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Received: 23 July 2020 | Revised: 6 October 2020 | Accepted: 12 October 2020

DOI: 10.1111/jonm.13186

SPECIAL ISSUE PAPER

WILEY

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

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Funding information
This study was funded by a grant from the National Office for Suicide Prevention (NOSP), Ireland.

Abstract

Aim: To explore the 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 LGBTI + 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. 1,064 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: Nurse managers can use the findings to advocate for practice and organisational change within their services to ensure that care and support is responsive and sensitive to the particular needs of LGBT + young people.

KEYWORDS

accessibility, adolescent, mental health services, sexual and gender minorities, young adult

1 | INTRODUCTION

Young people who identify as LGBT + experience additional emotional and psychological stresses compared with heterosexual and cisgender youth as a result of having to manage a stigmatized identity, encountering heterosexual and gender norms within society, and experiencing victimization, bullying and discrimination (Acevedo-Polakovich et al., 2013; Price-Feeney et al., 2020; Rodgers, 2017). 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, post-traumatic stress disorder, eating disorders and substance use disorders (Bosse, 2019; Marshal et al., 2011; Rodgers, 2017; Sefolosha et al., 2019). Significant disparities also exist between transgender and gender-diverse (TGD) youth and cisgender youth, with higher rates of depression, self-harm, suicidality, eating disorders and substance use disorders, and a greater exposure to bullying and harassment among the former (Dowshen et al., 2016; Eisenberg et al., 2020; Price-Feeney et al., 2020). Despite evidence of increased risk of mental health issues among LGBT + young people, studies indicate less health care utilization and higher unmet treatment needs among LGBT + youth as compared to the non-LGBT population (Dunbar et al., 2017; Sefolosha et al., 2019; Williams & Chapman, 2011), which some posit may be associated with the difficulties they may experience accessing health care (Rider et al., 2019; Sefolosha et al., 2019).

In terms of barriers to accessing services, Wagaman's (2014) study highlights how a lack of financial resources acts as a barrier to transgender youth beginning their medical transition, with Lefkowitz and Mannell (2017) noting how service providers can be dismissive of young people who identify as transgender, believing them to be too young to know their identity. While Wilson and Cariola's (2019) systematic review into mental health and LGBTQI + youth identifies the many mental health challenges experienced and alludes to the lack of knowledge among health professionals, the review does not report on barriers experienced by this group in accessing mental health services. Not surprisingly, a number of researchers call for further research into factors influencing sexual and gender minority youth decision-making in relation to accessing mental health care (Brown et al., 2016; Roberts et al., 2018; Wagaman, 2014) in order to improve services and enhance their engagement with mental health care.

2 | METHODS

The aim of this paper was to explore the barriers to mental health care in the Republic of Ireland from the perspectives of young LGBT + people aged 14–25. The findings reported are part of a larger study, which explored the mental health and well-being experiences of LGBTI people in Ireland (Higgins et al., 2016).

TABLE 1 Survey questions on barriers to accessing mental health services

Please tick whether the following are barriers for you accessing mental health services in Ireland. Please tick all that apply.
_____ There are no barriers.
_____ I am afraid of stigma or being labelled.
_____ I don't think the services are LGBTI-friendly.
_____ I have had bad previous experiences.
_____ I know of people who have bad previous experiences.
_____ I don't think the services can help me.
_____ Private services are too expensive.
_____ Other (please tell us): _____ __

Data were collected through an anonymous online survey. The survey included a number of validated scale-based questionnaires, single-item and open-ended questions focusing on mental well-being and distress and experiences in school, college and work. A more complete description of the questions included in the survey is reported elsewhere (Higgins et al., 2016). 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 (see Table 1). The survey was publicized 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, was 14 years of age or over and living in the Republic of Ireland was 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 descriptive statistics with the support of IBM SPSS Statistics Version 21 (IBM Corp. Released, 2012). The valid percentage is reported, that is the per cent when missing data are excluded from the calculations. Qualitative data were imported into NVivo10 (QSR International Pty Ltd, 2014) and analysed using Braun and Clarke's (2006) process of coding, comparing and merging codes into higher order themes. All data were first open-coded inductively. Following this, codes were compared for similarities and differences and merged into higher order themes. The final stage

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TABLE 2 Sexual orientation and gender identity of sample

	(*N* = 1,064)		(*N* = 859)	
	n	**%**	***n***	**%**
Sexual orientation				
Lesbian	166	15.6	137	15.9
Gay	395	37.1	288	33.5
Bisexual	248	23.3	207	24.1
Queer	91	8.6	82	9.5
Heterosexual/straight	21	2.0	17	2.0
Asexual	13	1.2	13	1.5
Questioning/not sure	48	4.5	45	5.2
Pansexual	56	5.3	48	5.6
Other	26	2.4	22	2.6
Gender identity				
Male	442	41.5	323	37.6
Female	475	44.6	404	47.0
Transgender	52	4.9	46	5.4
Male with a trans history	9	0.8	8	0.9
Female with a trans history	3	0.3	2	0.2
Intersex	5	0.5	5	0.6
Other	78	7.3	71	8.3
	Mean	**SD**	**Mean**	**SD**
Age	19.69	3.10	19.66	3.09

of analysis involved grouping barriers under three levels, namely mental health system; sociocultural context; and individual level. Coding was carried out by two researchers to enhance rigour of the process.

2.1 | Participant profile

In total, 2,264 LGBT + participants completed the survey. Of these, 1,064 were between the ages of 14 and 25 years. The gender of the participants was male (41.5%), female (44.6%) and transgender (4.9%). In terms of sexual orientation, the majority identified as gay (37.1%), followed by bisexual (23.3%) and lesbian (15.6%). More information on the gender identity and sexual orientation of the participants is presented in Table 2.

3 | RESULTS

3.1 | Quantitative findings

The majority of the 'young' participants (n = 1,064) indicated that there were barriers to them accessing mental health services (80.7%, n = 859). Although the mental health service utilization was not measured, for this group, an in-depth analysis of their responses to mental health questions within the survey clearly indicated a high level of mental health need. The mean Depression, Anxiety and Stress scores (DASS-42; Lovibond & Lovibond, 1995) were 16.6 (n = 717, SD = 12.6), 13.3 (n = 725, SD = 11.0) and 17.1 (n = 723, SD = 10.9), scores indicative of moderate levels of depression and anxiety, and mild levels of stress. In addition, 53.6% (n = 398) reported a history of self-harm, just over two-thirds had suicidal thoughts in their lifetime (69.4%, n = 507), and just over one-quarter had attempted to take their own life (28.2%, n = 206). Of those who reported a history of self-harm or had attempted to take their own life, a significant number of participants reported not seeking help (See Table 3).

The barriers identified from the six items listed included the following: fear of the stigma of being labelled (38.9%, n = 414); prohibitive cost of private mental health services (37.2%, n = 396); a belief that services could not help them (25.5%, n = 271); and that services were not LGBTI + friendly (18.3%, n = 195). A further 17.0% (n = 180) reported knowing someone who had a bad experience of mental health services, while 15.8% (n = 168) had a bad experience themselves.

3.2 | Qualitative findings

One hundred and four participants added qualitative comments that elaborated on *additional* barriers to accessing mental health services. Analysis of these comments led to the identification of further barriers at three levels: mental health system; sociocultural; and individual (see Figure 1). Where relevant and possible, the quantitative findings are integrated into the qualitative findings; however, the qualitative findings did not replicate the quantitative findings but added different perspectives. Below, participant quotes are accompanied by their self-identified sexual orientation and gender identity, age and ID number.

3.3 | Mental health system barriers

While the prohibitive cost of private mental health services (37.2%, n = 396) was identified in the quantitative data, participants

TABLE 3 Help-seeking among those who reported history

	(*N* = 859)	
	n	**%**
Ever sought support for the problems that led to self-harm		
Yes	251	57.0
No	189	63.0
Ever sought support for the problems that led to suicidal thoughts		
Yes	276	54.8
No	228	45.2
Ever sought support for the problems that led to suicidal attempts		
Yes	126	63.0
No	74	37.0

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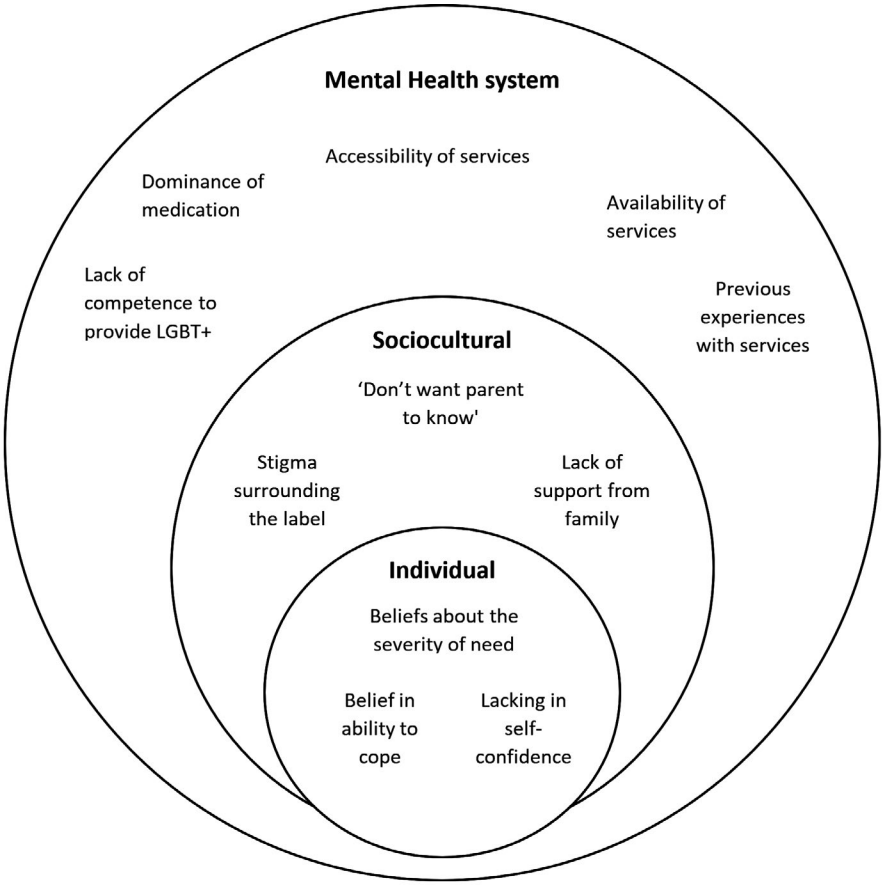

FIGURE 1 Barriers to accessing mental health services

identified several additional barriers at the level of the mental health system and organisation. These included 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.

3.3.1 | 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 LGBTI+ individuals. Underlining many of the comments was a perception that mental health practitioners lacked knowledge and understanding in relation to LGBTI+ 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, 20, 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, 25, 94)

Others feared that, due to practitioners' lack of knowledge, their LGBTI + 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, 16, 171)

> I think they will focus on my LGBTI identity without looking at other causes.
>
> (Queer, transgender, 20, 2198)

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

3.3.2 | Dominance of medication

Several participants commented on the dominance of medication as a form of treatment, fearing that if they sought help, professionals would

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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, 22, 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, 20, 113)

3.3.3 | 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, 20, 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, 23, 571)

Participants also described additional operational deficits, which acted as further barriers to access including the lack of quality care; waiting lists that 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, 18, 228)

> Waiting lists on the public health service are far too long.
>
> (Gay, male, 24, 1177)

> … there is only very short-term help offered, services often let you down.
>
> (Female, questioning, 22, 2048)

3.3.4 | Availability of services

Unavailability of services at a local level exacerbated issues around access, thereby necessitating travel and extra cost. Younger transgender 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 specialist services that were distant from where they lived.

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

> Public services are also costly if one doesn't have a medical card.
>
> (Queer, transgender, 21, 1330)

3.3.5 | Previous experiences with services

In keeping with the quantitative findings where 25% of participants expressed a belief 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, 16, 196)

> I have tried counselling before and didn't feel any benefits.
>
> (Lesbian, female, 20, 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, 15, 264)

3.4 | Sociocultural context barriers

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

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3.4.1 | Stigma surrounding the label

In line with the quantitative data that indicated that 40% feared being labelled mentally ill, stigma was also an issue in the qualitative comments. Some participants reported 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, 20, 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, 20, 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, 15, 288)

3.4.2 | '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 years of age, 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, 15, 363)

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

> I don't want to be a burden, or tell my parents about my situation.
>
> (Gay, male, 16, 1089)

> I don't want to worry my family by alerting them to the fact I'm not feeling good.
>
> (Bisexual, female, 20, 1135)

3.4.3 | 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 suggest that these attitudes deterred some participants from accessing services.

> My mother won't help me get them [mental health services].
>
> (Pansexual, transgender, 16, 212)

> My family wouldn't support me.
>
> (Bisexual, female, 16, 1061)

3.5 | 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.

3.5.1 | 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 with 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, 22, 2018)

> I feel like my problems are not serious enough.
>
> (Lesbian, female, 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, 16, 238)

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I feel that I did not need them as much as other people might have.

(Bisexual, female, 14, 118)

Others need it more than me, I would be wasting time.

(Gay, male, 16, 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 that 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, 18, 32)

If I don't go for help, I can pretend there is no problem.

(Gay, male, 20, 2112)

3.5.2 | 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, 1973)

I think I can help myself.

(Gay, male, 23, 2141)

I have a personal preference of dealing with it my way.

(Orientation not identified, Transgender, 17, 1114)

3.5.3 | 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, 24, 1667)

I have serious trust issues, I don't disclose stuff with family, boyfriend or close friends.

(Gay, male, 21, 2111)

Anxiety makes it difficult to speak.

(Bisexual, female, 18, 125)

Scared to open up to anybody else.

(Bisexual, female, 23, 1960)

Finally, two participants commented on feeling afraid that their mental health issue would not 'be believed' or that 'my problems aren't taken seriously'.

4 | 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 internalized feelings of shame and negative reactions from parents, peers and others, all of which can impact negatively on an individual's mental health and well-being (Saewyc, 2011). In another publication originating from the present study, it became evident that young LGBT + people are most vulnerable and often more unhappy than older LGBT + cohorts (deVries et al., 2020). Mental health services have a key role to play in supporting young LGBT + people, yet this study shows that despite a high level of need, participants experience a range of barriers to accessing these services, some of which are individual in nature, and others that 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 minimizing 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 et al., 2008, 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

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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 health care 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 at-risk young people accessing care, and that confidentiality and privacy are pertinent concerns for LGBT + young people when accessing services (Brown et al., 2016; Hughes et al., 2018; Williams & Chapman, 2011). 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 the onus falling on LGBT + people to educate those practitioners, particularly where transgender individuals' health care needs are concerned (Bradford et al., 2013; Grant et al., 2010). This places an unfair burden on LGBTI + 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 et al., 2012; Fish & Evans, 2016). These are practices that, no doubt, contribute to LGBT + individuals' sense of invisibility within services and that 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 LGBTI + youth organisations. They should be able to promote awareness of how their services can support LGBTI + youth's mental health care needs, signpost pathways to accessing services and provide reassurances of affirmative and inclusive practices, and confidentiality—issues that are especially important to LGBTI + youth (Bosse, 2019; Eisenberg et al., 2020; Williams & Chapman, 2011).

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 health care needs of LGBT + individuals. As a result, many nurses lack training, knowledge and comfort in providing care to LGBT + individuals (Carabez et al., 2016; Dorsen & Van Devanter, 2016; Rider et al., 2019). Services can begin to address these deficits by introducing LGBT + affirmative policies, procedures and referral networks, as well as cultural competency training to promote LGBT + inclusivity.

5 | 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 contextualized data that other methods, such as semi-structured interviewing, may have yielded. However, the analysis framework helped to enhance a rigorous process.

6 | 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 seeking 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 stigmatizing reactions and inappropriate 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.

7 | 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. In addition to promoting their service as inclusive, they also have a role in public health

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campaigns that encourage LGBT + youth to seek help and engage with mental health care.

ACKNOWLEDGEMENTS

We would like to thank GLEN (Gay and Lesbian Equality Network) and BeLonGTo youth services for commissioning this study, and the National Office for Suicide Prevention (NOSP) for funding it. We would also like to thank all the organisations and individuals who assisted with advertising the study, the LGBTI + participants who took the time to complete the survey and the Research Advisory Group for their guidance throughout the project.

ETHICAL APPROVAL

Ethical approval for the study was received from the Research Ethics Committee of the Faculty of Health Sciences in Trinity College Dublin [Ethical Approval Number: 140209].

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How to cite this article: Higgins A, Downes C, Murphy R, et al. LGBT + young people's perceptions of barriers to accessing mental health services in Ireland. *J Nurs Manag*. 2021;29:58–67. https://doi.org/10.1111/jonm.13186

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