Sexually Diverse and Gender-Expansive Youth in ACCESS Open Minds: Sociodemographics and Severity at Presentation to Diverse Youth Mental Health Services

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Abstract

Among youth, sexually diverse and gender-expansive youth face greater adversities and mental health risks than their cisgender and heterosexual counterparts. Within this community, gender-expansive youth often experience more adversities than sexually diverse youth. While substantial research has examined adversities and mental health disparities for sexually diverse and gender-expansive youth relative to the general population, no study has yet investigated how these two groups differ at their presentation to healthcare services. ACCESS Open Minds aimed to improve youth mental health services for youth aged 11-25 in diverse communities across Canada. Data from the initial intake for 975 youth (gender-expansive = 260, sexually diverse = 715) at one of 12 ACCESS Open Minds sites were used. The most frequently reported sexual orientation and gender identity were "Bisexual" and "Trans man", respectively. Relative to gender-expansive youth, more sexually diverse youth were visible minorities. There was no statistically significant difference between the groups on age, education/employment status, and housing situation. Using a Mann-Whitney *U* Test, no significant differences were found in self-reported distress and clinician-rated severity scores, but gender-expansive youth were rated by clinicians significantly lower on social and occupational functioning than sexually diverse youth. These results may reveal the role of social discrimination against gender-expansive individuals, leading to reduced social relations and work/school opportunities. Our findings provide insights about the diversity of youth presenting to health services and the similarities and differences in mental health severity among sexually diverse and gender-expansive youth.

Keywords: 2SLGBTQI+; Adolescents; Community mental health services; Primary mental health care; Young adults

Literature Review

Childhood and adolescence are marked by an increased risk of mental health problems (Kieling et al., 2024). Recently, the Lancet Psychiatry Commission on Youth Mental Health reported that between 63% to 75% of mental health problems were occurring before 25 years old (McGorry et al., 2024). They also reported that marginalized populations, like 2SLGBTQIA+ youth, were experiencing much higher rates of mental health problems than non-2SLGBTQIA+ youth. These findings reflect the mental health burden experienced by youth, especially those from marginalized groups.

While youth has always been a period of vulnerability to high risk of mental health problems, there has been an increase in mental health problems during this period since approximately 2010 (McGorry et al., 2024). In Canada, Wiens et al. (2020) conducted a longitudinal study assessing trends in mental health outcomes from 2011 to 2018 among youth aged 12 to 24 and found that the proportion of youth reporting poor or fair perceived mental health increased from around 4% to around 10% over the years. Additionally, the proportion of youth diagnosed with mood and anxiety disorders, as well as those experiencing suicidality, increased during this period (Wiens et al., 2020). These findings indicate that youth are facing elevated risks of mental health problems relative to other age groups and are experiencing more adverse health outcomes than in previous years, with some groups, like 2SLGBTQI+ individuals, reporting higher rates and experiencing greater disparities in access to quality care.

Sexually Diverse and Gender-Expansive Youth (SDGE)[1]

Definitions and Context

[1] SDGE was chosen as a term to promote inclusivity of members of minoritized sexual orientation and gender identity. Some terms become offensive over the years, as contexts and identities change and evolve. At the time of the writing of this thesis, it is used as a neutral and inclusive term.

2SLGBTQI+ is an acronym used to represent a diversity of sexual orientations and gender identities. Sexual orientation refers to whom a person is romantically and sexually attracted to, and those who are attracted exclusively to individuals of an opposing gender, within the gender binary, are heterosexual or straight. Individuals who do not identify as heterosexual or straight (e.g., lesbian, gay, bisexual, pansexual individuals, etc.) are sexually diverse. In contrast, gender identity refers to the socially constructed concept of gender, which relates to the feelings and presentation of masculinity/femininity regardless of the sex assigned at birth (Quintana & Pfaus, 2024). Individuals whose gender aligns with their sex assigned at birth are cisgender individuals, while individuals whose gender identity does not align with their sex assigned at birth, or do not express gender characteristics associated with their sex assigned at birth are gender-expansive (e.g., transgender, nonbinary, gender nonconforming individuals, etc.).

In 2023, approximately 1.3 million Canadians aged 15 and older were sexually diverse and gender-expansive (SDGE), which represented around 4.4% of the population (Statistics Canada, 2024). This reflects an increase from the previous year, where 4% of the population aged 15 and older identified as SDGE (Statistics Canada, 2023). The diversity of sexual orientations, gender identities, and pronouns has also expanded over the years (Renström, 2025; Russell et al., 2023), and research on the sociodemographics of SDGE individuals visiting health services could contribute to informing health care providers about this population's characteristics and reduce knowledge gaps (Makara et al., 2024).

SDGE Individuals' Adversities

Among youth, SDGE individuals face higher adversities than their cisgender and heterosexual peers, and substantial research has examined these challenges over the years. For example, people who are SDGE tend to delay seeking health care because of the fear of

discrimination, contributing to their heightened risk of chronic health issues (Hsieh & Shuster, 2021). Additionally, SDGE individuals face more barriers to accessing health care services and receiving care, which further contributes to health disparities. For example, in the United States, they are less likely to be insured than the general population (Margolies & Brown, 2019). This community is also more likely to conceal information and not receive appropriate care, as well as be refused services due to discrimination and stigma (Davis et al. 2016; Sabin, Riskind, and Nosek 2015). Among SDGE individuals, those who are gender-expansive often experience greater adversities in healthcare settings. For example, gender-expansive individuals, especially nonbinary individuals, often report that their bodies are mishandled by practitioners (e.g., by using gendered terms to describe body parts which can provide discomfort) and are reassigned binary genders (e.g., providers assuming that trans individuals transition from one gender to the other or ignoring processes of transition entirely), and those experiences or the knowledge that it may happen can lead to further avoidance of health care (Hsieh & Shuster, 2021; Shuster, 2016). Gender-expansive people seeking gender-affirming treatments experience even more obstacles. A qualitative study by Mizock and Lundquist (2016) analyzed the interviews of 45 transgender and gender nonconforming individuals about current mistakes made by psychotherapists and found different themes. Some of them were the lack of professional knowledge on gender identity, gatekeeping of access to treatments and surgeries, and discrimination. Overall, these studies demonstrate that in addition to other factors, health care avoidance and barriers in accessing and receiving care contribute to the adversities faced by SDGE individuals and the disparities in their health outcomes compared to non-SDGE individuals.

Beyond healthcare too, people who are SDGE experience greater social adversity. They report experiencing more negative social experiences, such as rejection and bullying from their

peers and family members, than cisgender and heterosexual people (Higa et al., 2014; Kiekens et al., 2020). This population is also experiencing a higher rate of homelessness, with 20% to 40% of homeless youth identifying as SDGE (Côté et al., 2024; Monika & Gunjan, 2024). One major factor contributing to these high rates is family rejection (Ecker, 2016). The proportion of homeless youth is even greater among transgender and nonbinary individuals than among sexually diverse youth (DeChants et al., 2021). Further, research indicates that social support and positive social interaction act as protective factors (McDonald, 2018). Together, these findings reflect the heightened social adversity faced by SDGE individuals, particularly those who are gender-expansive.

Lastly, SDGE individuals experience greater legal discrimination than their cisgender and heterosexual counterparts (Community-Based Research Center, 2021; Hébert et al., 2022), with gender-expansive individuals experiencing even greater legal discrimination than individuals who are sexually diverse (Williamson, 2024). Lee et al. (2024) examined the impact of state-level anti-transgender laws in the United States on the suicide risk among gender-expansive individuals. They found that in 19 states, 48 anti-transgender laws were enacted between 2018 and 2022. These laws could impact various aspects of daily life, such as the participation in sports, access to gender affirmation care, and bathroom usage (Lee et al., 2024). The relationship between suicide risk and anti-transgender laws was examined by looking at the effect of anti-transgender laws' enactment on the number of suicide attempts in the past year following the laws' enactment and the number of people attempting suicide at least once in the past year following the enactment. The study found that anti-transgender laws were associated with an increase in the number of suicide attempts in the past year and the number of individuals attempting suicide at least once in the past year, especially during the first two years after the

enactment. These findings indicate that SDGE individuals experience greater social adversity and legal discrimination than cisgender and heterosexual individuals, with people who are gender-expansive experiencing even higher rates of homelessness and facing more discriminatory laws than sexually diverse individuals.

SDGE Individuals' Mental Health

Multiple studies have reported that SDGE individuals experience worse mental health outcomes than their cisgender and heterosexual peers (e.g., Lu et al., 2025). A systematic review of systematic reviews found that sexually diverse individuals had more severe depression, generalized anxiety, and social anxiety symptoms than heterosexual people, and that gender-expansive individuals had more severe depression, anxiety, conduct disorder, and somatic disorder symptoms than cisgender individuals (O'Shea et al., 2024). This review reflects the mental health disparities faced by SDGE individuals.

SDGE individuals are also more likely to have suicidal ideation and make suicide attempts than their counterparts (Miranda-Mendizábal et al., 2017), with one study finding that sexually diverse individuals attempt suicide at more than three times the rate of heterosexual individuals (Raifman et al., 2020). SDGE youth, in particular, face an elevated risk of suicide, with nearly 25% of youth aged 12 to 14 who died by suicide, in a sample of 2,209 individuals aged 12 to 29, identified as sexually diverse or gender-expansive (Ream, 2019). In summary, SDGE individuals are more likely to have severe symptoms of mental health problems, as well as higher rates of suicidal ideation and attempts compared to cisgender and heterosexual individuals. Additionally, SDGE youth are at an even higher risk of dying by suicide than older SDGE individuals.

Overall, these studies reveal the difference in social and legal discrimination, health care opportunities, and mental health outcomes between SDGE individuals and their cisgender and heterosexual counterparts. They also reveal that gender-expansive individuals face worse adversity than sexually diverse individuals. However, most studies on SDGE individuals' mental health have compared them as an overall group to the general population, or studied sexually diverse individuals and people identifying as gender-expansive separately, making it difficult to compare the two groups. Therefore, research comparing sexually diverse individuals to gender-expansive individuals is needed.

ACCESS Open Minds

In the Canadian context, to improve mental health in youth and facilitate access to health care services, the Strategy for Patient-Oriented Research (SPOR) of the Canadian Institutes of Health Research (CIHR) funded a services research network called ACCESS Open Minds (ACCESS-OM), from 2014 to the present day (Canadian Institutes of Health Research, 2011; Iyer et al., 2019). This pan-Canadian initiative aimed at improving mental health services for youth aged 11-25 years old by transforming key service sites across Canada. These transformed sites were design to provide: (1) Early detection of youth needing help via outreach and awareness; (2) Rapid access through multiple access points and removal of referral or administrative barriers allowing an initial evaluation within 72h; (3) Tailored support aligned with youth's goals in non-stigmatizing environments; (4) Removal of age-based transition and smoother transitions between services; and (5) Youth and carers' engagement in services and spaces design (Iyer et al., 2019). Although the transformed sites were not designed exclusively for SDGE youth seeking care, they were designed to be youth-friendly, culturally safe for marginalized groups, and relatively free of barriers (Iyer et al., 2019).

Current Study

Given the increasing number of individuals identifying as SDGE, their high rates of mental health needs, and the growing diversity of sexual orientations, gender identities, and pronouns, it is essential for clinicians and service creators to understand the diversity and needs of SDGE individuals accessing health care services. In this study, to help services better plan to support SDGE youth, the sociodemographic characteristics of sexually diverse and gender-expansive youth were explored. Additionally, given the current gaps in the literature, including a lack of studies comparing sexually diverse individuals to gender-expansive individuals, this study aimed at comparing differences in severity at initial presentations between the two groups during their initial assessment at an ACCESS-OM site.

To achieve this, severity was broadly defined across three axes: distress, severity of mental health problems, and functioning. To account for the fact that youth could present with multiple, potentially overlapping and not easily distinguishable symptoms, transdiagnostic self-report and clinician-rated measures were used (Iyer et al., 2019). Symptom severity was evaluated using two measures, one assessing distress through youth self-report (Kessler et al., 2002) and another capturing clinician-rated severity of mental health symptoms (Berk et al., 2008). A self-report measure was included to provide complementary perspectives and to allow for comparability with clinician-rated assessments. This also aligns with the increasing push towards using patient-reported measures in healthcare as a way to gather their perspectives about their health and to give them a voice in their care (Ferrari et al., 2023). A separate measure assessed clinician-rated levels of social and occupational functioning (Hilsenroth et al., 2000).

Research Questions

1. What are the sociodemographic characteristics of SDGE youth who sought mental health help at diverse ACCESS-OM sites across Canada?

No studies have yet looked at the sociodemographic characteristics of SDGE youth in ACCESS-OM, but based on population-level data (Statistics Canada, 2024), we expect that more youth will be sexually diverse and cisgender than gender-expansive. Between these groups, we also expect that rates of housing insecurity will be higher among gender-expansive youth, as they experience higher rates of homelessness (DeChants et al., 2021).

2. Is there a difference in mental health severity at presentation between sexually diverse and gender-expansive youth?

In alignment with existing research, we hypothesize that gender-expansive youth will present at ACCESS Open Minds sites with higher severity than sexually diverse youth. However, we also hypothesize that due to the adversity they both face, both sexually diverse and gender-expansive youth will present with significant distress, clinician-rated severity of mental health problems, and moderate to significant difficulties in functioning.

Methods

Design and Setting

The ACCESS-OM project was approved by the Douglas Research Centre's research ethics board as well as local, community, and Indigenous bodies. ACCESS-OM follows the First Nations principles of ownership, control, access, and possession (OCAP) and Tri-Council guidelines for conducting research with Indigenous communities (Canadian Institutes of Health Research, 2019; First Nations Information Governance Centre, 2014).

ACCESS-OM included 14 sites across Canada that varied in geography, culture, resources, and population density, with sites opening in 2016 and 2017. These sites served

diverse populations, including Anglophone and Francophone youth, as well as individuals who face marginalization or specific challenging situations such as immigrants, refugees, ethnic minorities, state-protected youth, homeless youth, and first-year university students (Iyer et al., 2019). Eight sites were located in urban and rural regions across four different provinces, namely New Brunswick, Québec, Alberta, and Ontario, and six sites in Indigenous communities (reserves and remote Northern villages) across Canada (Nova Scotia, New Brunswick, Québec, Saskatchewan, and Northwest Territories) (Iyer et al., 2019). Two sites within Inuit communities were excluded from this study due to their decision to not follow the ACCESS-OM quantitative evaluation protocol because of cultural, local, and personal considerations (Boksa et al., 2022). The final sample represented 12 pan-Canadian sites, including four First Nations communities (Eskasoni First Nation, Elsipogtog First Nation, Cree Nation of Mistissini, Sturgeon Lake First Nation) (Boksa et al., 2022; Iyer et al., 2025).

ACCESS-OM's protocol followed a longitudinal design, collecting data from 2016 to 2021, that included a minimum evaluation protocol. The minimum evaluation protocol was implemented at all sites throughout the study period to assess whether ACCESS-OM increased the number of youth accessing services, reduced delays in seeking care, increased the proportion of youth receiving an initial assessment, and shortened treatment delays. It was also implemented to record participants' sociodemographic characteristics, clinical, functional, and subjective outcomes, service experiences, as well as outcomes related to the services offered by the sites (Iyer et al., 2019).

Participants

To be part of the larger ACCESS-OM study, youth aged 11 to 25 who were seeking services or were referred to one of the sites for mental health and/or substance-related problems

were eligible. If they had received services at a site pre-transformation, they needed to not have received services for a minimum of six months to be eligible. Additionally, youth who had a diagnosis of intellectual disability, a history of organic brain damage, and/or were unable to consent were not eligible for the research protocol (Iyer et al., 2019).

Procedures

Upon arrival at one of the sites, youth were presented with information about the larger ACCESS-OM evaluation study and if interested in participating, they could sign a consent form. Parental consent was also required for youth under specific ages, which varied across provinces. The sociodemographic information collected through the intake assessment was co-designed by youth. At intake, youth presenting to the service provided their sociodemographic information via self-report. The intake also included clinical interviews and clinician-reported measures. The present study focused on information regarding sociodemographics, and clinical presentation and functioning. For the sociodemographic characteristics of SDGE youth, the age, gender identity, sexual orientation, pronoun, ethnicity, housing situation, and education, training, or employment status (NEET: Not in Education, Employment, or Training or engaged in education, employment or training) were examined. Youth could indicate and specify their gender identity based on the following options: “Trans woman,” “Cis woman,” “Trans man,” “Cis man,” “Genderfluid,” “I don’t identify with these options, specify if desired,” and “Prefer not to answer.” While acknowledging the need to respect the distinctiveness of each gender identity, youth who endorsed the gender identity options of “Trans woman,” “Trans man,” “Genderfluid,” or “I don’t identify with these options, specify if desired” were combined into the gender-expansive category to facilitate statistical analyses, as it is more difficult to analyze many groups and small sized groups. This was also considered appropriate to reflect that many of the individuals in this

gender-expansive group share similar experiences of minoritization and marginalization. Youth could also indicate and specify their sexual orientation based on the following options: "Asexual," "Bisexual," "Gay," "Heterosexual or straight," "Lesbian," "Not sure," "Questioning," "Queer," "Two-spirited," "I prefer not to answer," and "Other, specify if desired." Using the same rationale as for creating the "gender-expansive" category, youth who endorsed the sexual orientation options of "Asexual," "Bisexual," "Gay," "Lesbian," "Not sure," "Questioning," "Queer," "Two-spirited," or "Other, specify if desired" were combined into the sexually diverse category. Because the "I prefer not to answer" options did not provide sufficient information regarding the youth's sexual orientation and gender identity, it was not included in the sample. The gender-expansive group included gender-expansive youth regardless of their sexual orientation because the sample size of gender-expansive youth who were not also in the sexually diverse group was too small (n = 30). Therefore, the sexually diverse group exclusively included youth who were cisgender and sexually diverse, and the gender-expansive group included youth who were gender-expansive and sexually diverse or heterosexual.

The Kessler Psychological Distress (K10) Scale (Kessler et al., 2002), Clinical Global Impression (CGI) of severity (Berk et al., 2008), and Social and Occupational Functioning Assessment (SOFAS) scales (Hilsenroth et al., 2000) were used in this study to evaluate youth-reported distress and clinician-reported illness severity and functioning, respectively. To ensure consistency and reliability, all local staff members received similar training. They also engaged in calibration sessions, where they compared their ratings on clinician-reported measures with those of their peers and expert clinician-scientists to arrive at a consensus (Iyer et al., 2019).

Self-Reported Distress: Kessler Psychological Distress Scale (K10)

Self-reported distress was assessed using the 10-item from the K10 scale, a measure of non-specific psychological distress (Kessler et al., 2002). The K10 is a widely used test, including in the World Health Organization World Mental Health Survey (Kessler et al., 2002), and has demonstrated strong temporal stability (Merson et al., 2021) and validity for use with children and adolescents (Smout, 2019). Additionally, K10 has been reported to be valid in First Nations people living off reserve, Métis, and Inuit (Bougie et al., 2016), and has been used previously with a Canadian sample (Enticott et al., 2018). The K10's items are oriented towards the severity of symptoms of anxiety and depression, but assess a unidimensional view of distress (Kessler et al., 2002). Each item included in the scale had a consistent severity level across sociodemographic groups in the original development sample, such as age, gender, race/ethnicity, and education (Kessler et al., 2002), meaning no single item was consistently scored higher by one group over another. On a 5-point Likert scale (0 = "none of the time," 1 = "a little of the time," 2 = "some of the time," 3 = "most of the time," 4 = "all of the time,") youth were asked to respond to items such as "In the past 30 days, how often did you feel so sad that nothing could cheer you up." The items were then scored from 0 to 40, with higher values indicating higher distress (Andrews & Slade, 2001; Kessler et al., 2002). In the Canadian context, scores below 12 are considered low levels of distress, between 12 and 19 as high levels of distress, and scores higher than 20 as very high levels of distress (Enticott et al., 2018). The scale showed good internal consistency ($\alpha = 0.89$) for the 10 items in this sample (Koo & Li, 2016).

Clinician-Reported Severity of Illness: Clinical Global Impression (CGI) Scale

Clinician-reported severity of illness was assessed using the single item from the CGI scale (Berk et al., 2008) with anchors adapted from the trans-diagnostic CGI (Dunlop et al.,

2017). On a 7-point Likert scale (from 1 = “No mental health problem” to 7 = “Among the most extremely severe of mental health problems,”) clinicians or trained personnel were asked to consider their clinical experience and rate the severity of the youth’s mental health problem. The higher the item was scored, the higher the severity of the mental health problem that the youth had. The CGI was chosen for its simplicity and to improve completion rates (Iyer et al., 2019).

Clinician-Reported Functioning: Social and Occupational Functioning Assessment Scale (SOFAS)

Functioning was assessed using the SOFAS, a single item measure evaluating the social and occupational functioning on a continuum from 1 to 100 by clinicians or trained personnel (Hilsenroth et al., 2000). The higher the score, the better the functioning. The SOFAS is specifically designed to assess the level of functioning without accounting for the severity of mental health problems (Goldman et al., 1992; Hilsenroth et al., 2000). While there is often a correspondence between functioning and severity levels, it is possible that some people may have moderate to severe symptoms but function at high levels or vice versa.

Statistical Analysis

To test the hypotheses that there would be more youth in the sexually diverse group than in the gender-expansive group, and that housing insecurity would be higher among gender-expansive youth, Chi-square (χ^2) tests were used, as these variables are categorical (McHugh, 2013). Additionally, exploratory analyses were conducted between sexually diverse youth and gender-expansive youth on age, NEET, and ethnicity, to further elaborate on the differences between the groups. Chi-square (χ^2) tests were used to analyze differences in NEET and ethnicity, and because the groups did not meet the condition of normality for a *t*-test (Kim,

2015), the non-parametric equivalent of a *t*-test, called a Mann-Whitney *U* Test (Hinton, 2010), was used to analyze the difference in age.

To test the hypothesis that gender-expansive youth will present with higher severity (i.e., higher scores on CGI and K10, and lower scores on SOFAS) than sexually diverse youth, a Mann-Whitney *U* Test was used. The Mann-Whitney *U* Test determines the presence or not of a significant difference between two groups but does not assess which group has higher values. Therefore, when a significant difference was found, the means were examined to understand the direction and extent of the difference between the two groups.

Results

Sample

A final sample of 5,280 youth (see Figure 1 for the flow chart) with a mean age of 19.2 years (SD = 3.42) received an initial evaluation at one of the 12 ACCESS-OM participating sites and consented to the study. Among youth who reported their ethnicity, 1,648 identified as White, 818 as visible minority, and 1,006 as Indigenous. The current study only included youth who identified as sexually diverse and/or gender-expansive. The sample included 715 sexually diverse youth out of 2,557 youth who reported their sexual orientation and 260 gender-expansive youth out of 4,852 youth who reported their gender identity. For the severity analysis, 81 youth were removed due to not having responded to at least one of the severity measures, resulting in a sample of 667 sexually diverse youth and 227 gender-expansive youth.

Sociodemographics

There were significantly more sexually diverse youth than gender-expansive youth who visited ACCESS-OM sites. Additionally, the mean age was not statistically different between sexually diverse and gender-expansive youth, and the two groups were not significantly different

in terms of their housing situation or their NEET status. However, they differed significantly in their reported ethnicity, with a higher proportion of visible minority youth being among sexually diverse youth than among gender-expansive youth (see Table 1).

Regardless of their reported gender identity, and when including write-in responses, youth identifying as sexually diverse reported identifying as “Asexual,” “Bisexual,” “Gay,” “Lesbian,” “Not sure,” “Questioning,” “Queer,” “Two-spirited,” “Pansexual,” or reported identifying with “More than one sexual orientation.” Among 37 youth who selected “Other” as their sexual orientation, 20 youth did not provide further specification. Across all sexual orientations, the most frequently reported were bisexual and asexual, and people who were unsure of their sexual orientation (see Table 2).

Regardless of their sexual orientation, and including write-in responses, youth identifying as gender-expansive reported gender identities such as “Trans woman,” “Trans man,” “Genderfluid,” or “Nonbinary.” Among 50 youth who selected “I don’t identify with these options” as their gender identity, 44 youth did not provide further specification. Across all gender identities, most youth identified as trans men, trans women, and genderfluid (see Table 2).

Regardless of their sexual orientation or gender identity, youth also reported their preferred pronouns among “She/her”, “He/him”, “They/them”, and “Other”. Among people who chose “Other” and specified their pronouns, 10 preferred to use multiple pronouns (e.g., “She/her-They/them”). The most common pronoun was “She/her” followed by “He/him” (see Table 2).

Severity of Mental Health Difficulties at Presentation

Contrary to the hypothesis, the scores on K10 and CGI were not significantly different between sexually diverse and gender-expansive youth. However, consistent with the hypothesis, gender-expansive youth presented with significantly more social and occupational impairment, as determined by SOFAS scores, than sexually diverse youth (see Table 3).

Discussion

The first purpose of this study was to investigate the sociodemographic characteristics of sexually diverse and gender-expansive youth who visited ACCESS-OM sites (Iyer et al., 2019) to help service providers understand the diversity and needs of SDGE youth accessing health care services, and help them be more supportive and inclusive towards this community. The second purpose was to investigate the difference in mental health severity between sexually diverse youth and gender-expansive youth at initial presentation to ACCESS-OM sites, using the K10 (Kessler et al., 2002), CGI (Berk et al., 2008), and SOFAS (Hilsenroth et al., 2000) measures. This research was novel as no prior study had examined how these two groups differ at their presentation to healthcare services. Because more individuals identify as sexually diverse than gender-expansive in the general Canadian population (Statistics Canada, 2024) and gender-expansive youth are more likely to experience homelessness (DeChants et al., 2021), it was hypothesized that more youth would be sexually diverse than gender-expansive, and that gender-expansive youth would have higher rates of housing insecurity. Contrary to the hypothesis, there was no difference in rates of housing insecurity, but there were significantly more sexually diverse youth than gender-expansive youth. Regarding other sociodemographic characteristics, there was a significant difference in the reported ethnicity, with more sexually diverse youth identifying as visible minorities than gender-expansive youth. Additionally, because gender-expansive individuals face more adversity (DeChants et al., 2021; Hsieh & Shuster, 2021; Lee et

al., 2024; Mizock & Lundquist, 2016; Shuster, 2016), it was hypothesized that their mental health severity would be higher than sexually diverse youth. Contrary to the hypothesis, gender-expansive youth did not present with higher levels of self-reported distress and clinician-reported severity of mental health problems compared to sexually diverse youth. However, gender-expansive youth were rated by their clinicians as having significantly lower levels of social and occupational functioning compared to sexually diverse youth.

Service Planning and Providers

Difficulties that SDGE youth might experience in healthcare settings can be the result of providers' assumptions of heteronormativity (i.e., the belief that everyone is heterosexual) and cisnormativity (i.e., the belief that everyone's gender aligns with their sex assigned at birth). These assumptions can be associated with a lack of knowledge and false beliefs about gender identity and sexual orientation, for example, thinking that the trans identity is the same thing as homosexuality, which often results in negative experiences of care for SDGE youth (Laiti et al., 2019). Providing a breakdown of the sexual orientations, gender identities, and pronouns reported by SDGE youth is essential to reduce heteronormativity and cisnormativity assumptions among youth Canadian services and increase knowledge about the diversity of sexual orientations, gender identities, and pronouns endorsed by SDGE youth. By being knowledgeable of the diversity of youth seeking help, providers can be better prepared to provide appropriate and inclusive care, for example, by developing forms that are not heteronormative or cisnormative (e.g., including multiple gender identity and sexual orientation options), displaying markers of inclusivity (e.g, 2SLGBTQIA+ flags), and being trained in 2SLGBTQIA+ affirmative care (Fields, 2023).

However, researchers and providers can face the problem that there are no up-to-date recommendations about what should be included in the sociodemographics forms to be inclusive of SDGE individuals. For example, in the present study, "pansexual" was written-in by 68 youth when they specified their sexual orientation and similarly, nonbinary was endorsed by 17 youth when they specified their gender identity. Neither option was available in the sociodemographic form, which had been co-designed with youth. Additionally, 21 youth had pronouns that differed from "She/her," "He/him," and "They/them." These results may reveal that some sexual orientations, gender identities, and pronouns were omitted during the creation of the sociodemographic questionnaire in 2015-2016 or that between 2016 and 2021, new terms were established to reflect distinct experiences of sexually diverse and gender-expansive individuals, and youth specified their sexual orientation, gender identity, and pronouns, with these new terms. However, creating a sociodemographic form with the help of youth resulted in more diverse sexual orientation and pronoun options, compared to what was suggested in 2016 (Fallin-Bennett et al., 2016; GLMA, 2006; Levitt, 2013) as the ACCESS-OM questionnaire also had the "Two-spirited" sexual orientation and "They/them" pronoun options. Therefore, it is clear that co-designed sociodemographic questionnaires are a minimum standard for use in mental health service settings, and all questionnaires should include an option to specify. Additionally, "Pansexual" and "Nonbinary" should be added in future questionnaires, and people should have the option to select more than one option to account for people identifying with more than one sexual orientation, gender identity, and pronoun. Regarding gender identities, the "I don't identify with these options" option was selected by approximately 20% of gender-expansive youth, which may reflect that too few categories were proposed. Additionally, most gender-

expansive youth did not specify a gender identity when selecting "I don't identify with these options," which may reflect a fear of identifying with something different.

Overall, these findings suggest the importance of using co-designed sociodemographic forms and options where youth can specify their sexual orientation, gender identity and pronouns at a minimum. Sexual orientation, such as "Pansexual" and gender identity, such as "Nonbinary" should also be added in future forms, as well as more diverse gender identities. Additionally, sociodemographic questionnaires should allow individuals to select multiple sexual orientations, gender identities, and pronouns. Sexual orientation, gender identity, and pronouns options should also be regularly revisited to include newer terms and remove terms that may be seen as offensive.

Similarities and Differences Among SDGE Individuals

Contrary to most research about SDGE individuals which compares them to their cissexual/heterosexual peers, this study looked at sexually diverse individuals and gender-expansive individuals as two different groups. Although it is crucial to understand the health disparities faced by SDGE individuals compared to heterosexual and cisgender individuals, those studies do not take into account the unique difficulties and experiences faced by sexually diverse individuals and gender-expansive individuals (e.g., hormonal treatments or gender dysphoria for gender-expansive individuals). Additionally, studying SDGE individuals as a group can lead to the prioritization of sexuality over gender identity, which may not reflect gender-expansive individuals' experiences (Steinke et al., 2017). Although studying sexually diverse and gender-expansive individuals separately is important, this study revealed that SDGE youth are not different on some aspects. For example, there was no significant difference between the groups in NEET status, indicating that they did not differ in the proportion of people who were not

currently in education, employed or in training. The groups were also not statistically different in housing situations, indicating that they did not differ in the proportion of people who were in stable (e.g., in a house or apartment), supported (e.g., in a group home or supported housing) and precarious (e.g., in a homeless shelter, on the street, or couch surfing) housing. Concerningly, this study revealed that both groups experienced high rates of precarious housing and NEET, with around 7% of sexually diverse youth and more than 10% of gender-expansive youth living in precarious housing, and around 30% of sexually diverse youth and more than 35% of gender-expansive youth being NEET. These high rates might reflect social precarity, a structurally induced condition of vulnerability where people lack economic and social support (Butler, 2009). Precarity in employment, education, and housing among SDGE individuals has been reported over the years (Baams et al., 2019; Kinitz et al., 2023; Sansone, 2019) and has been linked with missed opportunities and negative outcomes (Goodyear et al., 2024; LoSchiavo et al., 2020). These results suggest that members of the 2SLGBTQIA+ community face similar difficulties regarding their education/employment, and living situation. Additionally, these results are consistent with previous research documenting social procarity among SDGE individuals.

SDGE individuals have similarities, but the difference in SOFAS scores reflects that sexually diverse and gender-expansive are distinct groups and that youth differ in their experiences of social and occupational functioning. A possible explanation for the difference in SOFAS, despite no difference in NEET status and housing situations, is what each measure captures. Unlike NEET status and housing, SOFAS captures concepts such as youth's ability to maintain friendships and function well at school or work, and the extent to which they experience interpersonal conflicts. Therefore, having few friends would affect the SOFAS score but not the housing situation or employment, education, or training. Additionally, NEET status

and housing situation may not capture more nuanced experiences. For example, an individual only working five hours per week would not be classified as NEET because of their employed status, yet may still experience significant functioning impairments. These results suggest that despite similarities, sexually diverse and gender-expansive individuals face different experiences and that the difference in SOFAS but not in NEET and housing could be explained by what is captured by each measure.

Severity

Difference in SOFAS Scores Among SDGE Youth

When compared to sexually diverse youth, gender-expansive youth were rated as having higher levels of social and occupational functioning impairment. One possible explanation is that gender-expansive youth experienced more discrimination than sexually diverse youth. This idea is consistent with other research that reports that transgender individuals experience higher rates of discrimination than non-transgender lesbian, gay and bisexual individuals (Su et al., 2016) and that transgender boys are more likely to experience multiple victimizations than sexually diverse girls (Mitchell et al., 2023). While discrimination itself was not explicitly considered by SOFAS, discrimination may have resulted in social withdrawal or interpersonal difficulties/strain, as well as impeded work performance or created workplace conflicts, which in turn would be reflected in lower social and occupational functioning scores. Another possible explanation is that, even without direct discrimination, gender-expansive youth may still experience fears of being discriminated against and worries about not being accepted or recognized as their true gender identity (White Hughto et al., 2015; Price et al., 2023). Such fear, in turn, may have impacted the number and quality of their social relationships or prevented them from pursuing work opportunities or advancements. In sum, gender-expansive youth may experience greater

discrimination and fears of being discriminated against, which can subsequently prevent them from seeking opportunities, thus impacting their social and occupational functioning.

There was a significant difference in SOFAS scores between sexually diverse and gender-expansive youth, with their scores reflecting moderate difficulty and serious impairment, respectively, in social, occupational, or school functioning. These findings highlight that all SDGE youth face significant challenges. Given that childhood and adolescence are critical periods for social development (Blakemore & Mills, 2014), targeted efforts should aim to improve their social and occupational functioning.

Similarities in K10 and CGI Scores Among SDGE Youth

Although gender-expansive youth reported higher scores on SOFAS than sexually diverse youth, the two groups did not differ on other measures of severity. One possible explanation is that because both sexually diverse and gender-expansive youth reported very high levels of distress and were rated as having moderate severe problems by clinicians, it might have made it harder to detect a difference between the groups in severity. Additionally, the lack of difference in scores on the K10 and CGI scales may reflect that other important constructs, such as suicidality, were not captured by the scales. Because suicidality is more prevalent among gender-expansive individuals (Nath et al., 2024) than among sexually diverse individuals, it would have been expected that gender-expansive individuals report greater distress on the K10 scale than sexually diverse youth, had suicidality been measured. Together, the fact that both sexually diverse and gender-expansive youth were presenting to mental health services with moderate to very high severity and that suicidality was not included in the measures may help explain why K10 and CGI scores were not different between sexually diverse youth and gender-expansive youth.

An additional hypothesis for the similar K10 and CGI scores involves the role of resilience, which is the ability to effectively adapt to difficult or challenging life experiences (American Psychological Association, 2018). Despite experiencing greater social and occupational functioning impairments than sexually diverse youth, gender-expansive youth may have relied on their resilience to be protected from more severe mental health problems and distress. For example, Singh et al.'s (2011) study found that gender-expansive individuals' ability to define their gender and embrace their self-worth was associated with better coping with societal discrimination. Since self-acceptance is not assessed by the SOFAS, greater self-acceptance may not have resulted in higher social and occupational functioning scores but could have contributed to lower distress and fewer mental health problems. In another research, connectedness and support from gender-expansive peers were associated with reduced distress by helping individuals better cope with enacted stigma (Bockting et al., 2013). Online or in-person community support is also not captured by the SOFAS and, like self-acceptance, may influence K10 and CGI scores without affecting SOFAS ratings. Peer support has been reported as a crucial resilient factor for gender-expansive youth (Kia et al., 2023), and research demonstrates that transgender youth were more likely than cisgender sexually minoritized girls to connect with the 2SLGBTQIA+ community online (Palmer et al., 2013). Therefore, resilience factors such as accepting one's identity or feeling connected to other members of one's group may have protected gender-expansive youth against worse mental health severity.

Moreover, although youth did not experience different distress and mental health severity symptoms at presentation, long-term social and occupational functioning impairment can lead to worse mental health problems over time. Consistent with this idea, social isolation and loneliness at Time 1 were associated with mental health problems between 0.25 to 9 years later (Loades et

al., 2020). Therefore, gender-expansive youth, experiencing higher social and occupational functioning impairments than sexually diverse youth when presenting to ACCESS-OM sites, may report higher K10 and CGI scores in the future.

Strengths, Limitations, and Future Directions

One strength of this study is that it compared sexually diverse youth with gender-expansive youth, which has not been frequently addressed in the existing literature. The study also measured the mental health severity of SDGE youth at the presentation of health services, which had never been studied previously. Additionally, the study used validated and recognized severity measures. Another strength of this study is the sample size of gender-expansive individuals. Multiple studies on SDGE issues have small sample sizes of gender-expansive individuals compared to sexually diverse individuals (e.g., Källström et al., 2022; Lu et al., 2025), while this study had 260 gender-expansive youth and 715 sexually diverse youth. Lastly, an important strength is that the sample came from diverse real-world settings in Canada. However, the study has some limitations. Firstly, although there was a self-reported measure of the intensity of mental health problems, the study lacked a self-reported measure of social and occupational functioning. Because self-reported measures are important when working with children and adolescents, self-reported measures like the Child and Adolescent Social and Adaptive Functioning Scale (CASAFS, Price et al., 2002) should be included in future studies. Additionally, although SOFAS is a validated measure, having only one item may not reflect all aspects of social and occupational functioning. Measures that more specifically assess social functioning at home and in school, as well as those capturing experiences in school or work settings, should be used to complement the SOFAS. Moreover, this study did not look at the evolution of severity over the years, and therefore could not confirm the hypothesis that lower

scores on SOFAS would result in higher scores on CGI and K10. Therefore, further studies should measure severity at multiple time points. Another limitation is that gender-expansive individuals were grouped together regardless of their sexual orientation, because only 30 youth identified as both gender-expansive and heterosexual. However, gender-expansive individuals with different sexual orientations may have different outcomes. Therefore, lower scores on SOFAS might be due to the prevalence of gender-expansive youth who also identified as sexually diverse. Further studies should look at gender-expansive individuals' severity for those who are sexually diverse and for those who are not sexually diverse.

Because this study only focused on gender expansive and sexually diverse youth who sought mental health services at ACCESS-OM sites and did not have a comparative sample of gender expansive and sexually diverse youth in the general population, we are unable to comment on the extent to which similar findings (e.g., extent of precarity in housing) would also be true of non-help-seeking SDGE youth.

Conclusion

This study contributes to the growing literature on SDGE individuals' mental health outcomes by looking at sociodemographic characteristics and the difference in mental health severity between sexually diverse youth and gender-expansive youth presenting for services at diverse ACCESS-OM sites. As most previous research has determined physical and mental health disparities between SDGE individuals and cisgender and heterosexual people, this study aimed to compare sexually diverse youth and gender-expansive youth. With respect to sociodemographic characteristics, SDGE youth had similarities; our analysis also revealed the diversity of sexual orientations, gender identities, and preferred pronouns, reflecting the importance of creating clinical spaces that allow for the expression of and are sensitive to such diversities. Gender-

expansive youth did not differ in their reported level of distress and clinician-reported symptoms severity compared to sexually diverse youth. However, gender-expansive youth had more severe social and occupational functioning impairments. In terms of implications, youth mental health services should continue to integrate interventions and support for social and vocational recovery, instead of only focusing on psychological symptoms. Such interventions should also be tailored to particularly vulnerable groups and their experiences, for example, discrimination experiences that may be unique to gender-expansive individuals. Future research should address the lack of recommendations regarding inclusive sociodemographic questionnaires for providers and researchers. Research should not only examine the content of these forms, but also how often the questionnaires should be updated and, if these are co-designed, who should be included on the design team. Additionally, providers should always verify whether the recommendations remain relevant based on how service users complete the forms, as research is necessarily retrospective and new terminology could be used by the time a study is published. Research should also compare the mental health severity of sexually diverse youth, gender-expansive youth, and youth who identify as both sexually diverse and gender-expansive in larger sample sizes than this study. Finally, research should examine the co-design and effectiveness of social and vocational interventions that adequately consider young people's marginalized identities, something that is currently missing in the literature.

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Table 1

Comparing Sociodemographic Categories of Sexually diverse and Gender-expansive Youth

Variables	Sexually diverse	Gender-expansive	Test Statistic	*p* Value
	M (*SD*) / *n* (%)	*M* (*SD*) / *n* (%)		
Sample	**715**	**260**	**$\chi^2(1) = 212.33$**	**< .001**
Age	19.7 (2.9)	19.7 (3.0)	$U = 91664$	.882
Housing	678	218	$\chi^2(2) = 6.67$	.063
Stable	610 (89.97)	184 (84.40)		
Supported	22 (3.24)	9 (4.13)		
Precarious	46 (6.78)	25 (11.47)		
Ethnicity	**671**	**212**	**$\chi^2(2) = 5.51$**	**.036**
White	386 (57.53)	138 (65.09)		
Visible Minority	137 (20.42)	27 (12.74)		
Indigenous	148 (22.06)	47 (22.17)		
NEET Status	439	171	$\chi^2(1) = 2.76$	.097
Not NEET	312 (71.07)	109 (63.74)		
NEET	127 (28.93)	62 (36.26)		

Note. Significant results are bolded. Abbreviation: NEET, not in education, employment, or training.

Table 2

Reported Sexual Orientations, Gender Identies, and Pronouns of Sexually diverse and Gender-expansive Youth

Category	Frequency	Percentage
	n	%
Sexual Orientation	872[a]	
Asexual	72	8.26
Bisexual	387	44.38
Gay	60	6.88
Lesbian	64	7.34
Not sure	72	8.26
Questioning	44	5.05
Queer	42	4.82
Two-spirited	17	1.95
Pansexual	68	7.80
More than one orientation	9	1.03
Other	37	4.24
Gender Identity	260	
Trans woman	56	21.54
Trans man	86	33.08
Genderfluid	51	19.62
Nonbinary	17	6.54
Do not identify with the options	50	19.23
Pronouns	867	
She/her	540	62.28
He/him	241	27.80
They/them	65	7.50
Other	21	2.42

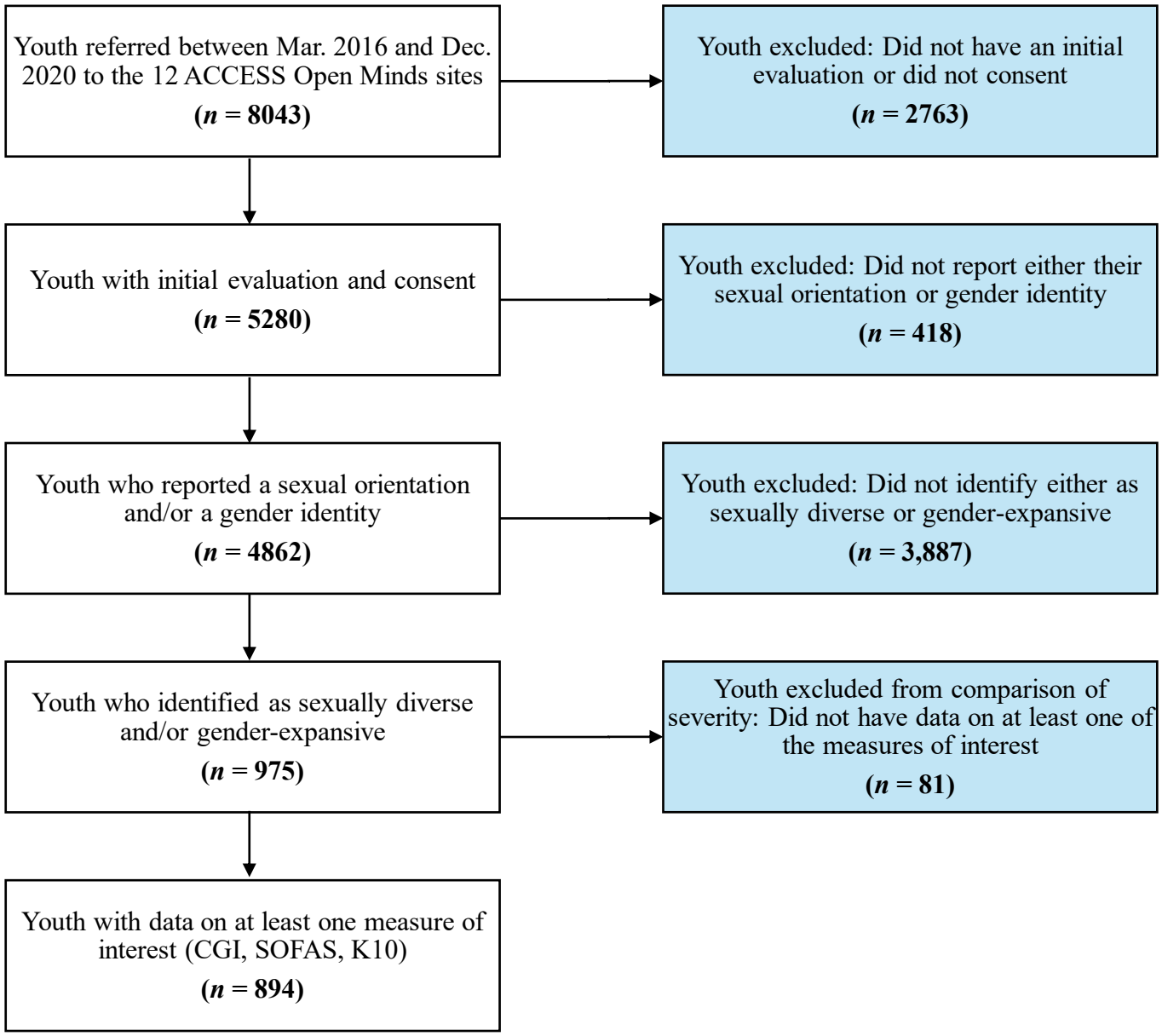
[a] Number corresponding to the reported sexual orientation regardless of the reported gender identity.

Table 3

Severity Scores of Sexually diverse and Gender-expansive Youth

Severity Measures	Sexually diverse	Gender-expansive	Test Statistic	*p* Value
	M (*SD*)	*M* (*SD*)		
K10	23.6 (8.1)	23.7 (9.1)	*U* = 42628	.632
CGI	3.9 (1.1)	3.9 (1.0)	*U* = 66907	.980
SOFAS	61.9 (13.5)	58.6 (14.1)	*U* = 59501	.008

Note. Abbreviations: K10, Kessler psychological distress scale; CGI, clinical global impression scale; SOFAS, social and occupational functioning assessment scale.

Figure 1

Flowchart Describing Sample Sizes