REPORT / PEERS IN RESEARCH

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Peers in Research:

Interventions for Developing LGBTQ-Affirmative Behavioral Health Services in Texas

Submitted to the Texas Department of Health and Human Services

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Introduction

Lesbian, gay, bisexual, transgender, and queer (LGBTQ) individuals experience disproportionally high levels of mental health issues (Institute of Medicine, 2011). LGBTQ individuals have higher rates of depression, anxiety, suicidality, substance dependence, and co-morbid issues (Bockting, Miner, Romine, Hamilton, & Coleman, 2013; Burgess, Tran, Lee, & van Ryn, 2008; Cochran & Mays, 2009; Cochran, Sullivan, & Mays, 2003; Grant et al., 2010; King et al., 2008; James et al., 2016) compared to individuals who do not identify as LGBTQ. Research further suggests that LGBTQ individuals have higher rates of mental health and substance use service utilization (Burgess, Tran, Lee, & van Ryn, 2008; Cochran & Mays, 2005; Cochran et al., 2003; Tjepkema, 2008) compared to individuals who are not sexual or gender minorities. These high levels of mental health and substance use issues (and subsequent service utilization rates) stem from experiencing high levels of discrimination, prejudice, stigma, and violence that LGBTQ individuals face in a homophobic[i], transphobic[ii], cissexist[iii], and heterosexist[iv] culture (Bockting et al., 2013; Corliss, Cochran, Mays, Greenland, & Seeman, 2009; Grella, Greenwell, Mays, & Cochran, 2009; James et al., 2016; Robles et al., 2016).

Despite the fact that LGBTQ individuals have higher rates of mental health and substance use issues and service utilization, research also suggests that LGBTQ individuals face substantial barriers to receiving quality care which may delay access to treatment and resolution of these issues (Avery et al., 2001; James et al., 2016). LGBTQ individuals report experiencing various forms of discrimination and insensitive care in mental health settings, including denial of services, pressure to change their sexual orientation and/or to de-transition (i.e., stop being transgender), assumptions that they are heterosexual, being advised to try to "pass" as straight, seclusion in residential settings, having their mental health issue(s) attributed to their sexual or gender identity (or vice versa), and having to provide basic education to service providers about sexual and gender identity (Grant et al., 2010; James et al., 2016; Kidd, Veltman, Gately, Chan, & Cohen, 2011; Willging, Salvador, & Kano, 2006a; Willging, Salvador, & Kano, 2006b)

According to the Institute of Medicine (2011) a main contributor to the disparities in mental health outcomes and quality of care that LGBTQ individuals face is a lack of LGBTQ-affirmative training and education. LGBTQ-affirmative treatment is defined as treatment that affirms an LGBTQ identity as an equally positive identity as a non-LGBTQ identity. Currently all of the major mental health professions in the United States endorse LGBTQ-affirmative treatment as an ethical standard but training and education is lacking. Therefore, it is critical to assess and develop effective interventions aimed at providing LGBTQ-affirmative behavioral health services.

Current Study

In order to develop interventions towards providing LGBTQ-affirmative behavioral health services in Texas, the current study took a multi-step approach. First, in November 2016, TIEMH researchers surveyed public mental health providers in Texas to examine their skills, knowledge, and attitudes towards providing LGBTQ-affirmative mental health services. Second, in May 2018 a workgroup composed of a group of LGBTQ-identified peer specialists and peer recovery coaches examined survey results in relation to the national Culturally and Linguistically Appropriate Standards (CLAS) in health and health care (U.S. Department of Health and Human Services, 2013) to develop interventions aimed at providing LGBTQ-affirmative behavioral health services in Texas. This workgroup is part of the Peers in Research (PIR) project, which is an ongoing project that involves people with lived experience of behavioral health issues and recovery in research processes.

Methods

1. Provider Survey

Purpose. The purpose of the survey was to examine the extent to which public mental health providers in Texas are qualified to provide LGBTQ-affirmative services as well as to assess needs related to better serving LGBTQ populations.

Survey Distribution. In September 2016, emails were sent to executive directors of the 39 Local Mental Health Authorities (LMHAs) in Texas asking that they forward the survey link to direct care providers at their organization. Survey administration took place over a period of four weeks and upon closure, there were 575 valid survey responses. The survey was administered online using Qualtrics survey software, which is a secure survey platform approved by the University of Texas at Austin for Category I data.

Survey Questions. Survey respondents were asked a series of demographic questions, including gender, ethnicity, race, age, educational attainment, income, zip code, and sexual orientation. Next, respondents were asked questions about their employment characteristics including job role, organizational type, and whether or not they provide direct care to clients. Respondents were also asked to complete Versions 1 and 3 of the Sexual Orientation Counselor Competency Scale© (SOCCS) which is a widely-used, psychometrically valid and reliable assessment tool (Bidell, 2005). Version 1 of the SOCCS has three separate sub-scales measuring LGB-affirmative 1) skills, 2) attitudinal awareness, and 3) knowledge, while Version 3 of the SOCCS has three separate sub-scales measuring transgender-affirmative 1) skills, 2) attitudinal awareness, and 3) knowledge. The SOCCS uses a likert scale that ranges from 1 (not at all true) to 7 (totally true). To assess LGBTQ-affirmative practices, respondents were asked to fill out the second half of the Gay Affirmative Practice (GAP) Scale which is a reliable and valid instrument used to measure how often practitioners engage in LGBTQ-affirmative practices (Crisp, 2002). The GAP uses a frequency scale that ranges from 1 (never) to 5 (always). Finally, respondents were asked about whether they have ever provided care to LGBT individuals, whether they believe clients' gender identity and sexual orientation matter for the care they provide and why or why not, whether or not they feel qualified to provide care to LGBT individuals and why or why not, and training needs for providing care to LGBT clients.

Data Analysis. Quantitative survey data were analyzed using SPSS statistical software. Descriptive statistics were run for all quantitative variables and an urban/rural variable was created using zip code data and the USDA's 2013 Rural-Urban continuum codes. Qualitative (open-ended) survey data were analyzed using NVIVO qualitative data analysis software (QSR International, 2012). Codes emerged directly from the data and were developed iteratively and constantly refined – that is some codes were merged while others were disaggregated as more data were analyzed. Qualitative codes that emerged from this analysis were recorded in a codebook with precise and concrete definitions.

2. Peer Workgroup

Purpose. The purpose of the workgroup was to gather recommendations from LGBTQ-identified behavioral health peers that could be used to design interventions to increase LGBTQ cultural competency among behavioral health

service providers in Texas. These recommendations were informed by reviewing results of the survey data and the national CLAS standards.

Recruitment. In February 2018, an email was sent to all individuals certified as peer specialists in the state of Texas asking those that identify as LGBTQ to complete a brief survey about agency needs related to serving LGBTQ people in services (see Appendix A for the results of this survey) as well the opportunity to indicate their interest in participating in a paid workgroup examining cultural competency serving LGBTQ clients. Additionally, through snowball sampling efforts this email was sent to some recovery coaches in Texas. In total, 26 individuals completed this survey and 22 of these individuals indicated that they were interested in participating in the workgroup. Invitations to attend an informational webinar on the workgroup were then sent to 20 individuals (one individual was not invited because they lived out of state and another was not invited because they had never been employed as a peer). Of the 20 individuals who received invitations, 16 signed up to attend one of the two informational webinars. Of the 16 individuals who signed up to attend, 11 individuals attended one of the webinars. All of these 11 individuals agreed to participate in the workgroup.

Consultants. The workgroup was composed of 11 individuals who self-identified as LGBTQ. Nine of these individuals were certified as mental health peer specialists (Certified Peer Specialist), one was certified as a peer recovery coach (Peer Recovery Support Specialist), and one was dually certified. Nine were currently providing direct care in a peer role, whereas two had previously provided direct care in a peer role but were now employed at a mental health training and consultation non-profit organization.

Procedure. The workgroup was held on May 14, 2018 from 10am to 4pm. As consultants, workgroup participants were paid a fee for the day of work and their travel expenses were reimbursed. The workgroup was co-facilitated by a TIEMH researcher and an independent facilitator/consultant (Shane Whalley, LMSW) with experience providing mental health services and conducting trainings on the LGBTQ community. The workgroup consisted of a mixture of didactic presentation, group discussion, group work, and Liberating Structures (i.e., communication microstructures designed to facilitate active participation from all participants; Lipmanowicz & McCandless, n.d.). Table 1 displays the agenda for the workgroup. To ensure accuracy in reporting, the last four agenda items were audio recorded. After the workgroup, the audio recordings were transcribed and recommendations were summarized under relevant CLAS standards.

Table 1: Agenda

Agenda Item	Goal	Activity
Welcome, Agenda, Introductions	Orient to the structure and goals of the day	Impromptu Networking (Liberating Structure)
Community Guidelines, LGBTQ Basics	Develop community standards and discuss appropriate language	Didactic Presentation; Group Discussion
Review Survey Data	Orient consultants to survey data and highlight specific findings	Didactic Presentation; Group Discussion
Overview of CLAS Standards	Orient consultants to CLAS standards	Group Work
Recommendations	Develop recommendations for future	What, So What, Now What? (Liberating Structure)
Resources and Advocacy Tools	Develop a list of LGBTQ specific resources and tools	Group Discussion
Wrap Up	Identify Next Steps	Group Discussion

Results

Provider Survey Results: Demographic Data

There were 575 valid responses to the survey. The majority of respondents were female (77.1%), Non-Hispanic (74.4%), white (74.4%), heterosexual (85.5%), lived in an urban area (87.4%), and were highly educated (53.3% had a post-college degree). See Table 2 for a description of the demographic characteristics of the survey respondents.

Table 2: Demographic Data

	N (%)
Gender	
Male	128 (22.4%)
Female	441 (77.1%)
Transgender	2 (0.3%)
Other/Not listed	1 (0.2%)
Ethnicity	
Hispanic	182 (32.6%)
Non-Hispanic	377 (67.4%)
Race	
American Indian or Alaskan Native	3 (0.5%)
Asian or Pacific Islander	6 (1.1%)
Black/African American	117 (20.8%
White	419 (74.4%)
More than one race	7 (1.2%)
Other	11 (2%)
Education	
Less than 12th grade	0 (0%)
High school diploma/GED	20 (3.5%)
Some college, no degree	62 (10.8%)
Associate or technical two-year degree	29 (5.1%)
Bachelor's degree	156 (27.3%)
Graduate or professional degree	305 (53.3%)
Income	
Less than $25,000	36 (6.3%)
$25,000-$49,000	325 (57.1 %)
$50,000-$74,999	126 (22.1%)
$75,000-$99,000	39 (6.9%)
$100,000-$149,000	24 (4.2%)
$150,000 or more	19 (3.3%)
Sexual Orientation	
Bisexual	19 (3.3%)
Gay	29 (5.1%)
Heterosexual/straight	490 (85.5%)
Lesbian	18 (3.1%)
Other	17 (3.0%)
Urbanicity	
Urban	493 (87.4%)
Rural	71 (12.6%)

Provider Survey Results: Employment Data

The majority of respondents were employed in a community mental health center/local mental health authority (97.7%; see Table 3). Respondents were employed in a variety of job roles, with case manager being the most commonly reported job role (25% of respondents; see Table 4). Seventy-five percent of respondents reported that they provided direct care to people receiving services (see Figure 1). Data were analyzed separately to determine if there were differences between respondents who did and did not provide direct care, but no differences were found.

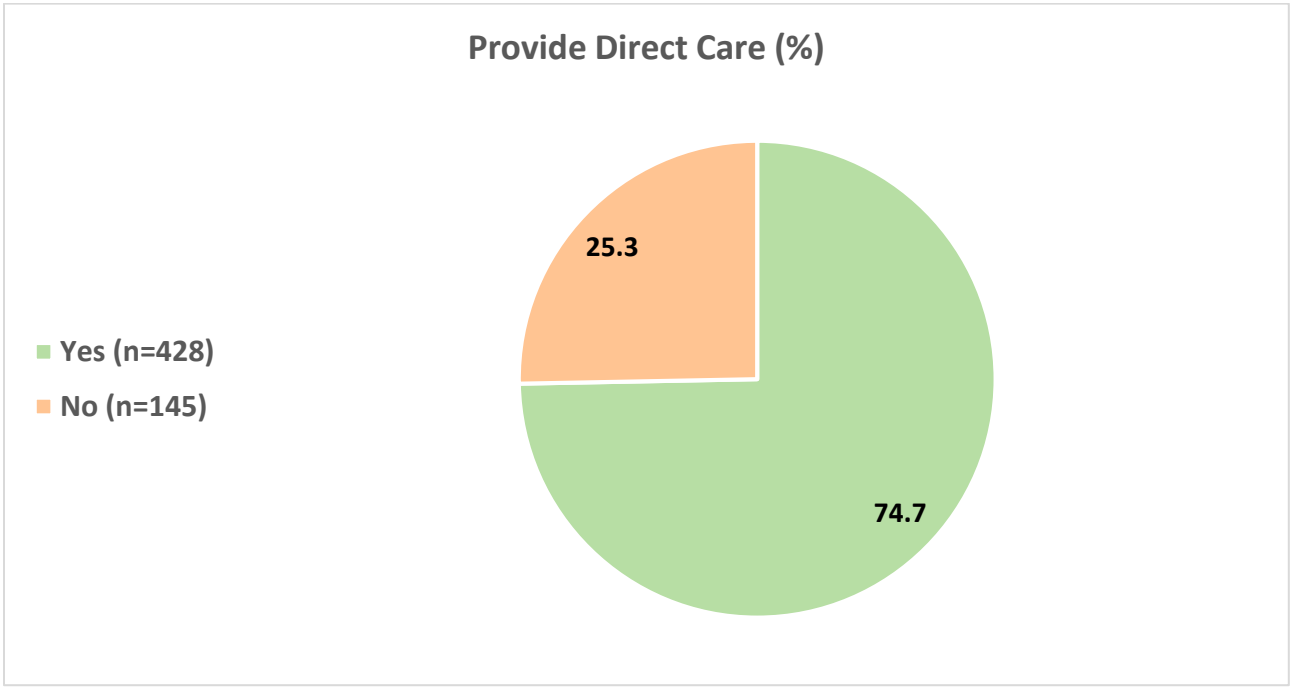
Table 3: Type of Employer Organization

	N (%)
Community Mental Health Center/Local Mental Health Authority	561 (97.7%)
Other	13 (2.3%)
Total	574 (100.0%)

Table 4: Job Role

	N (%)
Administrative Support	70 (12.6%)
Case Manager	139 (25%)
Consumer Representative	4 (0.7%)
Doctor	4 (0.7%)
Education/Rehab	9 (1.6%)
Executive Leadership	28 (5%)
Family Partner	8 (1.4%)
Human Resources	1 (0.2%)
Nurse	26 (4.7%)
Other clinical/direct care	85 (15.3%)
Peer Specialist	14 (2.5%)
Psychiatrist	8 (1.4%)
Psychologist	6 (1.1%)
Quality Management	10 (1.8%)
Recovery Coach	7 (1.3%)
Social Worker	49 (8.8%)
Staff Trainer	2 (0.4%)
Other	86 (15.5%)
Total	575 (100%)

Figure 1: Provide Direct Care



Provider Survey Results: Providing Services to LGBT Clients

Respondents were asked if they had ever provided services to gay, lesbian, or bisexual clients and 81% of respondents indicated that they had while 11% indicated that they had not and 8% were unsure (see Figure 2). Similarly, respondents were asked if they had ever provided services to transgender clients and 51% indicated they had, 34% indicated that they had not, and 15% were unsure (see Figure 3).

Figure 2: Ever Provided Services to Gay, Lesbian, or Bisexual Clients

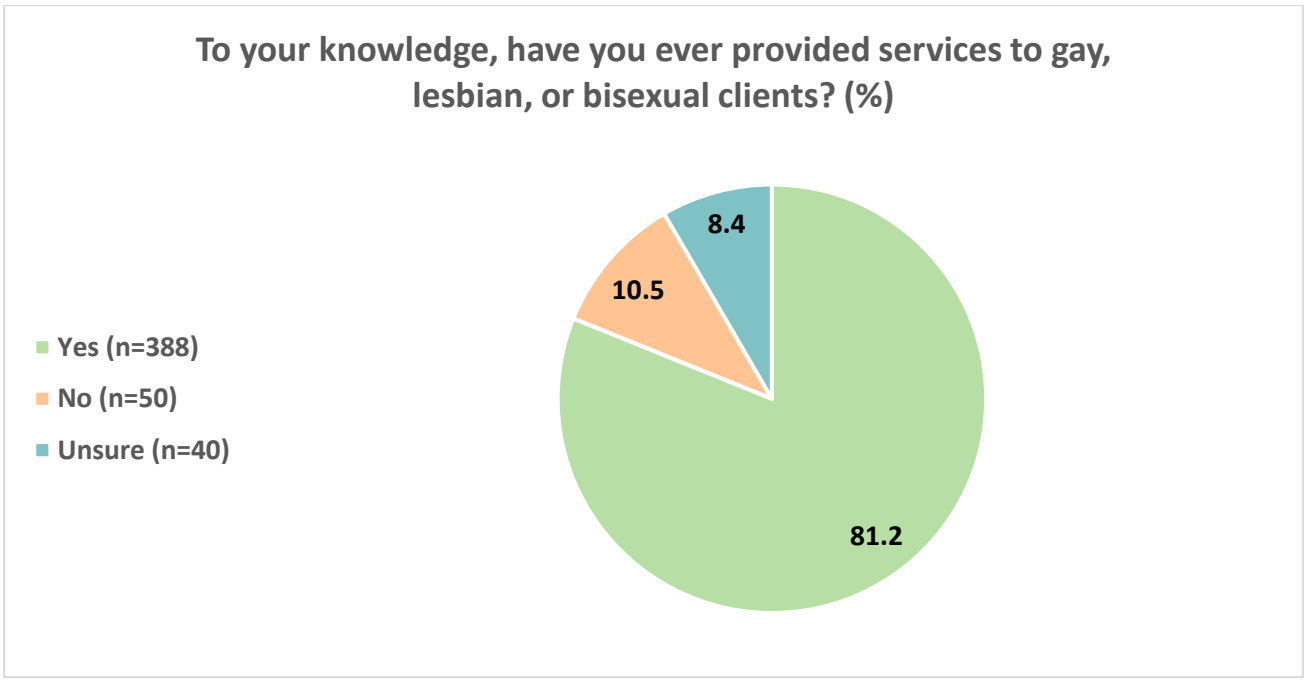
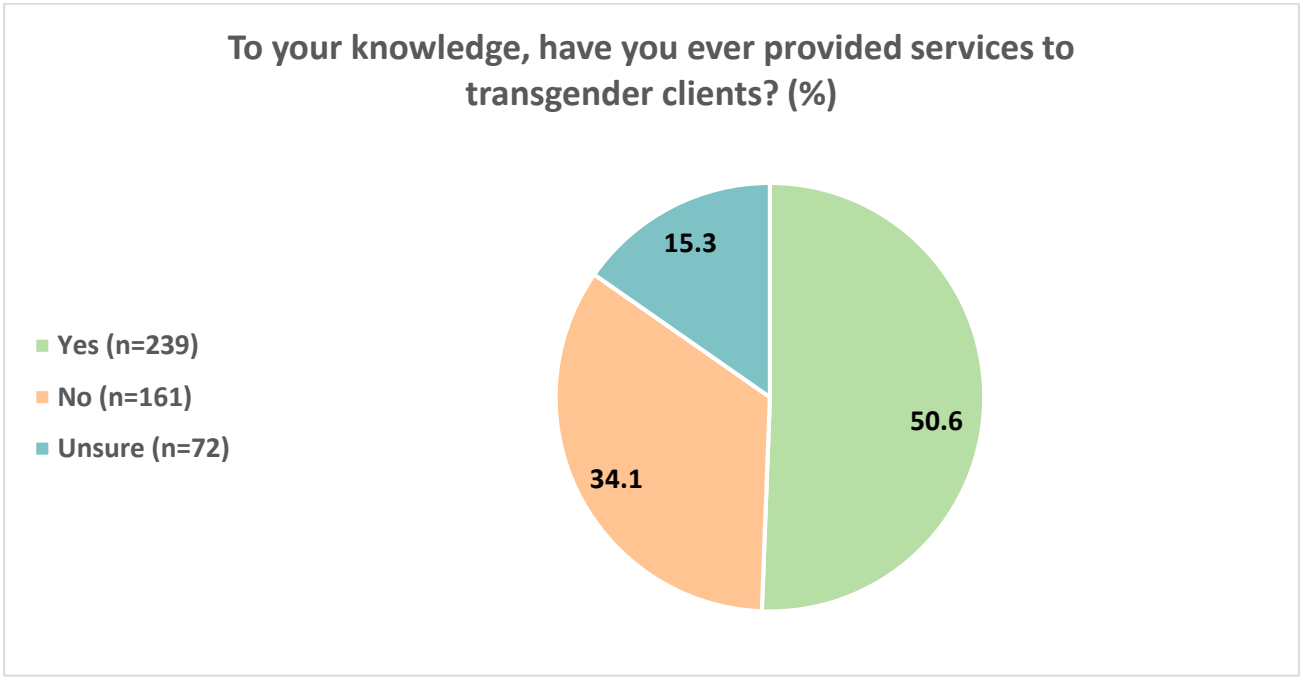


Figure 3: Ever Provided Services to Transgender Clients



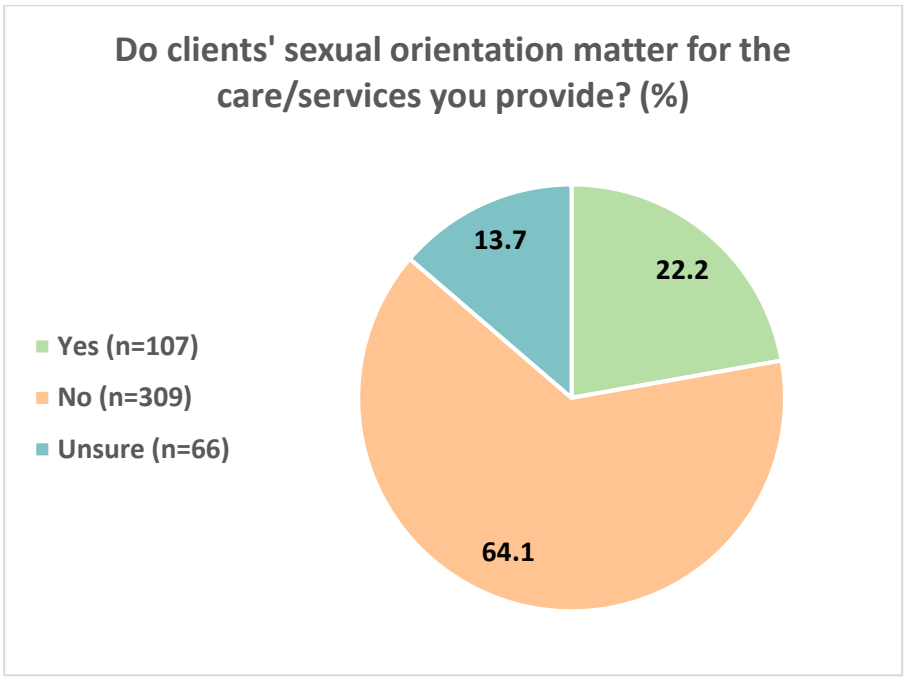
Survey respondents were asked to indicate if sexual orientation matters for the care/services that they provide and to indicate why or why not (see Figure 4). Sixty-four percent of respondents indicated that sexual orientation did not matter for the care/services they provided and the most common qualitative explanations for this were: sexual orientation does not matter for treatment (n=86), they provide services to everyone and do not discriminate on the basis of sexual orientation (n=52), they treat everyone the same (n=51), and service providers should not care about sexual orientation (n=44).

Twenty-two percent of respondents indicated that sexual orientation does matter for the care/services they provide and the most common qualitative explanations for this were: LGB individuals may have experienced more stigma, discrimination, barriers, and challenges with implications for their mental health (n=28), sexual orientation matters for mental health and mental health treatment (n=26), understanding all aspects of a person is important for customizing services (n=16), and service providers need to be open-minded and sensitive (n=10).

Similarly, respondents were asked to indicate if clients' identification as transgender matter for the care/services they provide (see Figure 5). Fifty-seven percent of respondents indicated that it does not matter and the most common qualitative explanations for this were: gender identity does not matter for treatment (n=105), they provide services to everyone and do not discriminate (n=47), service providers should not care about gender identity (n=31), and they treat everyone the same (n=30).

Twenty-six percent of respondents indicated that whether a client identifies as transgender does matter for care/treatment and the most common qualitative explanations for this were: gender identity matters for mental health and mental health treatment (n=41), transgender individuals may have experienced more stigma, discrimination, barriers, and challenges (n=23), understanding all aspects of a person is important for customizing services (n=16), and if it matters to the client (n=8).

Figure 4: Sexual Orientation and Care/Services



YES, IT MATTERS BECAUSE…

- LGB individuals may have experienced more stigma, discrimination, barriers, & challenges (n=28)
- Sexual orientation matters for mental health and mental health treatment (n=26)
- Understanding all aspects of a person is important to customize services (n=16)
- Service providers need to be open-minded and sensitive, rather than biased/judgmental (n=10)

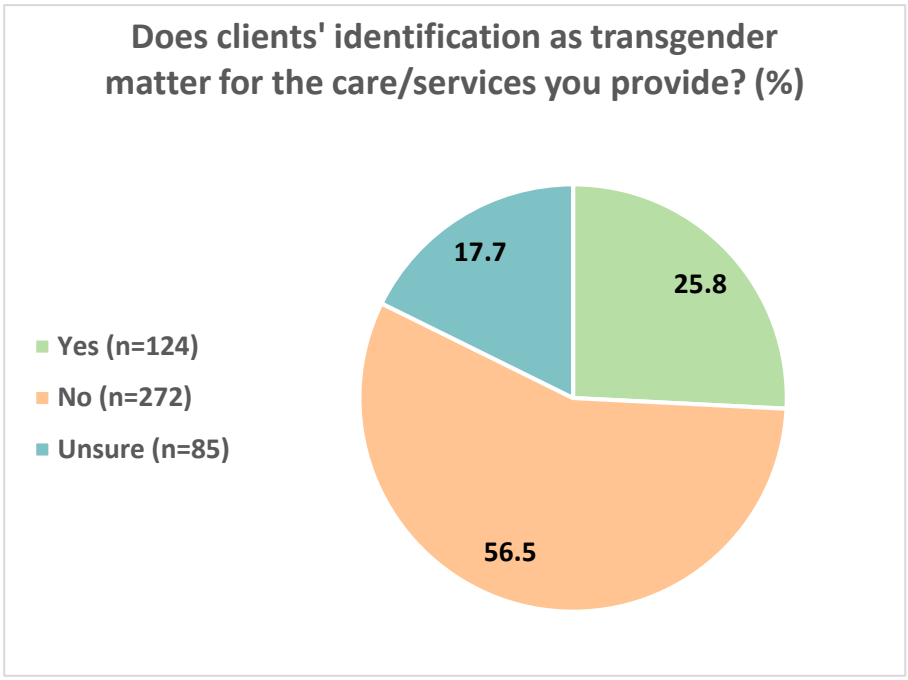
NO, IT DOES NOT MATTER BECAUSE…

- Sexual orientation does not matter for treatment (n=86)
- Provide services to everyone, do not discriminate (n=52)
- Treat everyone the same (n=51)
- Service providers should not care about sexual orientation

UNSURE IF IT MATTERS BECAUSE…

- If it matters to the client (n=12)
- Sexual orientation matters for mental health and mental health treatment (n=6)
- LGB individuals may have experienced more stigma, discrimination, barriers, & challenges (n=5)
- Treat everyone the same (n=5)

Figure 5: Transgender and Care/Services



IF YES, WHY…?

- Gender identity matters for mental health and mental health treatment (n=41)
- Transgender individuals may have experienced more stigma, discrimination, barriers, & challenges (n=23)
- Understanding all aspects of a person is important to customize services (n=16)
- If it matters to the client (n=8)

IF NO, WHY NOT…?

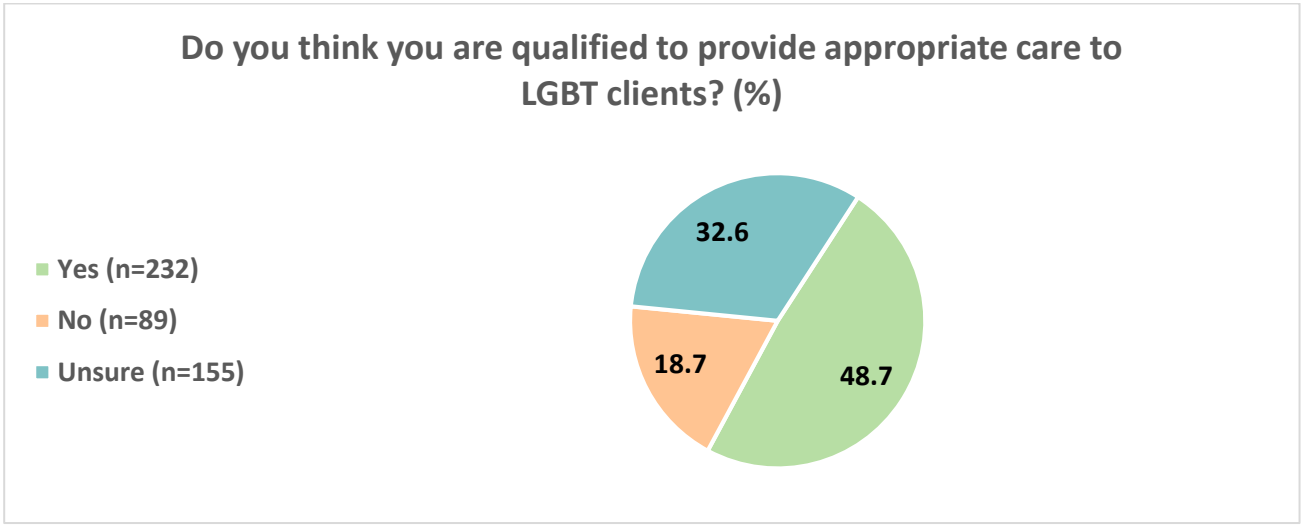
- Gender identity does not matter for treatment (n=105)
- Provide services to everyone, do not discriminate (n=47)
- Service providers should not care about gender identity/be biased (n=31)

IF UNSURE, WHY…?

- If it matters to the client (n=10)
- Only if the reason for seeking services is related to being transgender (n=7)
- Transgender individuals may have experienced more stigma, discrimination, barriers, & challenges (n=4)

Survey respondents were asked to indicate if they believed they are qualified to provide appropriate care to LGBT clients (see Figure 6). Forty-nine percent indicated that they were qualified, 19% indicated that they were not qualified, and 33% indicated that they were unsure if they were qualified or not. The most commonly reported explanation for not being qualified or being unsure about their qualification was a need for training (n=110). Among individuals who reported that they were qualified to provide care to LGBT clients the most common explanation for this qualification was that they treat everyone the same (n=37).

Figure 6: Qualified to Provide Appropriate



IF NO OR UNSURE, WHY NOT…?

- I need training (n=110)
- I need (more) experience working with LGBT clients (n=20)
- I have had some training, but I need more (n=9)
- Sexual orientation/gender identity is not relevant to my work (n=5)
- I have a values/beliefs conflict (n=4)

IF YES, WHY…?

- I treat everyone the same (n=37)
- I am qualified to work with all clients (n=28)
- I have worked with LGBT clients before (n=27)
- I am trained on LGBT issues (n=25)
- I identify as LGBT (n=22)

Figure 7: Recommendations for Trainings

PLEASE DESCRIBE RECOMMENDATIONS YOU HAVE FOR TRAININGS ON PROVIDING CARE TO LGBT CLIENTS…

Training Needs for Specific Populations:

- Training on issues specific to transgender populations (n=9)
- Training on how to support different populations within the LGBT umbrella (n=2)
- Training on differences between LGBT identities (n=2)

Social and Cultural Issues Training Needs:

- How cultural stigma affects LGBT individuals (n=12)
- LGBT culture and history (n=6)
- Socio-cultural issues LGBT individuals face (n=6)
- Family and relationship issues (n=3)
- Workplace discrimination and other work issues (n=2)

Clinical and Therapeutic Training Needs:

- Sensitivity training (n=17)
- Therapies/treatment methods for LGBT clients (n=13)
- Training on stressors/issues LGBT individuals face (n=10)
- Mental health and LGBT (n=7)
- How to support LGBT individuals specific needs (n=7)
- Acceptance/tolerance (n=7)
- Barriers to treatment among LGBT clients (n=7)
- Treatment for addressing stressors LGBT clients face (n=7)
- How to talk to clients about sexual orientation (n=7)
- How to suspend prejudice in sessions (n=6)
- Community resources for LGBT clients (n=6)
- Pronoun usage (n=5)
- Cultural competency (n=5)
- Diagnoses associated with LGBT clients (n=3)
- Use of language (n=3)
- Understanding LGBT clients (n=3)
- Suicide risk (n=2)

Figure 8: Recommendations for Trainings, Continued

PLEASE DESCRIBE RECOMMENDATIONS YOU HAVE FOR TRAININGS ON PROVIDING CARE TO LGBT CLIENTS…

Alternative Training Approaches:

- Examine your biases (n=5)
- Interaction with members of the LGBT community (n=5)
- Self-education (n=3)
- Support groups (n=2)

Training Logistics

- Internal trainings (n=7)
- Mandatory training (n=6)
- In-person training (n=3)
- Continuing education (n=3)

Training for Specific Populations:

- Training for leadership/directors (n=3)
- Training for LGBT clients (n=1)

Training Techniques:

- Role playing (n=4)
- Case studies (n=2)
- Empathy exercises (n=1)
- Clinical training (n=1)

Development/Delivery:

- Training delivered by LGBT clients about their experiences receiving services (n=5)
- Training that incorporates LGBT individuals and their lived experience into training materials (n=5)
- Training delivered by LGBT professionals (n=2)
- Training that incorporates testimony from friends and family of LGBT individuals (n=1)
- Training developed in partnership with LGBT community representative (n=1)
- Training delivered by qualified trainers, not activists (n=1)
- Training delivered by Texas Counseling Association (n=1)
- Training delivered by providers who serve LGBT clients (n=1)

Survey respondents were asked to provide recommendations for training needs on providing care to LGBT clients. These recommendations were qualitatively coded and grouped into categories. Categories that emerged from this coding include training needs for providing care to specific populations within the LGBT community, training needs related to social and cultural issues faced by LGBT individuals, and clinical and therapeutic training needs (see Figure 7). Additionally, respondents identified specific training approaches, training logistics, training needs for specific populations, training techniques, and methods for developing and delivering training (see Figure 8).

Survey respondents were also asked to complete two scales for measuring competency providing services to LGBT clients – the SOCCS and the GAP Scale. Version 1 of the SOCCS measures LGB[v]-affirmative skills, attitudinal awareness, and knowledge while Version 3 measures transgender-affirmative skills, attitudinal awareness, and knowledge. Figure 9 displays the sub-scale means for Version 1 and Version 3 of the SOCCS. On average respondents demonstrated LGB and transgender-affirmative attitudes but scored lower on knowledge about and skills providing LGB and transgender-affirmative services. Table 5 displays the means, standard deviations, and number of responses for each item on Version 1 of the SOCCS. To see the means for each item on the three sub-scales of Version 1 of the SOCCS see Table 6 (attitudinal awareness), Table 7 (skills), and Table 8 (knowledge). Table 9 displays the means, standard deviations, and number of responses for each item on Version 3 of the SOCCS. To see the means for each item on the three sub-scales of Version 3 of the SOCCS see Table 10 (attitudinal awareness), Table 11 (skills), and Table 12 (knowledge).

Figure 9: SOCCS Version 1 (LGB Competency) and SOCCS Version 3 (Transgender Competency) Sub-Scale Means

Means range from 1-7, with higher means indicating greater agreement

Table 5: Sexual Orientation Counselor Competency Scale Version 1 (LGB competency)

	Mean (SD)	N
I have received adequate clinical training and supervision to counsel lesbian, gay, and bisexual (LGB) clients.	3.43 (1.95)	572
The lifestyle of a LGB client is unnatural or immoral.	6.19*(1.61)	562
I check up on my LGB counseling skills by monitoring my functioning/competency – via consultation, supervision, and continuing education.	3.37 (2.03)	567
I have experience counseling gay male clients.	3.39 (2.34)	569
LGB clients receive less preferred forms of counseling treatment than heterosexual clients.	2.41 (1.77)	559
At this point in my professional development, I feel competent, skilled, and qualified to counsel LGB clients.	3.79 (2.06)	562
I have experience counseling lesbian or gay couples.	2.54 (2.10)	557
I have experience counseling lesbian clients.	3.49 (2.34)	563
I am aware some research indicates that LGB clients are more likely to be diagnosed with mental illnesses than are heterosexual clients.	3.88 (2.10)	563
It's obvious that a same sex relationship between two men or two women is not as strong or as committed as one between a man and a woman.	6.49*(1.29)	561
I believe that being highly discreet about their sexual orientation is a trait that LGB clients should work towards.	6.29*(1.41)	556
I have been to in-services, conference sessions, or workshops, which focused on LGB issues (in Counseling, Psychology, Mental Health).	2.99 (2.25)	563
Heterosexist and prejudicial concepts have permeated the mental health professions.	3.47 (1.88)	550
I feel competent to assess the mental health needs of a person who is LGB in a therapeutic setting.	4.43 (2.13)	558
I believe that LGB couples don't need special rights (domestic partner benefits, or the right to marry) because that would undermine normal and traditional family values.	6.28*(1.55)	562
There are different psychological/social issues impacting gay men versus lesbian women.	4.53 (1.79)	535
It would be best if my clients viewed a heterosexual lifestyle as ideal.	6.46*(1.34)	533
I have experience counseling bisexual (male or female) clients.	3.37 (2.28)	538
I am aware of institutional barriers that may inhibit LGB people from using mental health services.	3.79 (2.07)	536
I am aware that counselors frequently impose their values concerning sexuality upon LGB clients.	3.63 (2.00)	536
I think that my clients should accept some degree of conformity to traditional sexual values.	6.30*(1.38)	531
Currently, I do not have the skills or training to do a case presentation or consultation if my client were LGB.	4.58*(2.14)	538

I believe that LGB clients will benefit most from counseling with a heterosexual counselor who endorses conventional values and norms.	6.41*(1.34)	536
Being born a heterosexual person in this society carries with it certain advantages.	4.29 (2.18)	533
I feel that sexual orientation differences between counselor and client may serve as an initial barrier to effective counseling of LGB individuals.	3.10 (1.78)	528
I have done a counseling role-play as either the client or counselor involving a LGB issue.	2.25 (2.06)	531
Personally, I think homosexuality is a mental disorder or a sin and can be treated through counseling or spiritual help.	6.36*(1.54)	536
I believe that all LGB clients must be discreet about their sexual orientation around children.	6.02*(1.65)	538
When it comes to homosexuality, I agree with the statement: 'You should love the sinner but hate or condemn the sin'.	6.07*(1.81)	539
Total Mean	4.42 (0.96)	575

1=not at all true, 4=somewhat true, 7=totally true

Means range from 1-7, with higher means indicating greater agreement

* Indicates reverse scored items, such that higher scores indicate less agreement with the truth of these statements (or higher degrees of competency)

Table 6: Sexual Orientation Counselor Competency Scale Version 1: Attitudinal Awareness Sub-Scale

	Mean (SD)	N
It's obvious that a same sex relationship between two men or two women is not as strong or as committed as one between a man and a woman.	6.49*(1.29)	561
It would be best if my clients viewed a heterosexual lifestyle as ideal.	6.46*(1.34)	533
I believe that LGB clients will benefit most from counseling with a heterosexual counselor who endorses conventional values and norms.	6.41*(1.34)	536
Personally, I think homosexuality is a mental disorder or a sin and can be treated through counseling or spiritual help.	6.36*(1.54)	536
I think that my clients should accept some degree of conformity to traditional sexual values.	6.30*(1.38)	531
I believe that being highly discreet about their sexual orientation is a trait that LGB clients should work towards.	6.29*(1.41)	556
I believe that LGB couples don't need special rights (domestic partner benefits, or the right to marry) because that would undermine normal and traditional family values.	6.28*(1.55)	562
The lifestyle of a LGB client is unnatural or immoral.	6.19*(1.61)	562
When it comes to homosexuality, I agree with the statement: 'You should love the sinner but hate or condemn the sin'.	6.07*(1.81)	539
I believe that all LGB clients must be discreet about their sexual orientation around children.	6.02*(1.65)	538
Total Sub-scale Mean	6.26*(1.21)	575

1=not at all true, 4=somewhat true, 7=totally true

Means range from 1-7, with higher means indicating greater agreement

* Indicates reverse scored items, such that higher scores indicate less agreement with the truth of these statements (or higher degrees of competency)

Table 7: Sexual Orientation Counselor Competency Scale Version 1: Skills Sub-Scale

	Mean (SD)	N
I feel competent to assess the mental health needs of a person who is LGB in a therapeutic setting.	4.43 (2.13)	558
At this point in my professional development, I feel competent, skilled, and qualified to counsel LGB clients.	3.79 (2.06)	562
Currently, I do not have the skills or training to do a case presentation or consultation if my client were LGB.	3.58*(2.14)	538
I have experience counseling lesbian clients.	3.49 (2.34)	563
I have received adequate clinical training and supervision to counsel lesbian, gay, and bisexual (LGB) clients.	3.43 (1.95)	572
I have experience counseling gay male clients.	3.39 (2.34)	569
I check up on my LGB counseling skills by monitoring my functioning/competency – via consultation, supervision, and continuing education.	3.37 (2.03)	567
I have experience counseling bisexual (male or female) clients.	3.37 (2.28)	538
I have been to in-services, conference sessions, or workshops, which focused on LGB issues (in Counseling, Psychology, Mental Health).	2.99 (2.25)	563
I have experience counseling lesbian or gay couples.	2.54 (2.10)	557
I have done a counseling role-play as either the client or counselor involving a LGB issue.	2.25 (2.06)	531
Total Sub-scale Mean	3.39 (1.58)	575

1=not at all true, 4=somewhat true, 7=totally true

Means range from 1-7, with higher means indicating greater agreement

* Indicates reverse scored items, such that higher scores indicate less agreement with the truth of these statements (or higher degrees of competency)

Table 8: Sexual Orientation Counselor Competency Scale Version 1: Knowledge Sub-Scale

	Mean (SD)	N
There are different psychological/social issues impacting gay men versus lesbian women.	4.53 (1.79)	535
Being born a heterosexual person in this society carries with it certain advantages.	4.29 (2.18)	533
I am aware some research indicates that LGB clients are more likely to be diagnosed with mental illnesses than are heterosexual clients.	3.88 (2.10)	563
I am aware of institutional barriers that may inhibit LGB people from using mental health services.	3.79 (2.07)	536
I am aware that counselors frequently impose their values concerning sexuality upon LGB clients.	3.63 (2.00)	536
Heterosexist and prejudicial concepts have permeated the mental health professions.	3.47 (1.88)	550
I feel that sexual orientation differences between counselor and client may serve as an initial barrier to effective counseling of LGB individuals.	3.10 (1.78)	528
LGB clients receive less preferred forms of counseling treatment than heterosexual clients.	2.41 (1.77)	559
Total Sub-scale Mean	3.60 (1.29)	572

1=not at all true, 4=somewhat true, 7=totally true

Means range from 1-7, with higher means indicating greater agreement

Table 9: Sexual Orientation Counselor Competency Scale Version 3 (Transgender Competency)

	Mean (SD)	N
I have received adequate clinical training and supervision to work with transgender clients/patients.	2.73 (1.89)	512
The lifestyle of a transgender individual is unnatural or immoral.	6.09*(1.65)	504
I develop my clinical skills regarding transgender clients/patients via consultation, supervision, and continuing education.	3.30 (2.12)	501
I have experience working with transgender clients/patients.	3.19 (2.28)	508
Transgender clients/patients receive less preferred forms of clinical treatment than non-transgender clients.	3.23 (2.00)	497
At this point in my professional development, I feel competent, skilled, and qualified to work with transgender clients/patients.	3.36 (2.01)	504
I have experience working with transgender couples and/or families.	2.17 (1.88)	504
I have experience working with male to female transgender individuals.	2.76 (2.18)	501
I am aware some research indicates that transgender individuals are more likely to be diagnosed with mental illnesses than are non-transgender individuals.	3.81 (2.14)	493
A transgender person is not as psychologically stable as a non-transgender person.	6.13*(1.44)	499
Being highly discreet about their gender identity and expression is a trait that transgender individuals should work towards.	6.35*(1.33)	498
I have been to professional in-services, conference sessions, or workshops focusing on transgender issues.	2.44 (1.95)	504
Prejudicial concepts about gender have permeated the mental health professions.	3.79 (2.03)	497
I feel competent to assess a person who is transgender in a therapeutic setting.	3.69 (2.12)	497
Transgender people don't need special rights (e.g. employment, marriage, housing, or legal).	6.08*(1.69)	498
There are different issues (i.e., psychosocial, medical) impacting male-to-female versus female-to-male transgender individuals.	4.44 (1.89)	468
It would be best if my clients/patients viewed traditional gender expression as ideal.	6.26*(1.49)	468
I have experience working with transgender female to male individuals.	2.47 (2.07)	470
I am aware of institutional barriers that may inhibit transgender people from using healthcare services.	4.07 (2.09)	467
I am aware that healthcare practitioners impose their values concerning gender upon transgender clients/patients.	3.83 (2.04)	467
My clients/patients should accept some degree of conformity to traditional gender roles and expression.	6.28*(1.41)	464
Currently, I do not have the skills or training to do a case presentation or consultation if my client/patient were a transgender individual.	4.43*(2.17)	472
Transgender individuals will benefit most from a provider endorsing conventional values and norms about gender.	6.33*(1.34)	466

Being born a non-transgender person in this society carries with it certain advantages.	4.27 (2.30)	471
Gender identity differences between provides and clients/patients may serve as an initial barrier to effective clinical care with transgender individuals.	3.63 (1.85)	467
I have done a training role-play involving a transgender clinical issue.	1.80 (1.58)	474
I think being transgender is a mental disorder.	6.35*(1.44)	472
Transgender individuals must be discreet about their gender identity and expression around children.	6.07*(1.57)	468
When it comes to transgender individuals, I believe they are morally deviant.	6.48*(1.29)	471
Total Mean	4.28 (0.93)	517

1=not at all true, 4=somewhat true, 7=totally true

Means range from 1-7, with higher means indicating greater agreement

* Indicates reverse scored items, such that higher scores indicate less agreement with the truth of these statements (or higher degrees of competency)

Table 10: Sexual Orientation Counselor Competency Scale Version 3: Attitudinal Awareness Sub-Scale

	Mean (SD)	N
When it comes to transgender individuals, I believe they are morally deviant.	6.48*(1.29)	471
Being highly discreet about their gender identity and expression is a trait that transgender individuals should work towards.	6.35*(1.33)	498
I think being transgender is a mental disorder.	6.35*(1.44)	472
Transgender individuals will benefit most from a provider endorsing conventional values and norms about gender.	6.33*(1.34)	466
My clients/patients should accept some degree of conformity to traditional gender roles and expression.	6.28*(1.41)	464
It would be best if my clients/patients viewed traditional gender expression as ideal.	6.26*(1.49)	468
A transgender person is not as psychologically stable as a non-transgender person.	6.13*(1.44)	499
The lifestyle of a transgender individual is unnatural or immoral.	6.09*(1.65)	504
Transgender people don't need special rights (e.g. employment, marriage, housing, or legal).	6.08*(1.69)	498
Transgender individuals must be discreet about their gender identity and expression around children.	6.07*(1.57)	468
Total Sub-scale Mean	6.24*(1.09)	513

1=not at all true, 4=somewhat true, 7=totally true

Means range from 1-7, with higher means indicating greater agreement

* Indicates reverse scored items, such that higher scores indicate less agreement with the truth of these statements (or higher degrees of competency)

Table 11: Sexual Orientation Counselor Competency Scale Version 3: Skills Sub-Scale

	Mean (SD)	N
Currently, I do not have the skills or training to do a case presentation or consultation if my client/patient were a transgender individual.	4.43*(2.17)	472
I feel competent to assess a person who is transgender in a therapeutic setting.	3.69 (2.12)	497
At this point in my professional development, I feel competent, skilled, and qualified to work with transgender clients/patients.	3.36 (2.01)	504
I develop my clinical skills regarding transgender clients/patients via consultation, supervision, and continuing education.	3.30 (2.12)	501
I have experience working with transgender clients/patients.	3.19 (2.28)	508
I have experience working with male to female transgender individuals.	2.76 (2.18)	501
I have received adequate clinical training and supervision to work with transgender clients/patients.	2.73 (1.89)	512
I have experience working with transgender female to male individuals.	2.47 (2.07)	470
I have been to professional in-services, conference sessions, or workshops focusing on transgender issues.	2.44 (1.95)	504
I have experience working with transgender couples and/or families.	2.17 (1.88)	504
I have done a training role-play involving a transgender clinical issue.	1.80 (1.58)	474
Total Sub-scale Mean	2.92 (1.45)	516

1=not at all true, 4=somewhat true, 7=totally true

Means range from 1-7, with higher means indicating greater agreement

* Indicates reverse scored items, such that higher scores indicate less agreement with the truth of these statements (or higher degrees of competency)

Table 12: Sexual Orientation Counselor Competency Scale Version 3: Knowledge Sub-Scale

	Mean (SD)	N
There are different issues (i.e., psychosocial, medical) impacting male-to-female versus female-to-male transgender individuals.	4.44 (1.89)	468
Being born a non-transgender person in this society carries with it certain advantages.	4.27 (2.30)	471
I am aware of institutional barriers that may inhibit transgender people from using healthcare services.	4.07 (2.09)	467
I am aware that healthcare practitioners impose their values concerning gender upon transgender clients/patients.	3.83 (2.04)	467
I am aware some research indicates that transgender individuals are more likely to be diagnosed with mental illnesses than are non-transgender individuals.	3.81 (2.14)	493
Prejudicial concepts about gender have permeated the mental health professions.	3.79 (2.03)	497
Gender identity differences between provides and clients/patients may serve as an initial barrier to effective clinical care with transgender individuals.	3.63 (1.85)	467
Transgender clients/patients receive less preferred forms of clinical treatment than non-transgender clients.	3.23 (2.00)	497
Total Sub-scale Mean	3.60 (1.29)	572

1=not at all true, 4=somewhat true, 7=totally true

Means range from 1-7, with higher means indicating greater agreement

To assess LGBT-affirmative practices, respondents were asked to complete two versions of the GAP Scale. Table 13 displays the means, standard deviations, and number of responses for each item on the version of the scale measuring LGB competency while Table 14 displays the means, standard deviations, and number of responses for each item on the version of the scale measuring transgender competency. Overall, these data indicate that respondents do not often engage in LGBT-affirmative practices.

Table 13: Gay Affirmative Practice Scale (LGB competency)

	Mean (SD)	N
I help clients identify their internalized homophobia/biphobia.	2.94 (1.35)	366
I help LGB clients overcome religious oppression they have experienced based on their sexual orientation.	2.77 (1.42)	367
I inform clients about LGB affirmative resources in the community.	2.57 (1.37)	371
I acknowledge to clients the impact of living in a homophobic/bi-phobic society.	2.45 (1.36)	367
I provide interventions that facilitate the safety of LGB clients.	2.44 (1.42)	366
I help lesbian/gay/bisexual (LGB) clients address problems created by societal prejudice.	2.39 (1.35)	368
I educate myself about LGB concerns.	2.32 (1.17)	370
I verbalize that a LGB orientation is as healthy as a heterosexual orientation.	2.18 (1.41)	367
I help clients reduce shame about homosexual or bisexual feelings.	2.16 (1.32)	373
I facilitate appropriate expression of anger by LGB clients about oppression they have experienced.	2.03 (1.31)	366
I respond to a client's sexual orientation when it is relevant to treatment.	1.85 (1.15)	372
I demonstrate comfort about LGB issues to LGB clients.	1.83 (1.18)	370
I discuss sexual orientation in a non-threatening manner with clients.	1.73 (1.21)	371
I create a climate that allows for voluntary self-identification by LGB clients.	1.58 (0.99)	372
I am open-minded when tailoring treatment for LGB clients.	1.54 (0.91)	366
Total Scale Mean	2.20 (1.01)	380

1=Never, 2=Rarely, 3=Sometimes, 4=Usually, 5=Always; Means range from 1-5, with higher means indicating greater frequency

Table 14: Gay Affirmative Practice Scale Modified (Transgender competency)

	Mean (SD)	N
I help clients identify their internalized transphobia	2.71 (1.40)	225
I help transgender clients overcome religious oppression they have experienced based on being transgender.	2.55 (1.40)	225
I inform clients about transgender affirmative resources in the community.	2.46 (1.37)	225
I acknowledge to clients the impact of living in a transphobic society.	2.26 (1.40)	225
I help transgender clients address problems created by societal prejudice.	2.24 (1.35)	225
I educate myself about transgender concerns.	2.22 (1.17)	225
I verbalize that a transgender identity is as healthy as a non-transgender identity.	2.16 (1.40)	225
I provide interventions that facilitate the safety of transgender clients.	2.14 (1.34)	224
I help clients reduce shame about identifying as transgender.	2.04 (1.33)	228
I facilitate appropriate expression of anger by transgender clients about oppression they have experienced.	1.99 (1.26)	225
I demonstrate comfort about transgender issues to transgender clients.	1.75 (1.10)	225
I respond to a client's gender identity when it is relevant to treatment.	1.71 (1.10)	224
I discuss gender identity in a non-threatening manner with clients.	1.62 (1.07)	226
I create a climate that allows for voluntary self-identification by transgender clients.	1.54 (0.95)	225
I am open-minded when tailoring treatment for transgender clients.	1.53 (0.91)	227
Total Scale Mean	2.07 (0.99)	231

1=Never, 2=Rarely, 3=Sometimes, 4=Usually, 5=Always; Means range from 1-5, with higher means indicating greater frequency

Workgroup Results

CLAS Standards. Consultants identified several CLAS standards that were particularly important to providing culturally appropriate care to LGBTQ individuals and suggested specific steps that the state and behavioral health organizations in Texas could take to implement these standards. In this section, consultants' recommendations are presented in relation to the CLAS standards.

Principal Standard:

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Consultant Recommendations for Implementation:

- Organizations should provide an LGBTQ glossary of terms to all staff
- Organizations should be sensitive to individuals' language preferences, including changing intake forms and software to allow space for chosen names and pronouns; non-binary gender identities, gender expressions, and sexual orientations; and diverse partnership types
- Organizations should implement family bathrooms and shower facilities (i.e., single occupancy facilities)
- Organizations should make efforts to build a culturally inclusive and safe environment for LGBTQ staff and people in services (e.g., efforts should be made to display signage and visual representations of the LGBTQ community in buildings and on websites; efforts should be made to develop a culture where it's safe to ask and answer questions about gender and sexuality)
- Funding should be designated for state-wide implementation of LGBTQ trainings for behavioral health staff
- Funding should be designated to examine and model what other states are doing to increase LGBTQ competency among behavioral health employees

Governance, Leadership, and Workforce:

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.

Consultant Recommendations for Implementation:

- Organizational governance and leadership should be trained on LGBTQ issues and needs
- Organizations should implement a process for staff and people in services to be able to easily communicate with upper management about LGBTQ issues and needs
- Organizations should implement an advisory committee composed of LGBTQ staff and people in services that reports to organizational leadership with recommendations for promoting LGBTQ health equity

3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.

Consultant Recommendations for Implementation:

- Efforts should be made to Increase LGBTQ representation in organizational and state-level governance and leadership

4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Consultant Recommendations for Implementation:

- All staff who interact with people in services should be trained on LGBTQ issues; this training should be mandatory
- LGBTQ training should begin with New Employee Orientation training and be continual

- LGBTQ training should provide trainees with an LGBTQ glossary of terms to train staff on appropriate language use and basic information on gender identities; gender expressions; and sexual orientations
- Organizations should provide a specific training for all staff on challenges faced by the transgender community
- LGBTQ training should be trauma-informed
- LGBTQ training should include bias training
- LGBTQ training should include first-person accounts from LGBTQ individuals who have received services
- LGBTQ training should include information on how to ask relevant questions about gender and sexuality and how sexual and gender identities may matter for the individual they are working with as part of a whole-person approach
- LGBTQ training should include information on how to approach sensitive (yet important) topics with individuals such as relationships, dating, sex, and bodies
- LGBTQ training should include information on how to help people who are questioning and/or coming out as well as how to provide non-pathologizing support to parents and partners

Engagement, Continuous Improvement, and Accountability:

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.

Consultant Recommendations for Implementation:

- Organizations should implement non-discrimination policies that cover gender identity, gender expression, and sexual orientation
- Organizations should implement LGBTQ specific support groups
- Organizations should celebrate LGBTQ Pride Month in June and highlight LGBTQ Pride regularly; celebration should include distributing Pride t-shirts and displaying Pride flags and signage

10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.

Consultant Recommendations for Implementation:

- Organizations should conduct regular focus groups and surveys to gauge the success of CLAS-related activities (e.g., data collection efforts should focus on LGBTQ individuals' levels of satisfaction with current implementation and solicit feedback in terms of what is and is not working well)
- Funding should be designated for research to examine the extent to which LGBTQ CLAS-related activities currently exist at behavioral health organizations across Texas
- Funding should be designated for research to examine if implementation of LGBTQ CLAS-related activities results in lower costs (as measured by fewer hospitalizations, emergency visits, etc.)

11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.

Consultant Recommendations for Implementation:

- Organizations should collect accurate and reliable demographic data to evaluate the impact of training on health equity and outcomes. To do so, organizations must modify intake forms to include non-binary sexual orientations, gender identifies, and gender expressions

13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.

Consultant Recommendations for Implementation:

- Organizations should partner with LGBTQ community organizations when conducting research
- LGBTQ community organizations should develop staff trainings
- Organizations should partner with LGBTQ ally organizations (e.g., PFLAG; Equality Texas)
- Organizations should engage in community building and outreach with the LGBTQ community

14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.

Consultant Recommendations for Implementation:

- Organizations should add LGBTQ-specific language to external and internal grievance resolution processes
- Organizations should implement rights violations if staff do not honor a person's chosen name and pronouns

15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

Consultant Recommendations for Implementation:

- Organizations should acknowledge and honor the LGBTQ community and the work that organizations are doing to implement CLAS

Discussion and Summary

Data collected from both the survey and the workgroup suggest several key needs as Texas works to develop LGBTQ-affirmative behavioral health services. These needs are summarized and discussed in this section.

Training Needs

Survey results indicate that although most providers in Texas do not hold overtly prejudicial attitudes towards LGBTQ clients, most providers lack the knowledge and skills to provide appropriate care to LGBTQ clients, or are not aware of its importance. This appears to be due to a lack of training and education on providing LGBTQ-affirmative behavioral health services. Both survey respondents and workgroup consultants provided recommendations for developing an LGBTQ-affirmative training for staff at behavioral health organizations in Texas. These recommendations include:

- Mandatory training for all staff; training should begin with New Employee Orientation and be ongoing
- Training should provide trainees with an LGBTQ glossary of terms to train staff on appropriate language use and basic information on gender identities, gender expressions, and sexual orientations
- Training should be developed in consultation with members of the LGBTQ community and include first-person accounts from LGBTQ individuals who have received services
- Training should include information on how to ask relevant questions about gender and sexuality
- Training should include information on how sexual and gender identities may matter for the individual they are working with as part of a whole-person approach; this information should emphasize the importance of gender and sexuality for behavioral health
- Training should include information on how to approach sensitive (yet important) topics with individuals such as relationships, dating, sex, and bodies

Policy Changes

Data collected from workgroup consultants indicate organizations should make specific policy changes as they work towards providing LGBTQ-affirmative care. These policy changes include:

- Implementing non-discrimination policies that cover gender identity, gender expression, and sexual orientation for staff and people receiving services
- Implementing policies to ensure that intake forms and software allow space for chosen names and pronouns as well as non-binary gender identities, gender expressions, and sexual orientations
- Implementing LGBTQ-specific language to external and internal grievance resolution policies and procedures, including policies that protect individuals' right to use their chosen names and pronouns
- Implementing policies that mandate conducting regular evaluation research to assess LGBTQ individuals' levels of satisfaction with current implementation and solicit feedback in terms of what is and is not working well
- Implementing policies that mandate the development of an advisory committee composed of LGBTQ staff and people in services that reports to organizational leadership with recommendations for promoting LGBTQ health equity

Cultural and Environmental Changes

Data collected from workgroup consultants indicate organizations should make specific cultural and environmental changes as they work towards providing LGBTQ-affirmative care. These changes include:

- Organizations should implement family bathrooms and shower facilities (i.e., single occupancy facilities)
- Organizations should implement LGBTQ specific support groups
- Organizations should celebrate LGBTQ Pride Month in June and highlight LGBTQ Pride regularly; celebration should include distributing Pride t-shirts and displaying Pride flags and signage
- Organizations should make efforts to build a culturally inclusive and safe environment for LGBTQ staff and people in services (e.g., efforts should be made to display signage and visual representations of the LGBTQ community in buildings and websites; efforts should be made to develop a culture where it's safe to ask and answer questions about gender and sexuality)

Summary

A large body of research suggests that LGBTQ individuals have poorer (or more negative) mental health outcomes and higher rates of substance use compared to individuals who do not identify as LGBTQ due to societal discrimination and stigma (Corliss et al., 2009; Grella et al., 2009). Data presented in this report suggest that LGBTQ individuals who seek care at behavioral health organizations often encounter providers who lack the skills and knowledge to provide culturally appropriate care as well as organizational environments that are not LGBTQ-friendly. Remedying these disparities requires that behavioral health organizations implement training for all staff as well as make specific policy, environmental, and cultural changes. Future research should continue consulting with LGBTQ-identified peers to develop, implement, and facilitate LGBTQ-affirmative training for behavioral health staff in Texas.

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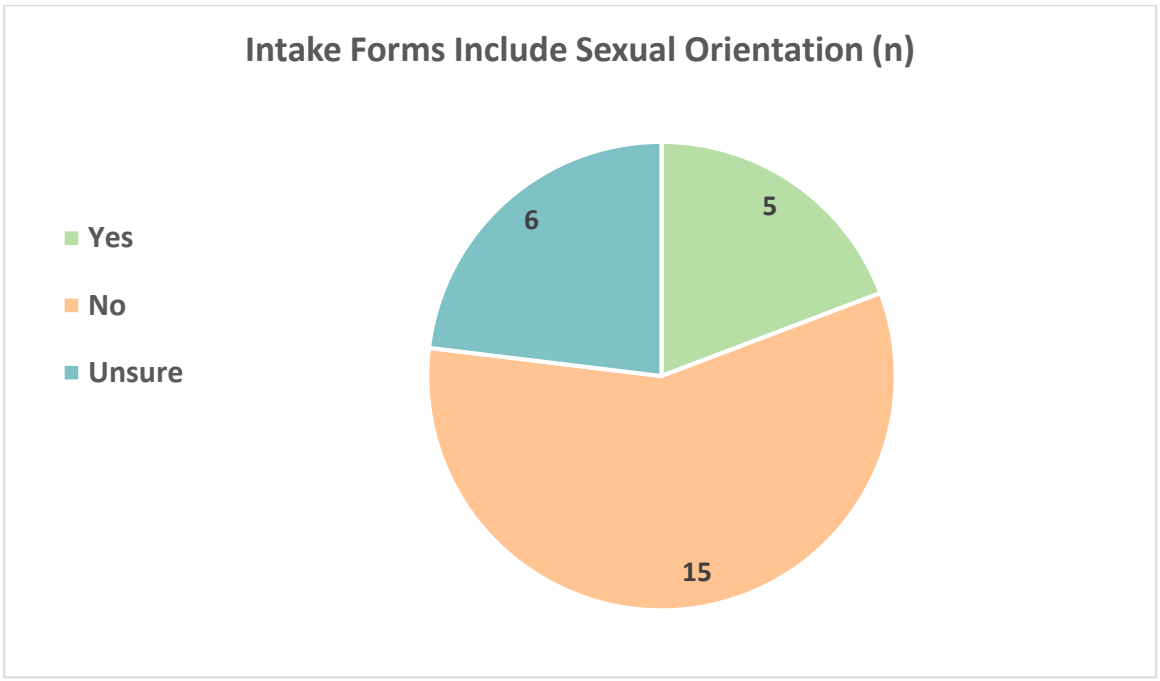
Appendix A: Recruitment Survey Results

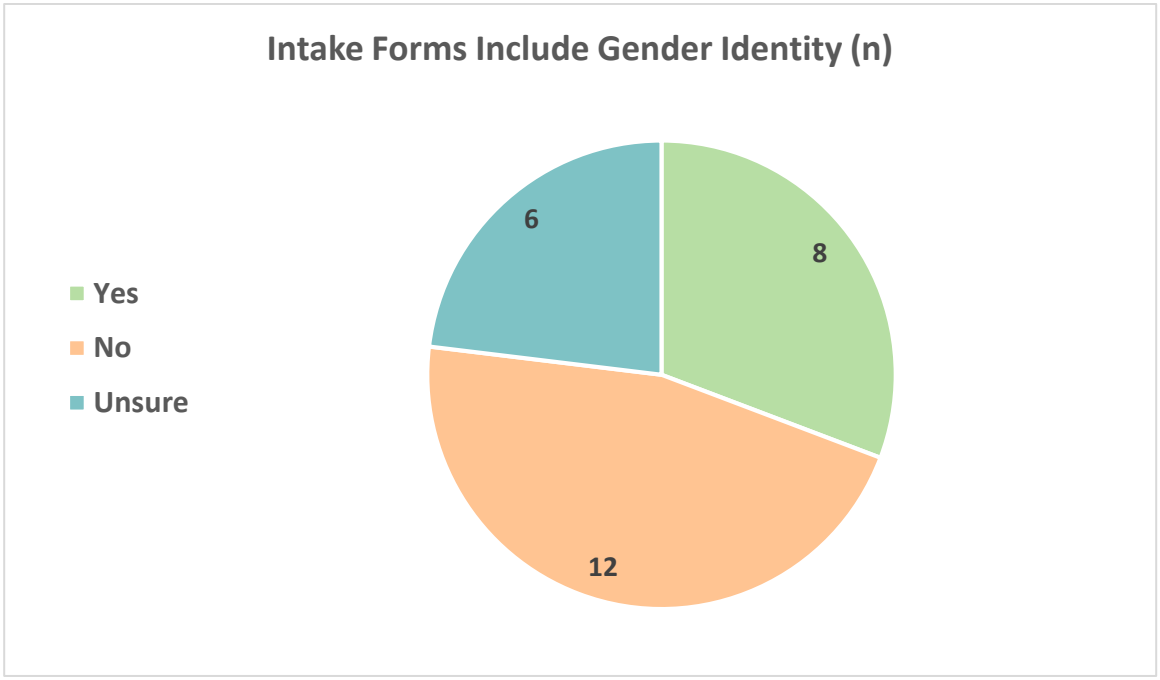
Demographic Data

	(N)
Gender Identity	
Male	11
Female	13
Genderqueer	1
Other	1
Ethnicity	
Hispanic or Latino	1
Non-Hispanic	24
Race (select all that apply)	
American Indian or Alaska Native	2
Asian or Asian American	0
Black or African American	4
Native Hawaiian or other Pacific Islander	0
White	23
Sexual Orientation	
Gay	8
Lesbian	8
Bisexual	5
Transgender	1
Asexual/None	2
Queer	1
Homosexual	1
Employer Organization- Type	
LMHA	9
MCO	1
Organization that services people experiencing homelessness	1
State hospital	1
Other	8

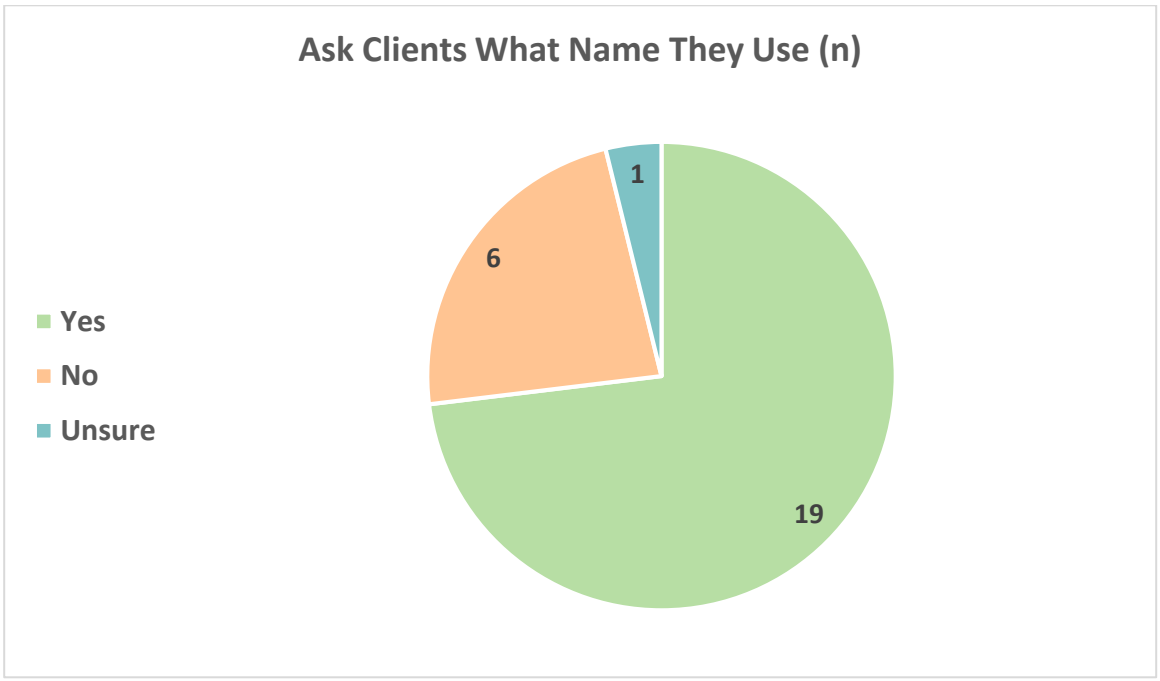
Do intake forms at your agency include sexual orientation?



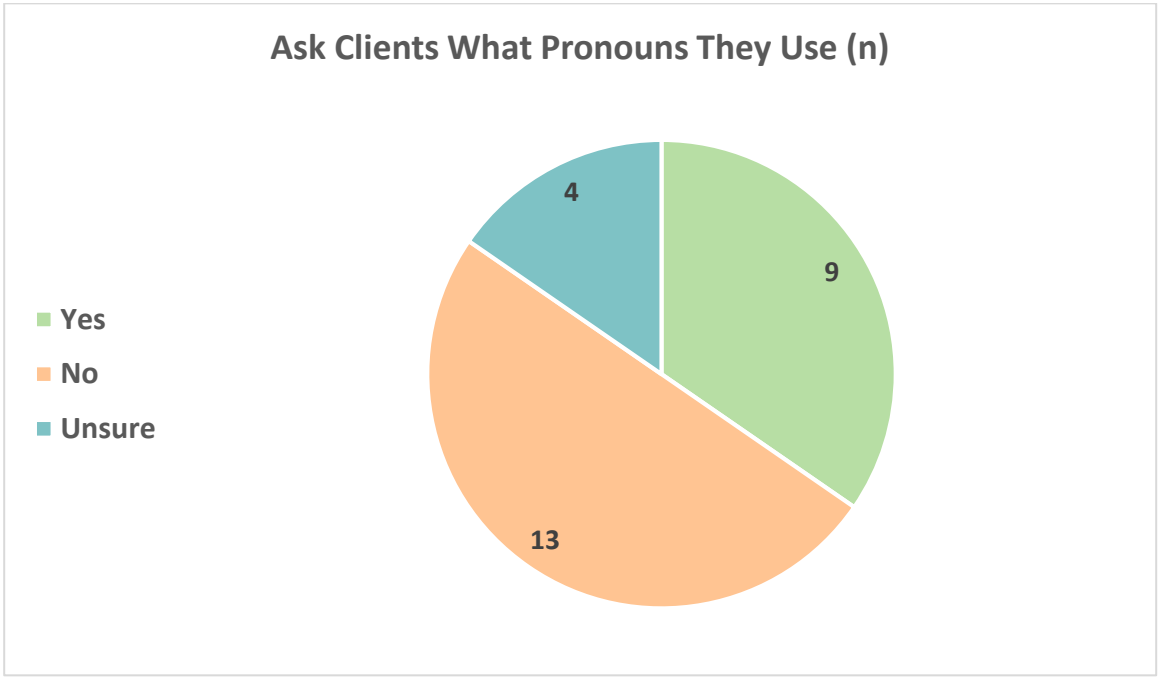
Do intake forms at your agency include a way for people to identify as transgender or gender non-binary?



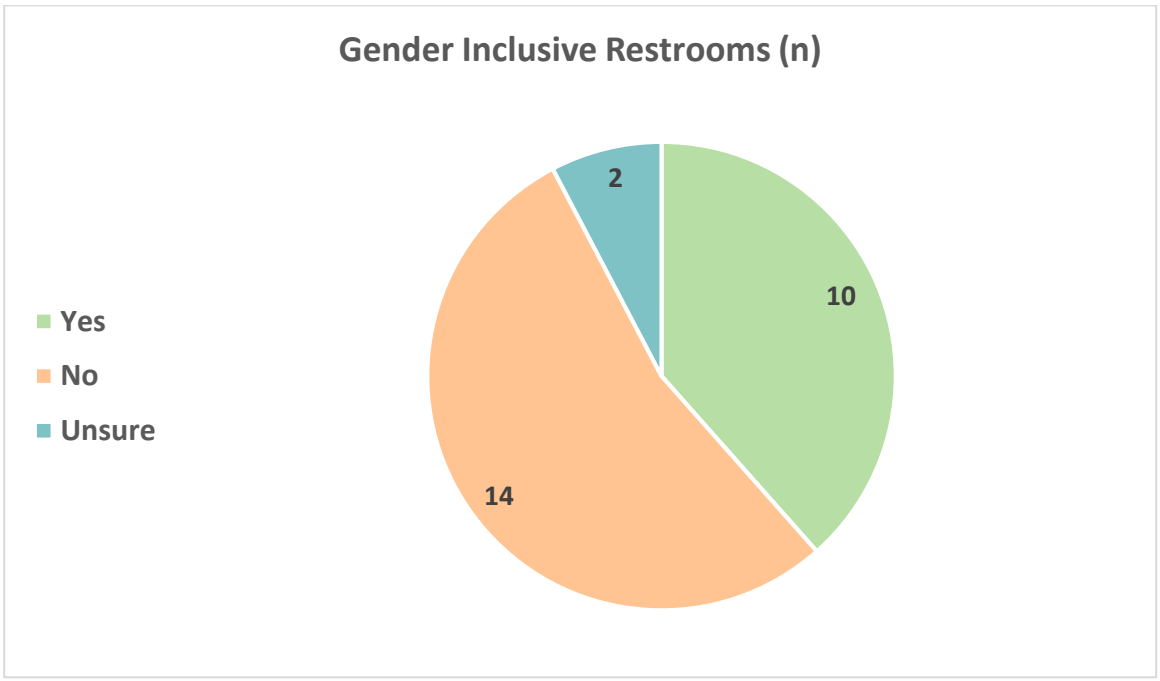
Does your agency ask clients when name they use?



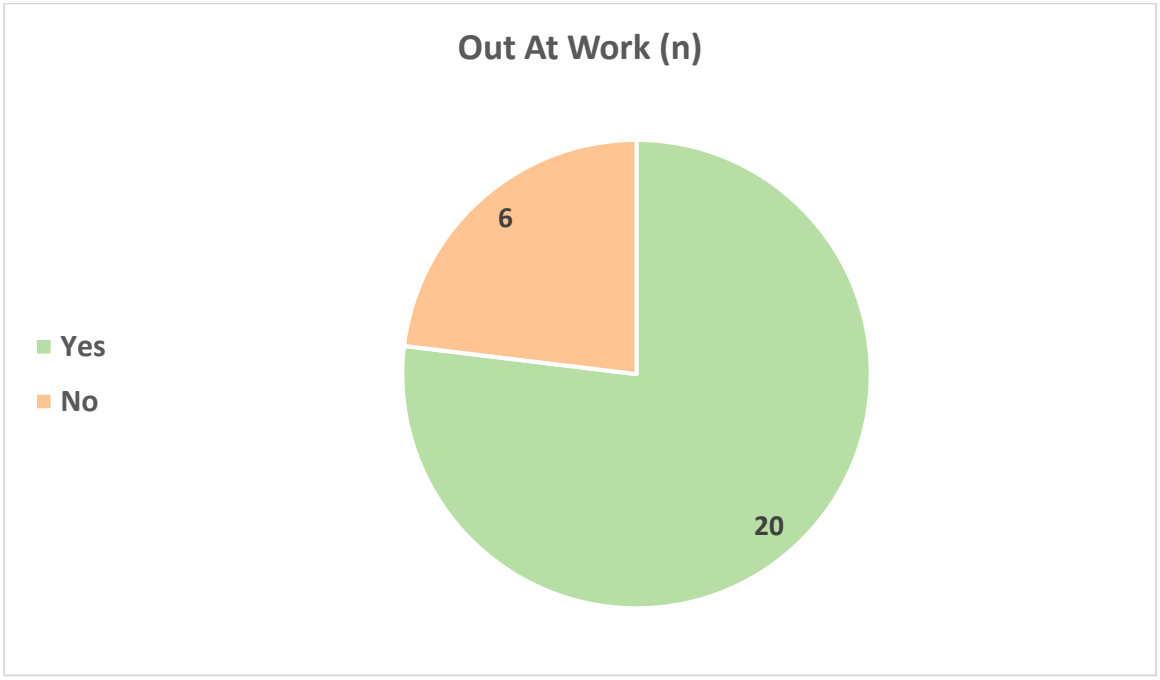
Does your agency ask clients what pronouns they use?



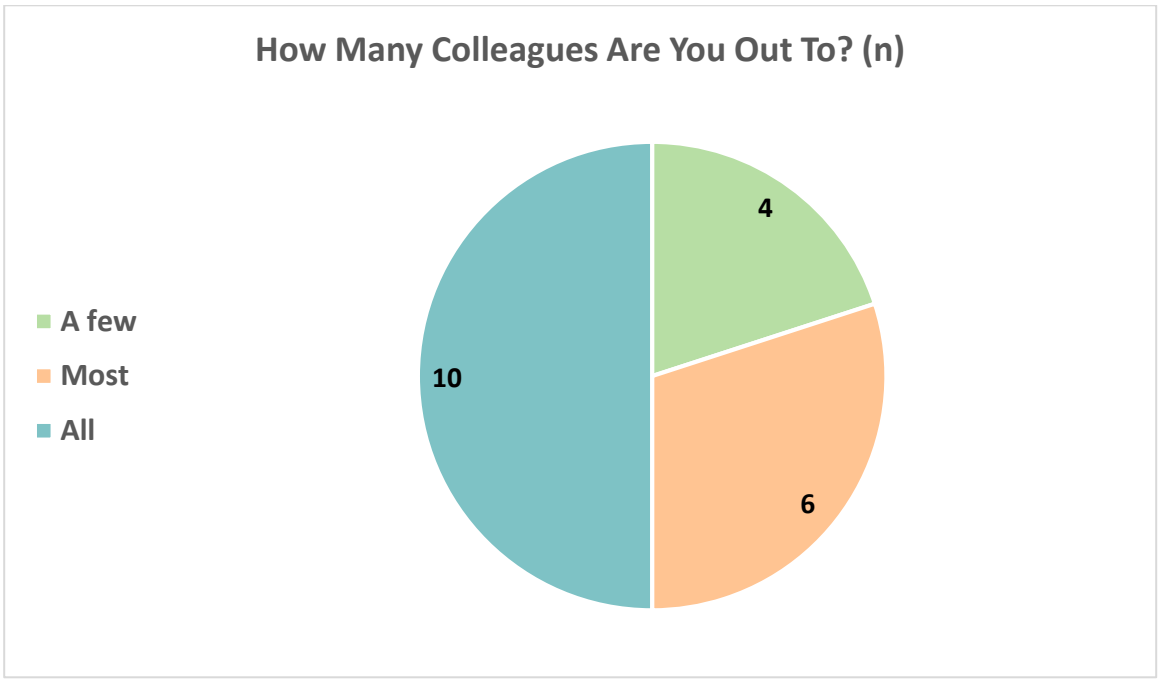
Does your agency have gender inclusive restrooms?



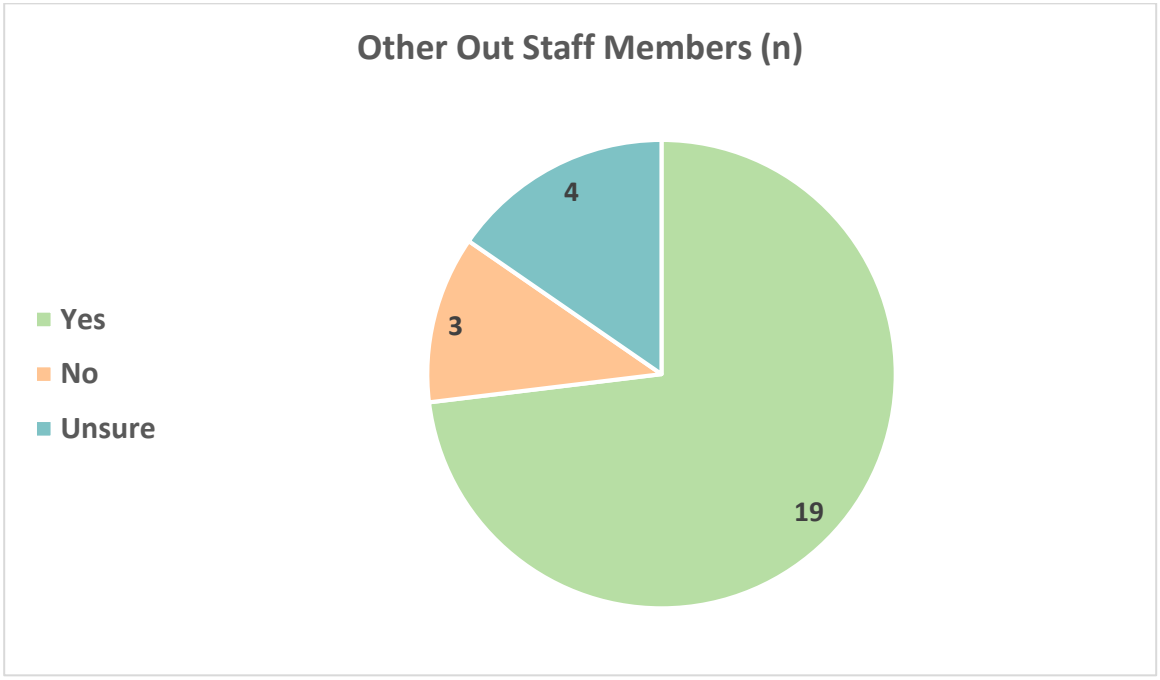
Are you out at work?



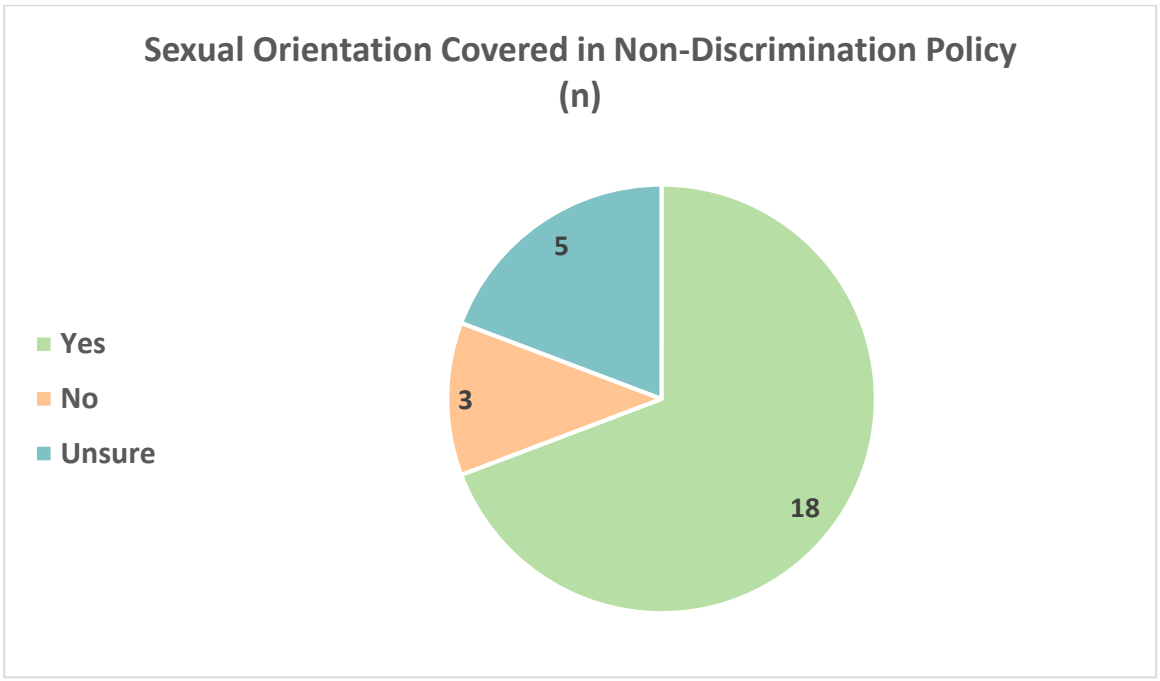
If you are out at work, about how many colleagues are you out to?



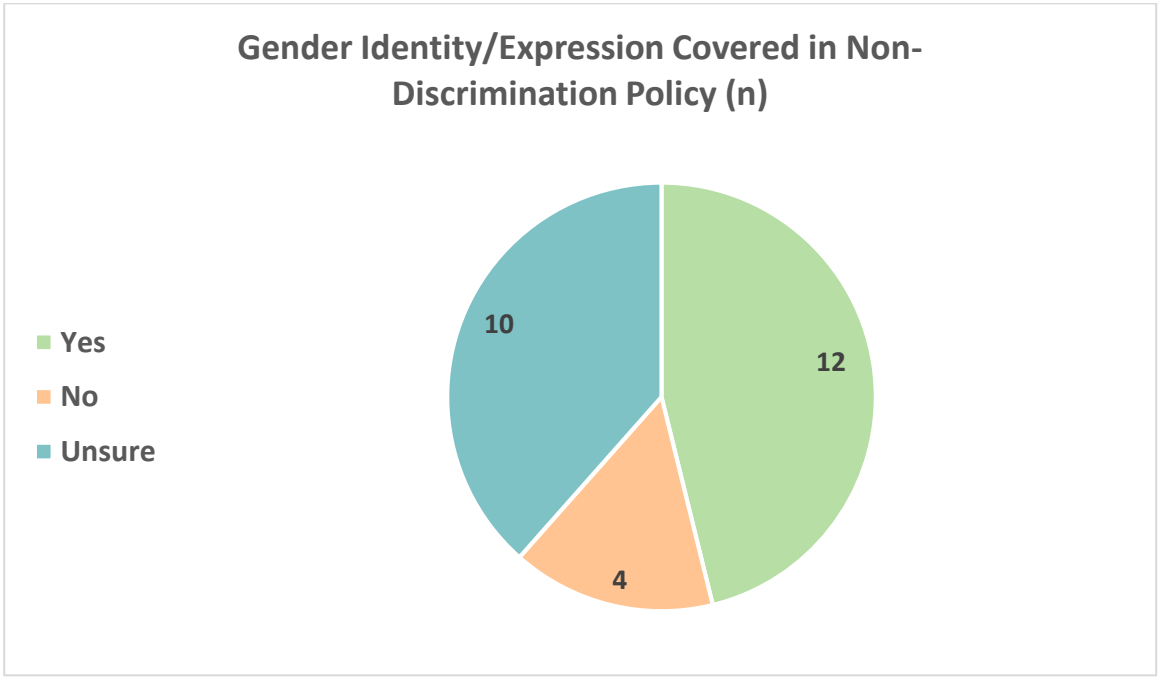
Are there other out staff members at your agency?



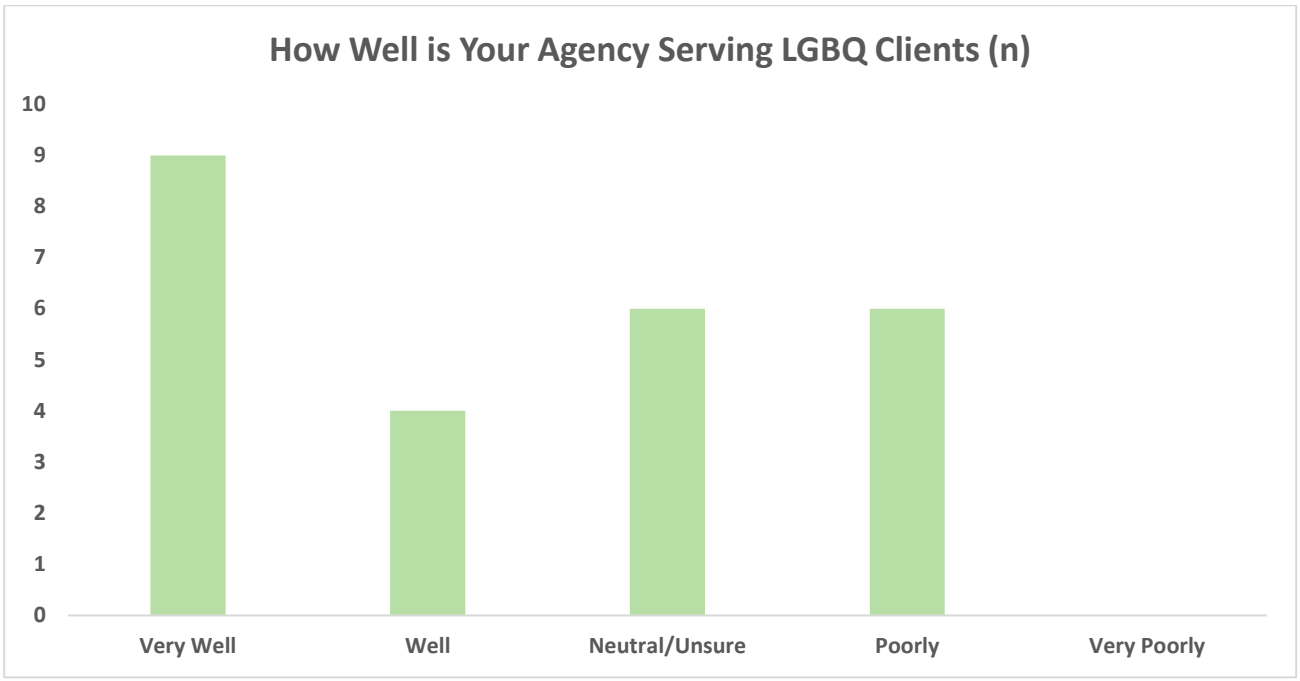
Is sexual orientation covered in the non-discrimination policy at your agency?



Is gender identity and/or expression covered in the non-discrimination policy at your agency?



How well do you think your agency is serving lesbian, gay, bisexual, and queer (LGBQ) clients?



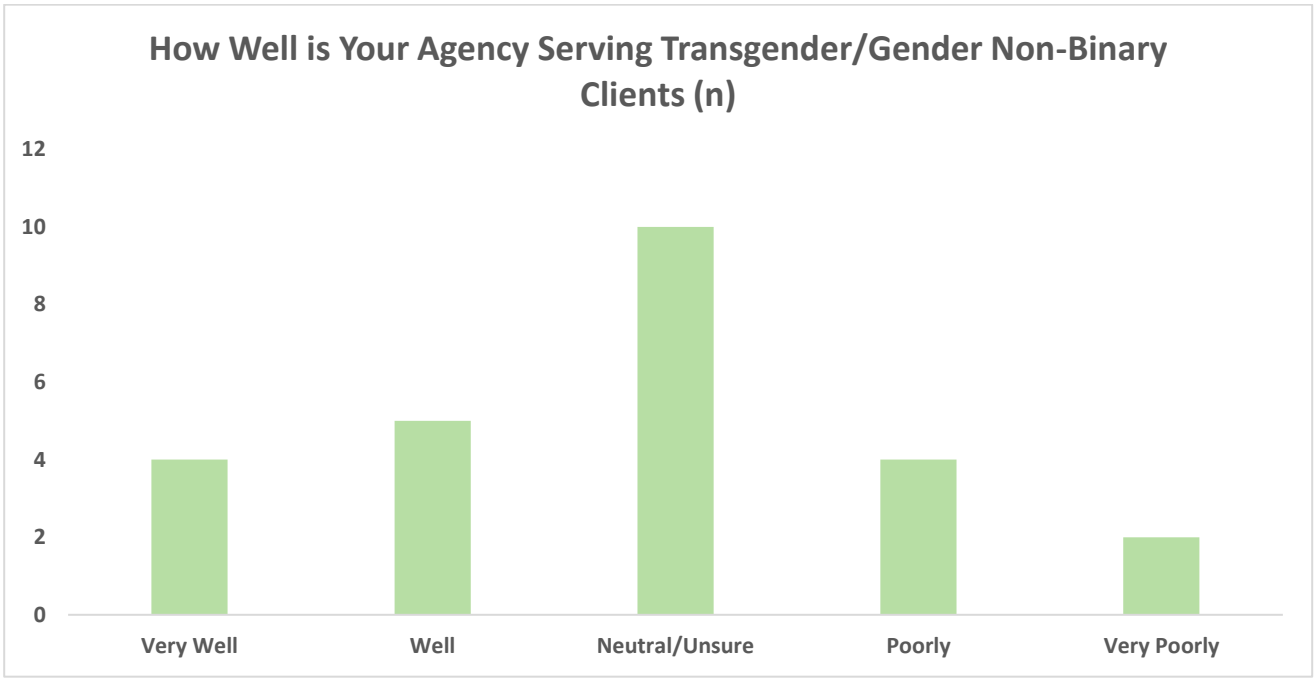
What do you think your agency needs to better serve LGBQ clients? (open-ended and coded into categories)

Acceptance
Acknowledgement
Curriculum development of LGBQ issues for peer trainings
Examine policies and procedures
Exposure
Knowledge, Education, & Training
LGBQ-focused programs: support groups, therapy programs
Representation: LGBQ peers, LGBQ individuals on councils and workgroups
Research and Data

What training(s) has your agency had on working with LGBQ clients? (open-ended, raw data)

Part of cultural competence and just once a year training day options	N/A
All of our trainings have included LGBTQ participants	Not sure
None beside non discrimination	NEO training
None	Just what I have brought in
None	None
Zero zip nada	We have had trainings regarding domestic violence that included LGBQ concerns
Unknown	Affirmative training
NONE	Webinars and Conferences
Unsure	None
Standard diversity training	None
None	Basic peer specialist certification training
None	None

How well do you think your agency is serving transgender and gender non-binary clients?



What do you think your agency needs to better serve transgender and gender non-binary clients? (open-ended and coded into categories)

Acceptance
Acknowledgement
Appropriate residential accommodations
Incorporate identities into billing and documentation software
Knowledge, Education, & Training: trainings conducted by transgender consumers, advocacy trainings
Representation: transgender/gender non-binary peers
Research and Data
Respectful staff

What training(s) has your agency had on working with transgender and gender non-binary clients? (open-ended, raw data)

Quick overviews	None
Nothing specific, but they need to be developed	N/A
Non-discrimination	I don't remember any LGBTQ training other than what is presented by HR and Client's Rights during NEO
None	None
None	None that I am aware of
Zero zip nada	Affirmative training
Unknown	Webinars and conferences
DON'T	Our agency has not had any training related to this
Unsure	Unknown
Unsure	None
Nothing specific. Just that each client must be treated equally and with respect. That's a given	It's incorporated into our basic peer specialist certification training
None	

[i] Homophobia refers to fear of, hatred towards, or discomfort with people who are gay, lesbian, or bisexual.
[ii] Transphobia refers to fear of, hatred towards, or discomfort with people who are transgender or identify as gender non-binary.
[iii] Cisexism refers to beliefs about the normalcy, naturalness, and superiority of identifying as cisgender (i.e., having a gender identity consistent with one's biological sex).
[iv] Heterosexism refers to beliefs about the normalcy, naturalness, and superiority of heterosexuality.
[v] The SOCCS measures sexual minority status (e.g., LGB) and gender minority status (e.g., transgender) separately.