chose multiple racial and ethnic categories were coded as multiracial. For analytic purposes, this variable was collapsed into five categories (white, Latino or Hispanic, Black or African American, multiracial, and other race and ethnicity). Gender identity categories in the survey included male, female, transgender male, transgender female, genderqueer, questioning, don't know, and another gender identity. Youth were also asked for their sex assigned at birth. For analyses, we used the sex and gender identity items to create a variable with four categories: cisgender boy or man (cisman), cisgender girl or woman (ciswoman), trans-identifying (trans), and another gender identity. Sexual orientation categories in the survey included gay, lesbian, bisexual, queer, pansexual, straight, questioning, asexual, and other sexual orientation. For analyses, sexual orientation was collapsed into gay or lesbian, bisexual or pansexual, and other sexual orientation. To assess socioeconomic status, we used an item asking about free lunch: "Are you eligible for free or reduced-price lunch at school? (If you are no longer in school, please answer based on the last year you were in school)."

Sample Representativeness

Because of the relatively high rate of dropoff between crisis services contact and study participation—which was not altogether unexpected, given the known difficulties researchers have encountered in recruiting both LGBTQ populations

[25, 26] and those experiencing suicidal crises [27]—we undertook additional analyses in an attempt to identify how representative the study sample was of overall crisis services contacts at the referring organization. The organization does not collect demographic information from all crisis contacts, but does collect demographic information for those persons contacting via the agency's online chat modality. We compared the demographic profile of youth in the study contacted via chat to the organization's overall chat contacts (comparisons assessed age, race and ethnicity, sexual orientation, and gender identity). We also compared the overall suicide risk profile of all crisis services contacts to those in the study sample, because suicide risk profiles are available for all crisis services contacts. These analyses identified no statistically significant differences in suicide risk profiles, age, gender identity, or race and ethnicity between the study sample and the available larger population. Analyses identified a slightly higher rate of gay or lesbian youth in the study (36%) compared to the overall chat sample (28%), and a higher rate of pansexual youth (19 vs. 13%; $\chi^2 = 10.2$; $p = .03$). These analyses remained consistent when comparing both the overall study sample ($n = 657$; as previously presented) and the study sample in this manuscript ($n = 524$; smaller because homelessness measures were added after data collection began). We further assessed sample representativeness by comparing all youth who were successfully referred for study participation ($n = 2008$) to those who completed the survey ($n = 657$) and those in the current analysis ($n = 524$). Again, only the sexual orientation measure was statistically significantly different between the samples, with a higher rate of gay or lesbian youth in the main study sample (36%) compared to those who were referred (28%), and a lower rate of youth identifying as bisexual (17% in study sample, 28% in the referred sample; $\chi^2 = 45.2$; $p < .001$). These findings were consistent when comparing the referred sample to the smaller analytic sample used in this manuscript (same percentages; $\chi^2 = 37.4$; $p < .001$).

Homelessness and Housing Instability

The authors assessed experiences of homelessness and housing instability with two items adapted from previous research [7]: "Have you ever experienced homelessness?" and "Have you ever had to spend the night somewhere other than your home, *because you had nowhere else to stay*?" For these analyses, an affirmative response to either item was referred to collectively as "homelessness."

Youth who identified any lifetime homelessness were also asked if they had stayed in any of the following locations in their lifetime or in the past 30 days: (a) in a youth or adult shelter; (b) in a public place, such as a train, subway, or bus station, restaurant, or office building; (c) on public transportation (like riding a bus, subway, or train all night); (d) in an abandoned building or squat; (e) outside in a park, on the street, on the beach, under a bridge or overhang, on a rooftop, or some other outdoor place; (f) with someone you did not know (a stranger); (g) with friends, extended family, or other acquaintances (couch-surfing); (h) some other place, please specify: [fill in the blank]; or (i) none of these.

Disclosure and Rejection

To assess LGBTQ identity disclosure, we used an item created by the authors: "Do the following people know that you are LGBTQ? (a) your parent or parents, (b) siblings (sisters, brothers), (c) other relatives, (d) adult(s) at school, (e) peers at school, (f) people at work, (g) straight friends, (h) friends who are also LGBTQ, and (i) people online." Each response option could be answered "yes," "no," or "not applicable or do not have this person in my life." These analyses used a binary indicator of outness to parents, wherein those who indicated that their parents know they are LGBTQ were coded as 1, those who responded negatively to this item were coded as 0, and those who indicated this item was not applicable were coded as missing.

Whether respondents had been rejected by their parents for disclosing their LGBTQ identity was measured with two items created by the authors: "My mother (or female caregiver) does not accept me as LGBTQ" and "My father (or male caregiver) does not accept me as LGBTQ." An affirmative response to either or both questions was coded as an indicator of having experienced parental rejection because of being LGBTQ.

Mental Health and Suicidality

Mental health disorder symptoms were assessed with several survey scales. The Beck Hopelessness Scale Short Form (four items) assessed feelings of hopelessness about the future with true–false statements (e.g., "My future seems dark to me"); scoring for the Beck scale sums the number of true responses, for a range of 0–4 [28]. Symptoms of PTSD were measured using the Abbreviated PTSD Civilian Checklist, which contains six items about past-month responses to stressful life experiences (e.g., "How much have you been bothered by: Feeling distant or cut off from other people?") with Likert response options (1 = *not at all* to 5 = *extremely*) and scores ranging from 5 to 30 [29]. The Center for Epidemiologic Studies Depression Scale Short Form (CES-D-4) measured the frequency of past week depression symptoms (0 = *rarely or none of the time* [less than 1 day] to 3 = *most or all of the time* [5–7 days]) with four items (e.g., "I felt lonely"), resulting in scores of 0–12 [30]. Thwarted belonging (five items, e.g., "These days, I feel disconnected from other people") and perceived burdensomeness (five items, e.g., "These days the people in my life would be better off if

I were gone") were measured using the Interpersonal Needs Questionnaire (INQ) [31]. Each construct is scored with Likert response options (1 = *not at all true of me* to 7 = *very true for me*) and has a range of 5–35. Three thwarted belonging items were reverse coded so that higher scores indicated more feelings of thwarted belonging.

Suicidal thoughts and attempts were measured with items adopted or adapted from the Columbia-Suicide Severity Rating Scale (C-SSRS) [32] and the Suicide Behaviors Questionnaire-Revised (SBQ-R) [33]. An adapted C-SSRS item assessed presence of any lifetime suicide attempt ("Have you ever tried to kill yourself?"). An adapted SBQ-R measure assessed self-rated likelihood of future suicide attempt ("How likely is it that you will attempt suicide someday? (a) no chance at all, (b) rather unlikely, (c) unlikely, (d) likely, (e) rather likely, (f) very likely"). For these analyses, a dichotomous indicator of likely, rather likely, or very likely vs. other responses was created.

Analysis

The overall number of respondents in these analyses ($n = 524$) is smaller than the overall study sample ($n = 657$) because the survey items assessing homelessness were added after data collection had begun. Bivariate analyses (Chi square and *t* tests, depending on variable type) assessed for statistically significant differences by homelessness in demographic characteristics, disclosure and rejection, mental health, and suicidality. For all disclosure and rejection, mental health, and suicidality variables wherein a statistically significant bivariate relationship was detected, subsequent multivariable regression analyses (linear, logistic, and multinomial logistic, depending on outcome variable type) assessed relationships with homelessness, adjusting for demographic characteristics. All analyses were conducted in Stata version 14 [34].

Results

Descriptive Results

Participant characteristics are shown in Table 1. Participants were 17.6 years of age on average ($SD = 3.10$; range 12–24), and were mostly cisgender women (34%), followed by cisgender men (22%), trans youth (23%), and youth who reported another gender identity (21%). Most youth identified as White (63%). The most common sexual orientation endorsed was gay or lesbian (36%), followed by bisexual (17%), pansexual (18%), questioning (8%), and other sexual orientations (21%). Thirty-two percent of youth were eligible for a free or reduced-price lunch at school, and 32% had ever experienced homelessness. Fifty-nine percent of respondents reported that their parents were aware of their LGBTQ identity, and 49% of all respondents had experienced parental rejection because of their LGBTQ identity.

Average scores on the mental health disorder symptom scales were 1.8 ($SD = 1.4$) on the Beck Hopelessness Scale Short Form, 20.7 ($SD = 5.8$) on the Abbreviated PTSD Civilian Checklist, 6.9 ($SD = 3.6$) on the CES-D-4, 21.5 ($SD = 6.9$) on the thwarted belonging component of the INQ, and 15.1 ($SD = 9.4$) on the perceived burdensomeness component of the INQ. Please note that scale scores were not standardized, and thus should be interpreted in reference to the possible scale total for each item rather than in reference to other scales (e.g., a higher average total on the CES-D-4 compared to the Beck Hopelessness scale should not be interpreted as evidence of more depression than hopelessness in this sample). Lifetime suicide attempts were reported by 34% of respondents, and 8% stated that they were likely, rather likely, or very likely to attempt suicide in the future.

Overall, 32% of respondents reported that they had ever experienced homelessness. Table 2 describes the locations in which respondents experienced homelessness. The most common lifetime experience of homelessness was couch-surfing, which was reported by 83% of youth who had experienced lifetime homelessness. The next most common lifetime experiences was living outside (17%), with a stranger (17%), in a youth or adult shelter (14%), or in a public place (14%). Among those who had experienced lifetime homelessness, 25% had some experience during the past month. Couch-surfing was also the most commonly reported experienced in the past month (81%), followed by staying with a stranger (17%) or in a youth or adult shelter (10%).

Bivariate Analysis Results

Table 1 also presents bivariate differences in demographics, disclosure to parents, and mental health outcomes by lifetime experiences of homelessness. Youth who reported ever experiencing homelessness were significantly less likely than those never experiencing homelessness to identify as cisgender women (30 vs. 37%, respectively) and more likely to identify as trans (26 vs. 21%) or nonbinary or another gender (27 vs. 19%). Youth with lifetime homelessness were also more likely to have ever been eligible for free or reduced-price lunch (47 vs. 25%), disclosed their LGBTQ status to their parents (69 vs. 55%), and experienced parental rejection (62 vs. 43%). Youth who had ever experienced homelessness reported statistically significantly higher scores on all mental health symptom measures. Youth who had ever experienced homelessness were also more likely than those never experiencing homelessness to report a lifetime suicide attempt (54 vs. 25%) and a likely future suicide attempt (15 vs. 5%).

Table 1 Participant characteristics

	Full sample (n = 524)	Among those ever experiencing homelessness (n = 167)	Among those without homelessness (n = 357)	Bivariate test statistic (*p* value)
	% (n)/mean (SD)			
Demographics				
Age (range 12–24)	17.57 (3.10)	17.74 (3.12)	17.50 (3.10)	−0.86 (0.39)[b]
Gender identity				7.08 (0.07)[a]
Cisman	21.50 (112)	18.1 (30)	23.1 (82)	
Ciswoman	34.4 (179)	29.5 (49)	36.6 (130)	
Trans	22.8 (119)	25.9 (43)	21.4 (76)	
Nonbinary/another gender	21.3 (111)	26.5 (44)	18.9 (67)	
Race/ethnicity				6.00 (0.20)[a]
White	63.0 (330)	58.7 (98)	65.0 (232)	
African-American/Black	8.8 (46)	9.6 (16)	8.4 (30)	
Latino/Hispanic	11.1 (58)	11.4 (19)	10.9 (39)	
Multiracial	12.2 (64)	16.8 (28)	10.1 (36)	
Another race/ethnicity	5.0 (26)	3.6 (6)	5.6 (20)	
Sexual orientation				3.90 (0.42)[a]
Gay/lesbian	36.4 (190)	36.5 (61)	36.3 (129)	
Bisexual	16.7 (87)	15.6 (26)	17.2 (61)	
Pansexual	17.6 (92)	21.6 (36)	15.8 (56)	
Questioning	8.2 (43)	6.0 (10)	9.3 (33)	
Another sexual orientation	21.1 (110)	20.4 (34)	21.4 (76)	
Eligible for free lunch	31.7 (166)	46.7 (78)	24.7 (88)	9.12 (< 0.01)[a]
Ever experienced homelessness	31.9 (167)	–	–	
Disclosure and parental rejection				
Out to parents	59.0 (296)	68.8 (108)	54.5 (188)	8.96 (< 0.01)[a]
Parental rejection[c]	49.1 (239)	61.6 (98)	43.0 (141)	14.90 (< 0.01)[a]
Mental health and suicidality				
Beck Hopelessness Scale Short Form (range 0–4)	1.8 (1.43)	2.2 (1.4)	1.7 (1.4)	−4.23 (< 0.01)[b]
Abbreviated PTSD Civilian Checklist (range 0–30)	20.7 (5.8)	23.2 (5.2)	19.6 (5.7)	−6.84 (< 0.01)[b]
Depression; CES-D-4 (range 0–12)	6.9 (3.6)	8.2 (0.3)	6.2 (0.2)	−6.29 (< 0.01)[b]
Thwarted belonging (range 5–35)	21.5 (6.9)	22.6 (6.4)	21.0 (7.0)	−2.52 (0.01)[b]
Perceived burdensomeness (range 0–35)	15.1 (9.4)	18.5 (9.3)	13.5 (9.0)	−5.71 (< 0.01)[b]
Lifetime suicide attempt	34.2 (164)	54.4 (81)	25.1 (83)	39.18 (< 0.01)[a]
Future suicide attempt is "Likely"	8.0 (40)	15.0 (24)	4.7 (16)	15.8 (< 0.01)[a]

[a]Chi-square; [b]*t* test, [c]n = 487 due to missing

Adjusted Regression Results

Table 3 presents results for adjusted regression models assessing the relationship between disclosure to parents and parental rejection with the outcome of homelessness, adjusted for demographic characteristics. In adjusted models, youth had 75% increased odds of homelessness if they had experienced parental rejection and 56% increased odds if they had disclosed their LGBTQ identity to their parents.

Table 4 gives the results of the adjusted regression models assessing the relationship between homelessness and mental health and suicidality outcomes. Youth who had experienced lifetime homelessness reported higher levels of hopelessness ($b = 0.50$; 95% CI 0.23, 0.77), PTSD ($b = 3.09$; 95% CI 2.04, 4.16), depression ($b = 1.80$; 95% CI 1.15, 2.46), and perceived burdensomeness ($b = 4.47$; 95% CI 2.72, 6.22). Youth with lifetime experiences of homelessness had more than 3 times the odds of reporting a lifetime suicide attempt (OR 3.30; 95% CI 2.13, 5.11) or a likely future suicide attempt (OR 3.07; 95% CI 1.51, 6.24).

Table 2 Homelessness characteristics (n = 167)

	% (n)
Among those experiencing homelessness, lifetime locations (not mutually exclusive)	
Couch-surfing	82.6 (138)
Outside	16.8 (28)
With a stranger	16.8 (28)
Youth or adult shelter	14.4 (24)
Public place (e.g. subway/bus station, office building)	13.8 (23)
Abandoned building or squat	9.0 (15)
Public transportation	4.8 (8)
Car	4.8 (8)
Another location	6.0 (10)
Experienced homelessness in the past month	25.1 (42)
Among those experiencing homelessness, past month locations (not mutually exclusive)	
Couch-surfing	81.0 (34)
Outside	7.1 (3)
With a stranger	16.7 (7)
Youth or adult shelter	9.5 (4)
Public place (e.g. subway/bus station, office building)	4.5 (2)
Abandoned building or squat	4.8 (2)
Public transportation	2.4 (1)
Car	0.0 (0)
Another location	6.0 (10)

Table 3 Adjusted logistic regression models of homelessness by parental rejection and disclosure to parents

	OR (95% CI)
Parental rejection	1.75 (1.15–2.67)
Disclosure to parents	1.56 (1.01–2.42)

Models are adjusted for age, gender identity, race/ethnicity, sexual orientation, and whether youth was ever eligible for free lunch at school

Discussion

Among youth contacting a national LGBTQ-focused crisis services provider, homelessness was prevalent, with 32% having ever experienced homelessness and one quarter of those reporting homelessness during the past month. The inclusiveness of our homelessness measure makes it difficult to compare these rates with national samples; however, nearly 1 in 3 young people contacting a national LGBTQ crisis services program had experienced lifetime homelessness, suggesting that the vulnerabilities concomitant to homelessness are likely prevalent in this population of young people. It is also important to note that trans youth reported the highest rates of homelessness. Crisis services and other programs serving LGBTQ youth should pay particular attention to the risk of homelessness among transgender young people.

Table 4 Adjusted linear and logistic regression models of mental health and suicidality outcomes by homelessness

	Ever experienced homelessness b (95% CI)/OR (95% CI)
Beck Hopelessness Scale Short Form	**0.50 (0.23–0.77)**[a]
Abbreviated PTSD Civilian Checklist	**3.09 (2.04–4.16)**[a]
Depression; CES-D-4	**1.80 (1.15–2.46)**[a]
Perceived burdensomeness	**4.47 (2.72–6.22)**[a]
Thwarted belonging	1.58 (0.23–2.92)[a]
Lifetime suicide attempt	**3.30 (2.13–5.11)**[b]
Future suicide attempt is "Likely"	**3.07 (1.51–6.24)**[b]

Bold values indicate statistically significant result ($p < 0.05$)

Models are adjusted for age, gender identity, race/ethnicity, sexual orientation, and whether youth was ever eligible for free lunch at school

[a]Beta (95% confidence interval)

[b]Odds ratio (95% confidence interval)

Having disclosed LGBTQ identity to parents and experiencing parental rejection because of LGBTQ identity were both associated with increased odds of experiencing homelessness among youth in this sample. Such findings support prior research identifying parental rejection as an important factor explaining increased rates of homelessness among LGBTQ youth [16, 17]. These results also highlight the importance of crisis services and other providers in providing services that are mindful of both the benefits and drawbacks of LGBTQ identity disclosure; it may be useful to train providers in the importance of carefully negotiating disclosure and its potential consequences among LGBTQ youth, with particular regard to housing consequences of disclosure in nonsupportive family environments. Working with youth to navigate the disclosure process can take many forms, including helping them think through the pros and cons of disclosure and the context for disclosure (e.g., the best people and places).

Youth in this sample who had experienced homelessness also reported greater hopelessness, depression, PTSD, and perceived burdensomeness, suggesting an increased burden of mental health symptoms among crisis services-using LGBTQ youth with homelessness experiences. These youth were also more likely to report a lifetime suicide attempt and to endorse a future suicide attempt as likely. The strong relationship between these mental health symptoms, suicidality, and housing experiences suggests that homelessness should be considered in the provision of crisis services, because specific housing experiences may be indicators of increased

suicide risk and mental health vulnerability. Crisis services may consider forming collaborations with organizational stakeholders in homelessness prevention (e.g., U.S. Department of Housing and Urban Development) to plan more effective ways to prevent homelessness.

Further, services for homeless and unstably housed youth should recognize that mental health and suicidality are likely to be prevalent among LGBTQ youth and that the provision of or linkage to mental health services may therefore be an important aspect of providing care to these youth. High rates of internet, cellphone, and smartphone use among unstably housed youth [21, 22] may lower barriers to service use as they improve the ease of access to phone-, text-, and chat-based crisis services. Promoting technology access in the delivery of homelessness services may therefore improve access to crisis services. However, given the high rate of couch-surfing among homeless and unstably housed youth in this study, many LGBTQ youth experiencing mental health or suicidal crises may not interact with homelessness services organizations such as drop-in centers and shelters. As such, we recommend that LGBTQ-youth crisis services providers consider how they can best prepare to assess and provide service referrals for those experiencing homelessness. Addressing the vulnerabilities of LGBTQ youth experiencing homelessness from both housing and crisis service provider angles could improve the odds of providing timely and effective assistance to this vulnerable population of young people.

Limitations

Because these findings come from cross-sectional data, we are unable to make arguments about causality in the relationships between homelessness, parental rejection and LGBTQ identity disclosure, and mental health and suicidality outcomes. Our sample was composed primarily of White female participants, which may also limit the generalizability of our findings. However, given the difficulty of recruiting LGBTQ youth who are in crisis into research studies and the underrepresentation in research of youth who have not disclosed their LGBTQ identities, we believe these data, which represent both groups of young people, make a significant contribution to the field. Further, samples from other studies of crisis lines with youth [35] and adults [36] predominantly featured White female participants, suggesting that this may be the predominant population using such services; however, these findings also suggest that crisis services may need to do more to reach other vulnerable groups.

Additional research would improve our knowledge about homelessness, mental health, and LGBTQ youth, including studies that account for frequency, duration, or location of homelessness experiences (e.g., street-based to couch-surfing experiences) and their relationship with mental health outcomes, and research to understand protective factors that may buffer against the negative consequences of parental rejection and homelessness.

Summary

This study examined disclosure to parents of LGBTQ identity and parental rejection, mental health, and homelessness among youth users of an LGBTQ suicide crisis service. We identified a high rate of homelessness, with nearly one-third of these youth reporting lifetime experiences of homelessness or housing instability (e.g., couch-surfing). Crisis services-using youth who disclosed their LGBTQ identity to parents or experienced parental rejection because of being LGBTQ reported higher rates of lifetime homelessness, and homelessness experiences were associated with reporting more symptoms of several mental health disorders and higher levels of suicidality. To ensure that LGBTQ youth at risk of mental health disorder symptoms, suicide, and homelessness are being most effectively served, we suggest that LGBTQ-focused crisis services for LGBTQ youth consider ways to assess for homelessness and use this information to help inform safety and services planning for these vulnerable youth.

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