LGBT+ young people's perceptions of barriers to accessing mental health services in Ireland

Abstract

Aim: This paper aims to explore barriers to accessing mental health services in the Republic of Ireland from the perspectives of young LGBT+ people aged 14-25.
Background: Significant mental health disparities exist between LGBT+ young people and their cisgender and heterosexual peers, yet they do not have equitable access to mental health services. Limited research has explored barriers which exist for LGBT+ young people in accessing services, particularly from their perspectives.
Method: An anonymous online survey design, consisting of closed and open questions, was used. The study was advertised through local and national organisations and media. 1064 LGBT+ participants aged 14-25 opted to complete the survey.
Results: Most participants reported several barriers to them accessing mental health services that were interlinked across three levels: individual; sociocultural; and mental health system.
Conclusion: Cultural competency training for practitioners which address issues and concerns pertinent to LGBT+ young people is key to addressing many of the barriers identified.
Implications for Nursing Management: Nurses managers can use the findings to advocate for practice and organisational change with their services to ensure that care is responsive and sensitive to the particular needs of LGBT+ young people.

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INTRODUCTION

Young people who identity as LGBT+ experience additional emotional and psychological stresses compared to heterosexual and cisgender youth as a result of managing a stigmatised identity, encountering heterosexual and gender norms within society, and experiencing victimisation, bullying and discrimination (Acevedo-Polakovich et al., 2013; Rodgers, 2017; Price-Feeney et al., 2020). This may contribute to lower self-esteem and a poorer quality of life (Bosse, 2019; Sefolosha et al., 2019). These stressors are also linked to greater mental health disparities between LGBT+ youth and their heterosexual and cisgender peers. LGBT+ young people are at increased risk of mental health and psychosocial issues, including depression, anxiety, self-harm, suicidal behaviours, posttraumatic stress disorder, eating disorders and substance use disorders (Marshal et al., 2011; Rodgers, 2017; Bosse, 2019; Sefolosha et al., 2019). Significant disparities also exist between Transgender and Gender Diverse (TGD) youth and cisgender youth, with higher rates of risk of depression, self-harm, suicidality, eating disorders, substance use disorders and a greater exposure to bullying and harassment among the former (Dowshen et al., 2016; Eisenberg et al., 2019; Price-Feeney et al., 2020). Despite evidence of increased risk of mental health issues among LGBT+ young people, studies indicate less healthcare utilisation d higher unmet treatment needs amongst LGBT+ youth as compared to the non-LGBT population (Williams & Chapman, 2011; Dunbar Sontag-Padilla et al., 2017; Sefolosha et al., 2019), which may be associated with the difficulties they may experience accessing health care (Rider et al., 2019; Sefolosha et al., 2019).

As research exploring barriers to accessing mental health services among LGBT+ young people is relatively limited (Wagaman, 2014; Brown et al., 2016), with scant qualitative evidence on the experiences of mental health care engagement among LGBT+ young people (Wilson & Cariola, 2019), this paper explores such barriers in the Republic of Ireland from the perspectives of young LGBT+ people aged 14-25. This is part of a larger study which explored the mental health and well-being experiences of LGBTI people in Ireland.

METHODS

Data were collected though an online anonymous survey. The survey included a number of validated scale-based questionnaires, single-item questions and open-ended questions focusing on mental well-being and distress and experiences in school, college and work. A more complete description of the survey is reported elsewhere (Reference inserted after review). To explore participants' perspectives on access to mental health services, participants were asked to indicate from a list of six possible items whether they felt any of these items were a barrier to them accessing mental health services. In addition, participants were provided with an open-ended space and invited to add qualitative comments on their perspectives regarding access to mental health services.

The survey was publicised and promoted through local and national social, health, youth and LGBT organisations, through radio broadcast and LGBT+ events. Any person who identified with a gender or sexual identity minority, were 14 years of age or over, and living in the Republic of Ireland were eligible to participate. The survey was hosted online using

the SurveyMonkey tool (SurveyMonkey Inc.) and made available through a web link on the websites of many LGBT+ organisations. Hard copies of the survey were also made available in several prominent LGBT+ organisations and sent via post to enable participation by those without internet access.

Ethical approval for the study was granted by the University's Research Ethics Committee. A waiver of parental/guardian consent for youth aged under 18 was obtained as the research carried minimal risk to participants. The waiver also facilitated participation by youth who were not out to their parents about their LGBT+ identity, thereby ensuring representation of this cohort within the sample. Quantitative data were analysed using IBM SPSS Statistics Version 21 (IBM Corporation 2012). Data analysis included descriptive statistics. Qualitative data analysis followed Braun & Clarke's (2006) six step process and was carried out by two researchers to enhance rigor of the process.

Participant profile

In total, 2264 LGBT+ participants completed the survey. Of these, 1064 were between the ages of 14-25 years. More information on the gender identity and sexual orientation of the participants is presented in Table 1.

Insert table 1

RESULTS

Quantitative findings

One-fifth of participants indicated that there were no barriers to them accessing mental health services (19.3%, n=205). Of those who identified barriers, these included: fear of the stigma of being labelled (38.9%; n=414); 'private services are too expensive' (37.2%; n=396); a belief that services could not help them (25.5%, n=271); and that services were not LGBT+ friendly (18.3%, n=195). A further 17% reported knowing someone who had a bad experience of mental health services, while 15.8% had a bad experience themselves.

Qualitative findings

One hundred and four participants added qualitative comments that elaborated on other barriers to accessing mental health services. A more in-depth analysis of these participants' responses to mental health questions within the survey revealed that two-thirds had a history of self-harm (66.3%, n=69), three-quarters had suicidal thoughts in their lifetime (75%, n=78) and just over one-quarter had attempted to take their own life (28.8%, n=30). Although the sample's mental health service utilisation was not measured, there was clearly a high level of mental health need. The qualitative findings revealed several barriers that were interlinked across three levels: individual; sociocultural; and mental health system (see Figure 1).

Insert Figure 1

Individual Level Barriers

Participants identified several individual level barriers to accessing mental health services, centring on their beliefs about the severity of need, ability to cope, and confidence to engage with services.

Beliefs about the severity of need: Individuals' self-assessment and self-acceptance of their need to access mental health services impinged upon access. Many people expressed the belief that, in comparison to others, their mental health problem was not bad enough to access treatment and they did not want to waste scarce resources by accessing services or affecting access for other people whom they perceived as being in greater need.

> *I always think my mental health isn't bad enough to need help. (Lesbian female, aged 19-25, participant #2018)*
>
> *I feel like my problems are not serious enough. (Lesbian female, 14-18, 1247)*
>
> *I think that there are people who have it worse than me and I don't want to take services up if someone needs it more than me. (Pansexual female, 14-18, 238)*
>
> *I feel that I did not need them as much as other people might have. (Bisexual female, 14-18, 118)*
>
> *Others need it more than me, I would be wasting time. (Gay male, 14-18, 283)*

A few people described choosing not to access services due to not being self-accepting of their own mental health difficulties. For one individual, avoiding confronting the problem was attributed to not wanting to be perceived as vulnerable by others, while another person explained that availing of services would be an admission of having a problem which they did not want to acknowledge.

> *I'm stubborn. I prefer to think I'm okay. I don't like to be seen as a very vulnerable person. (Gay male, 14-18, 32)*
>
> *If I don't go for help, I can pretend there is no problem. (Gay male, 19-25, 2112)*

Belief in ability to cope*:* Some participants believed that they could self-manage their mental health and preferred to deal with it themselves rather than accessing the help of services.

> *I believe I can help myself. (Lesbian female, 19-25, 1973)*
>
> *I think I can help myself. (Gay male, 19-25, 2141)*
>
> *I have a personal preference of dealing with it my way. (Transgender, 'unclassifiable', 14-18, 1114)*

Lacking in self-confidence: Some participants also expressed a lack of confidence in their ability to engage with mental health practitioners, believing they lacked the articulacy required to discuss their feelings and problems due to issues of trust, feelings of nervousness and dislike of opening up to others.

I don't like asking for help from someone that doesn't even know me and is getting paid to listen. (Gay male, 19-25, 1667)

I have serious trust issues, I don't disclose stuff with family, boyfriend or close friends. (Gay male, 19-25, 2111)

Anxiety makes it difficult to speak. (Bisexual female, 14-18, 125)

Scared to open up to anybody else. (Bisexual female, 19-25, 1960)

Two other participants commented on feeling afraid that their mental health issue would not "be believed" or that "my problems aren't taken seriously".

Sociocultural Context Barriers

Sociocultural barriers were focused on stigma, not wanting parents to know and a lack of family support.

Stigma surrounding the label: In line with the quantitative data, stigma also emerged in the qualitative comments, with some participants feeling that stigma envelops mental health problems, making it difficult for people to access help when needed.

There is a stigma, … I feel Ireland is backwards in ways and attitude towards mental health is one of them. (Gay male, 19-25, 2164)

For me personally, I don't feel stigmatised by seeking help with my mental health, but I think that others may, I feel this the same for everyone though regardless of sexual orientation or gender identity. (Gay male, 19-25, 2169)

A few participants also commented that they did not want anyone to know about their mental health problems, with one participant fearing that:

…if people find out, …they will use it as a weapon against me" (Gay male, 14-18, 288).

'Don't want parent to know': A prominent sociocultural barrier was participants not wanting family to find out about their mental health problem. For those under 18, this was particularly pertinent given that access to services often required their parents' consent or facilitation. Though the reasons for not wanting to disclose were not always elaborated on, for those who did articulate their reasons, these most often related to not wanting to worry or be a burden to family, having poor relationships with their parent(s), and not wanting them to know about their LGBT+ identity or mental health issues.

I don't want my mother to know about my depression. If I wanted to seek a mental health service I would have to tell my mother and she would tell my entire family. (*Homoromantic asexual, demi girl 14-18, 363)*

I didn't want my parents to know I'm in an emotionally bad situation. (Gay male, 14-18,1140)

I don't want to be a burden, or tell my parents about my situation. (Gay male, 14-18, 1089)

I don't want to worry my family by alerting them to the fact I'm not feeling good. (Bisexual female, 19-25, 1135)

I'm honestly too afraid to confide in my mum about how I'm feeling. (Lesbian, transgender , 14-18, 390)

Lack of support from family: In some cases, participants were prohibited or discouraged from accessing mental health services by family members. References to parents not believing in therapy and mental illness (n=2) suggests that these attitudes deterred some participants from accessing services.

My mother won't help me get them [mental health services]. (Pansexual, transgender, 14-18, 212)

My family wouldn't support me. (Bisexual female, 14-18, 1061)

Mental Health System Barriers

Participants identified several barriers at the level of the mental health system and organisation, including a lack of LGBT+ competence within services, dominance of medication as a form of treatment, challenges in the accessibility and availability of services, and prior experiences with services.

Lack of competence to provide LGBT+ affirmative care: Participants expressed concerns about the expertise, training and sensitivity of mental health staff to provide services to LGBT+ individuals. Underlining many of the comments was a perception that mental health practitioners lacked knowledge and understanding in relation to LGBT+ identities, in particular for individuals with non-binary gender identities.

Services are not adequately trained in LGBTI issues and culture. I spend half my time explaining the basics of being queer in Ireland. (Queer, transgender, 19-25, 2203)

There are no psychiatrists willing to see me. I'm "too complicated" and they're "not equipped to deal with" me because I'm trans and depressed and anxious and [names a service] refuse to refer me for surgery until I have a psychiatrist letter which I cannot get because no psych will see me. (Asexual, non-binary, 19-25, 94)

Others feared that, due to practitioner's lack of knowledge, their LGBT+ status would be pathologized and seen as the cause of the mental health problem.

I can access them easily but they don't know I am LGBTI so I don't know how they would react. (Lesbian female, 14-18, 171)

I think they will focus on my LGBTI identity without looking at other causes. (Queer, transgender, 19-25, 2198)

I can access them, but the quality of care is still extremely poor - too little training, and regulation. (Lesbian female, 19-25, 1529)

Dominance of medication: Several participants commented on the dominance of medication as a form of treatment, fearing that if they sought help professionals would dictate treatment, namely medication, and as a consequence they would lose their autonomy and sense of control over their life choices.

I don't want to be put on drugs to curve anxiety problems. Especially when I have improved so much on my own. (Pansexual, female, 19-25, 2027)

My biggest passion in life is writing. My imagination and kooky beliefs on life are my escape. I don't want any "professional" to unravel my thoughts and label me as sick or to tell me to take medication. My mind is my world and I don't want anything to ruin that for me. (Bisexual, female, 19-25, 113)

Accessibility of services: Several participants commented that services were not easily accessible. Participants reported that it is often unclear how and where to access mental health care, as they were poorly signposted or promoted. It was also felt that access points to services were limited, as mental health services are only accessible through referral from a general practitioner.

There's not a clear enough access route to help if you need to talk to someone. (Gay male 19-25, 2081)

I wish there was somewhere I could go where I felt comfortable because if I'm honest recently (past few months) I have felt very down. (Lesbian female 19-25, 571)

Participants also described additional operational deficits which acted as further barriers to access including: the lack of quality care; waiting lists which prohibited timely access to services; and the short-term nature of the help offered.

The mental health services in Ireland are very poor regardless if you are LGBTI+ or not. (Lesbian female, 14-18, 228)

Waiting lists on the public health service are far too long. (Gay male, 19-25, 1177)

… there is only very short-term help offered, services often let you down. (Female, questioning, 19-25, 2048)

Availability of services: Unavailability of services at a local level exacerbated issues around access, thereby necessitating travel and extra cost. Younger participants were particularly vulnerable in this regard due to their age (under 18) and thus, being reliant on their parents, primarily for reasons of consent, but also because of the need for transport and money to facilitate access to services.

> *Too far away and can't go there. (Gay, transgender, 14-18, 352)*

> *Public services are also costly if one doesn't have a medical card. (Queer, transgender, 19-25, 1330)*

Previous experiences with services: In keeping with the quantitative findings on beliefs that services could not help, a few participants who had attempted to access or had been successful in accessing services reported no discernible benefit. These experiences made them reluctant to return to services when help was needed.

> *I went to the services, but they didn't help me. (Lesbian female, 14-18, 196)*

> *I have tried counselling before and didn't feel any benefits. (Lesbian female, 19-25, 2003)*

One participant also commented on a lack of follow-up, which appeared to exacerbate the person's feelings of distress and aloneness.

> *My doctor suggested counselling which didn't happen and then didn't follow up by asking me about it. Overall people treat it [problem] like its nothing. They don't want to help or just won't. I am basically alone. (Gay male, 14-18, 264)*

DISCUSSION

For young LGBT+ people, adolescence and early adulthood are key developmental phases in terms of identity exploration and formation and coming out (Brennan et al., 2012). While many young people navigate these processes successfully, others experience them as challenging and may have to contend with internalised feelings of shame as well as negative reactions from parents, peers and others, all of which can impact negatively on an individual's mental health and well-being. Mental health services have a key role to play in supporting young LGBT+ people during this time, yet this study shows that there are a range of barriers to accessing these services, some of which are individual in nature, and others which relate to the sociocultural context and wider mental health system.

The findings indicate that young LGBT+ people's self-assessment and self-acceptance of their mental health issues are influential factors in help-seeking. Many of the themes created, in terms of minimising distress through denial and avoidance, coping based on self-reliance, and having difficulties with emotional expression, are broadly in line with the findings of other studies on help-seeking among young people (McDermott, Roen, & Scourfield, 2008; McDermott, Hughes, & Rawlings, 2018). A UK study of LGBT youth found that individuals drew on strategies based primarily on the notion of self-reliance and individual responsibility to respond to and cope with homophobia, rather than involving

either family or services as part of that response (McDermott et al., 2008). Another study of suicidality among LGBT youth found that help-seeking tended to be delayed until crisis point after attempts to cope through self-reliance had been exhausted (McDermott et al., 2018). Opting to rely on one's self to cope and manage mental health difficulties may be linked to a perception that mental health services cannot help, with around one-quarter of those who completed the quantitative survey questions holding this view. The qualitative comments suggest that this perception may also have been informed by participants' own, or others' negative interactions with mental health services.

While family acceptance and support is a protective factor against negative mental health outcomes and is linked to positive identity development and greater healthcare access for LGBT+ young people (Bosse, 2019; Wilson & Cariola, 2019), some of the qualitative data also highlights issues associated with the dilemma young participants experienced between needing parental support/consent to access services and feeling a strong sense of needing to conceal their mental health distress or identity from parents. Several other studies identified that 'not wanting parents to know' and fear of parental involvement were barriers to LGBT+ young people accessing care, and that confidentiality and privacy are pertinent concerns for LGBT+ young people when accessing services (Williams & Chapman 2011, Brown et al., 2016; Hughes et al., 2018). Fears regarding disclosure may also stem from living in a non-supportive context (Acevedo-Polakovich et al., 2013).

Significant barriers related to systemic deficits within mental health services, including a perceived lack of appropriately-educated practitioners and/or appropriate services, particularly for young people with non-binary gender identities. The lack of cultural competence within services left some participants fearful of encountering dismissive and pathologizing reactions, and having unwanted treatments, such as medication, foisted upon them. As was noted in this and other studies, knowledge deficits among practitioners result in an onus falling on LGBT+ people to educate those practitioners, particularly where transgender individuals' health care needs are concerned (Grant et al., 2010; Bradford, Reisner, Honnold, & Xavier, 2013). This places an unfair burden on LGBT+ individuals, particularly young people. Although positive attitudes among nurses towards LGBT+ people appear to be improving (Dorsen, 2012; Lim & Hsu, 2016), heterosexist practices are still commonplace, with some nurses mistakenly believing that a person's sexual orientation or gender identity is not relevant to the care they should provide (Beagan, Fredericks, & Goldberg, 2012; Fish & Evans, 2016). These are practices which, no doubt, contribute to LGBT+ individuals' sense of invisibility within services and which can limit the potential for a therapeutic alliance to be developed (Beagan et al., 2012; Stewart & O'Reilly, 2017).

Given young people's apparent negative outlook with regard to formal support services, and their lack of knowledge regarding how to access appropriate services, it is imperative that services develop greater outreach engagement with LGBT+ youth organisations. They should be able to promote awareness of how their services can support LGBT+ youth's mental healthcare needs, signpost pathways to accessing services and provide reassurances of affirmative and inclusive practices, and confidentiality; issues which are especially important to LGBT+ youth (Williams & Chapman, 2011; Bosse, 2019; Eisenberg et al., 2019).

Barriers to quality care provision for LGBT+ youth may also be decreased through education and professional development opportunities for practitioners. At present, however, nursing curricula lack emphasis on the healthcare needs of LGBT+ individuals. As a result, many nurses lack training, knowledge and comfort in providing care to LGBT+ individuals (Carabez, Eliason, & Martinson, 2016; Dorsen & Van Devanter 2016; Rider et al., 2019). Services can begin to address these deficits by introducing policies, procedures and cultural competency training to promote LGBT+ inclusivity.

LIMITATIONS OF THE STUDY

As the findings are based on a non-probability sample of LGBT+ people aged 14-25, it is not known how representative the sample is of the population of LGBT+ people aged 14-25 in Ireland. Moreover, as participants self-selected to take part in the survey, this may have biased the sample towards people who were interested in the subject and motivated to share their views. Given that the qualitative comments were derived from written survey responses, they did not provide the kind of rich contextualised data that other methods, such as semi-structured interviewing, may have yielded. However, the qualitative analysis framework helped to enhance a rigorous process.

CONCLUSION

This paper adds to the research exploring barriers to accessing services among LGBT+ youth from their own perspectives. It highlights how personal beliefs around help seeing and concealment of distress from parents inhibit LGBT+ young people's ability to seek help from mental health services. Negative perceptions regarding services' ability to help and fears regarding encountering stigmatising reactions and forced treatments were also identified as barriers. At a system level, a lack of culturally competent practitioners and a lack of suitable and accessible mental health services also inhibited access.

IMPLICATIONS FOR NURSING MANAGEMENT

Nurse managers can address some of the barriers identified by assessing whether practices, policies, informational systems, and caring environments are inclusive of LGBT+ young people and by advocating for and instigating organisational change within their services, such as ensuring that cultural competency training is available to enhance nurses' ability to provide sensitive and affirmative care to LGBT+ young people and their families.

ETHICAL APPROVAL

Ethical approval for the study was granted by the Research Ethics Committees of the Faculty of Health Sciences in Trinity College Dublin.

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REFERENCES

Acevedo-Polakovich, I. D., Bell, B., Gamache, P., & Christian, A. S. (2013). Service Accessibility for Lesbian, Gay, Bisexual, Transgender, and Questioning Youth. *Youth & Society*, *45*(1), 75–97. https://doi.org/10.1177/0044118X11409067

Beagan, B. L., Fredericks, E., & Goldberg, L. (2012). Nurses' work with LGBTQ patients: "they're just like everybody else, so what's the difference"? *Can J Nurs Res, 44*(3), 44-63.

Bosse, J. D. (2019). Sexual and Gender Identity Development in Young Adults and Implications for Healthcare. *Current Sexual Health Reports, 11*(4), 274-286. doi:10.1007/s11930-019-00215-w

Bradford, J., Reisner, S. L., Honnold, J. A., & Xavier, J. (2013). Experiences of transgender-related discrimination and implications for health: results from the Virginia Transgender Health Initiative Study. *Am J Public Health, 103*(10), 1820-1829. doi:10.2105/ajph.2012.300796

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology,* 3(2), 77-101.

Brennan, A. M., Barnsteiner, J., Siantz, M. L., Cotter, V. T., & Everett, J. (2012). Lesbian, gay, bisexual, transgendered, or intersexed content for nursing curricula. *J Prof Nurs, 28*(2), 96-104. doi:10.1016/j.profnurs.2011.11.004

Brown, A., Rice, S. M., Rickwood, D. J., & Parker, A. G. (2016). Systematic review of barriers and facilitators to accessing and engaging with mental health care among at-risk young people. *Asia Pac Psychiatry, 8*(1), 3-22. doi:10.1111/appy.12199

Carabez, R. M., Eliason, M. J., & Martinson, M. (2016). Nurses' Knowledge About Transgender Patient Care: A Qualitative Study. *ANS Adv Nurs Sci, 39*(3), 257-271. doi:10.1097/ans.0000000000000128

Dorsen, C. (2012). An Integrative review of nurse attitudes towards lesbian, gay, bisexual, and transgender patients. *Can J Nurs Res, 44*, 18-43.

Dorsen, C., & Van Devanter, N. (2016). Open arms, conflicted hearts: nurse-practitioner's attitudes towards working with lesbian, gay and bisexual patients. *J Clin Nurs, 25*(23-24), 3716-3727. doi:10.1111/jocn.13464

Dowshen, N., Meadows, R., Byrnes, M., Hawkins, L., Eder, J., & Noonan, K. (2016). Policy Perspective: Ensuring Comprehensive Care and Support for Gender Nonconforming Children and Adolescents. *Transgend Health, 1*(1), 75-85. doi:10.1089/trgh.2016.0002

Dunbar, M. S., Sontag-Padilla, L., Ramchand, R., Seelam, R., & Stein, B. D. (2017). Mental Health Service Utilization Among Lesbian, Gay, Bisexual, and Questioning or Queer College Students. *J Adolesc Health, 61*(3), 294-301. doi:10.1016/j.jadohealth.2017.03.008

Eisenberg, M. E., McMorris, B. J., Rider, G. N., Gower, A. L., & Coleman, E. (2020). "It's kind of hard to go to the doctor's office if you're hated there." A call for gender-affirming care from transgender and gender diverse adolescents in the United States. *Health Soc Care Community, 28*(3), 1082-1089. doi:10.1111/hsc.12941

Fish, J., & Evans, D. (2016). Promoting cultural competency in the nursing care of LGBT patients. *Journal of Research in Nursing, 21*, 159-162. doi:10.1177/1744987116643232

Grant, J. M., Mottet, J. D., Tanis, J., Herman, J. L., Harrison, J., & Keisling, M. (2010). *National Transgender Discrimination Survey Report on Health and HealthCcare*. Retrieved from https://transequality.org/sites/default/files/docs/resources/NTDS_Report.pdf

Hughes, E., Rawlings, V., & McDermott, E. (2018). Mental Health Staff Perceptions and Practice Regarding Self-Harm, Suicidality and Help-Seeking in LGBTQ Youth: Findings from a Cross-Sectional Survey in the UK. *Issues Ment Health Nurs, 39*(1), 30-36. doi:10.1080/01612840.2017.1398284

IBM Corp. Released 2012. *IBM SPSS Statistics for Windows, Version 21.0.* Armonk, NY: IBM Corp.

Lim, F. A., & Hsu, R. (2016). Nursing Students' Attitudes Toward Lesbian, Gay, Bisexual, and Transgender Persons: An Integrative Review. *Nurs Educ Perspect, 37*(3), 144-152. doi:10.1097/01.nep.0000000000000004

Marshal, M. P., Dietz, L. J., Friedman, M. S., Stall, R., Smith, H. A., McGinley, J., Thoma, B. C., Murray, P. J., D'Augelli, A. R., & Brent, D. A. (2011). Suicidality and depression disparities between sexual minority and heterosexual youth: a meta-analytic review. The Journal of adolescent health : official publication of the Society for Adolescent Medicine, *49*(2), 115–123. https://doi.org/10.1016/j.jadohealth.2011.02.005

McDermott, E., Roen, K., & Scourfield, J. (2008). Avoiding shame: young LGBT people, homophobia and self-destructive behaviours. *Cult Health Sex, 10*(8), 815-829. doi:10.1080/13691050802380974

McDermott, E., Hughes, E., & Rawlings, V. (2018). Norms and normalisation: understanding lesbian, gay, bisexual, transgender and queer youth, suicidality and help-seeking. *Cult Health Sex, 20*(2), 156-172. doi:10.1080/13691058.2017.1335435

Price-Feeney, M., Green, A., & Dorison, S. (2020). Understanding the Mental Health of Transgender and Nonbinary Youth. *Journal of Adolescent Health*. doi:10.1016/j.jadohealth.2019.11.314

Rider, G. N., McMorris, B. J., Gower, A. L., Coleman, E., Brown, C., & Eisenberg, M. E. (2019). Perspectives From Nurses and Physicians on Training Needs and Comfort Working With Transgender and Gender-Diverse Youth. *J Pediatr Health Care, 33*(4), 379-385. doi:10.1016/j.pedhc.2018.11.003

Rodgers, S. M. (2017). Transitional Age Lesbian, Gay, Bisexual, Transgender, and Questioning Youth: Issues of Diversity, Integrated Identities, and Mental Health. *Child Adolesc Psychiatr Clin N Am, 26*(2), 297-309. doi:10.1016/j.chc.2016.12.011

Sefolosha, A., van Wyk, N., & van der Wath, A. (2019). Reframing Personal and Professional Values: A Substantive Theory of Facilitating Lesbian, Gay, Bisexual, Transgender and Intersex Youth-Inclusive Primary Health Care by Nurses. *J Homosex*, 1-22. doi:10.1080/00918369.2019.1696106

Stewart, K., & O'Reilly, P. (2017). Exploring the attitudes, knowledge and beliefs of nurses and midwives of the healthcare needs of the LGBTQ population: An integrative review. *Nurse Educ Today, 53*, 67-77. doi:10.1016/j.nedt.2017.04.008

Wagaman, M. A. (2014). Understanding Service Experiences of LGBTQ Young People Through an Intersectional Lens. *Journal of Gay & Lesbian Social Services, 26*(1), 111-145. doi:10.1080/10538720.2013.866867

Williams, K. A., & Chapman, M. V. (2011). Comparing health and mental health needs, service use, and barriers to services among sexual minority youths and their peers. *Health Soc Work*, 36(3), 197-206. doi:10.1093/hsw/36.3.197

Wilson, C., & Cariola, L. A. (2019). LGBTQI+ Youth and Mental Health: A Systematic Review of Qualitative Research. *Adolescent Research Review*. doi:10.1007/s40894-019-00118-w

Table 1: Sexual orientation and gender identity of sample

		N	%
Sexual Orientation (n=1064)	Lesbian	166	15.6
	Gay	395	37.1
	Bisexual	248	23.3
	Queer	91	8.6
	Heterosexual/Straight	21	2.0
	Asexual	13	1.2
	Questioning/not sure	48	4.5
	Pansexual	56	5.3
	Other	26	2.4
Gender Identity (n=1064)	Male	442	41.5
	Female	475	44.6
	Transgender	52	4.9
	Male with a trans history	9	.8
	Female with a trans history	3	.3
	Intersex	5	.5
	Other	78	7.3

Figure 1: Barriers to accessing mental health services