What motivates community mental and behavioral health organizations to participate in LGBTQ+ cultural competency trainings?

Jessica N. Fish[1,2]

Evelyn C. King-Marshall[1,2]

Natasha D. Williams[1,2]

Elizabeth M. Aparicio[3,2]

Hannah M. Tralka[3,2]

Bradley O. Boekeloo[3,2]

[1] Department of Family Science, School of Public Health, University of Maryland

[2] University of Maryland Prevention Research Center

[1] Department of Behavioral and Community Health, School of Public Health, University of Maryland

Author Notes

Jessica N. Fish, https://orcid.org/0000-0001-9280-6156

We have no known conflicts of interest to disclose.

Correspondence concerning this article should be addressed to Jessica N. Fish, Ph.D., Department of Family Science, School of Public Health, University of Maryland. 4200 Valley Drive, Suite 1142, College Park, MD, 20740. jnfish@umd.edu

Abstract

The constantly evolving language, understanding, and cultural context regarding the mental health of lesbian, gay, bisexual, transgender, queer and other sexual and gender diverse individuals (LGBTQ+) require mental health providers to obtain LGBTQ+ cultural competency training to be affirmative and effective with this population. Unfortunately, many providers are not obtaining this ongoing training and mental health disparities continue to plague LGBTQ+ populations. Guided by the Consolidation Framework for Implementation Research (CFIR), we conducted 8 focus groups with community mental and behavioral health organization (MBHO) administrators (e.g., directors, clinical supervisors) and therapists to explore what factors facilitated or inhibited their adoption and implementation of a multi-component (workshop, clinical consultation, and organizational technical assistance) LGBTQ+ cultural competency training requiring administrator and therapist participation in multiple learning sessions over several months. Results from template analysis supported CFIR-aligned themes, including *characteristics of individuals, inner setting, outer setting,* and *process,* and two additional codes—*marketing,* and *other/previous training opportunities*—emerged from the focus group data. Findings suggest that therapists are motivated to engage in such a program because they want to feel more efficacious, and administrators see the benefits of the program for their clientele and marketing their services. Barriers to adoption and implementation include cost and personnel resistance, although participants believed these barriers were surmountable. Emphasizing therapist efficacy, clientele need, and benefits for marketing mental and behavioral health services could motivate MBHO and therapists' adoption and implementation of LGBTQ+ cultural competency training.

Keywords: LGBTQ; sexual and gender minority; mental health; mental health services; cultural competency

Public Policy Relevance Statement

LGBTQ+ populations show elevated rates of poor mental health and substance use relative to their heterosexual and cisgender counterparts but often experience stigma and marginalization when seeking mental health care. Mental and behavioral health organizations and therapists recognize a need for LGBTQ+ cultural competency training opportunities and are interested in participating in these trainings. Professional organizations and state licensing bodies should consider policies that require accredited graduate programs and continuing education opportunities to include LGBTQ+ training and competencies.

Introduction

Lesbian, gay, bisexual, transgender, queer and other sexual and gender diverse (LGBTQ+) youth and adults are more likely to experience mental health symptomology and meet the criteria of a substance use or mood disorder when compared to their heterosexual and cisgender peers (Bockting et al., 2013; Bostwick et al., 2010; Lipson et al., 2019; McCabe et al., 2009; Plöderl & Tremblay, 2015). There is consistent empirical evidence linking these disparities to experiences of sexuality- and gender-based bias, stigma, and discrimination (Argyriou et al., 2021; Hendricks & Testa, 2012; Meyer, 2003). Professional mental and behavioral health care is an essential factor in eliminating LGBTQ+ health inequities but accessing adequate and informed care can be difficult for LGBTQ+ people (Williams & Fish, 2020; Williams, Winer, Aparicio, Smith-Bynum, Boekeloo, & Fish, 2020). Despite well-documented need, many mental and behavioral health organizations (MBHOs) in the United States do not offer LGBTQ+-specific services (i.e., those which attend to the unique experiences and needs of LGBTQ+ people). In a recent national study, only 17.6% of state-approved substance abuse facilities and 12.6% of state-approved mental health facilities reported providing LGBTQ+-specific services (Williams & Fish, 2020). Furthermore, many therapists are un(der)prepared to work with this population. For example, many therapists cannot accurately conceptualize sexual orientation and gender identity (SOGI)-related challenges and concerns, and may inadvertently perpetuate stigma and bias with inaccurate language or assumptions/stereotypes about the population (Rees et al., 2021; Shelton & Delgado-Romero, 2011). This deficit in cultural competence is partly related to the lack of LGBTQ+-focused graduate training and continuing education opportunities for mental and behavioral health therapists (Graham et al., 2012; Nowaskie, 2020; Rock et al., 2010).

Given the persistence of mental health and substance use disparities between LGBTQ+ and cisgender, heterosexual populations (Liu & Reczek, 2021; Meyer et al., 2021; McCabe et al., 2021), and the growing proportion of people who identify as LGBTQ+ (Jones, 2021), it is increasingly essential to increase therapist access to LGBTQ+-related knowledge and cultural competency training.

LGBTQ+ Populations and Mental and Behavioral Health Services

Research suggests that LGBTQ+ people utilize mental and behavioral health care services at higher rates than their heterosexual and cisgender counterparts (Dunbar et al., 2017; Platt et al., 2018); however, LGBTQ+ clients often report less satisfaction with the care they receive (Avery et al., 2001; Benjamin et al., 2021). LGBTQ+ client satisfaction appears to be better among those who engage with services that acknowledge their unique experiences. For example, lesbian, gay, and bisexual (LGB) clients who participated in substance abuse treatment programs that acknowledge LGB-specific experiences reported higher satisfaction with their care than LGB clients in "traditional" (i.e., non-LGB-specific) treatment programs (Senreich, 2009, 2010). Studies also find that LGB clients respond well to LGB-adapted mental and behavioral health services. For example, Pachankis et al., (2015) conducted a randomized control trial using a cognitive-behavioral treatment adapted to address sexual orientation-related minority stress in young gay and bisexual men and found reductions in depressive symptoms and heavy alcohol use relative to waitlist clients. Other studies have found that mental health treatments that are tailored to meet the unique needs of LGBTQ+ clients (e.g., incorporating anti-oppression principles, adapting cognitive behavioral therapy techniques to the context of identity disclosure, etc.), are associated with reductions of acute stress disorder, social anxiety disorder, depression,

and panic attacks (Kaysen et al., 2005; Ross et al., 2007; Safren & Rogers, 2001; Walsh & Hope, 2010).

Many mental and behavioral health providers hold biased views and beliefs about LGBTQ+ people; however, even therapists who are personally supportive of LGBTQ+ people report feeling ill-equipped to address the unique needs of the population (Rock et al., 2010). This lack of preparation may explain, at least in part, why LGBTQ+ clients often report experiencing microaggressions and other forms of minority stress in the course of receiving mental and behavioral health care services (Rees et al., 2021). These microaggressions include therapists assuming that sexual orientation is the cause of presenting issues, warning about the "dangers" of queer identification, using cis- and heteronormative language, and having expectations about gender expression that leave LGBTQ+ clients feeling uncomfortable, unwelcome, or that their identity is inherently problematic (Nadal et al., 2010, 2012; Platt & Lenzen, 2013; Shelton & Delgado-Romero, 2011).

Oftentimes, therapists attribute feeling ill-equipped to work with the LGBTQ+ community due to perceived deficits in their graduate training programs (Rock et al., 2010). Few mental and behavioral health disciplines mandate specific benchmarks in training their graduate students on how to provide services that acknowledge and incorporate the unique experiences of LGBTQ+ clients (Williams et al., 2020). Furthermore, LGBTQ+ language, cultural norms, and research understanding are ever- evolving. Many clinicians rely on continuing education units (CEUs) and other professional development opportunities to build their competency and comfort in working with specific subpopulations and presenting problems (APA, 2021; Hartwell et al., 2021). However, LGBTQ+-focused continuing education opportunities are limited, and not a requirement for most professional mental health organizations (e.g., American Association for

Marriage and Family Therapy, National Association of School Psychologists, American Counseling Association) or by state licensing boards (Williams et al., 2020). As the need for LGBTQ+-focused training increases, it is important to assess what factors might encourage individual mental and behavioral health therapists to engage in LGBTQ+-cultural competency trainings.

Generally, interventions to improve provider cultural competency have been effective in increasing provider knowledge; evidence for the impact of these efforts on provider attitudes, awareness, and skills is mixed with some trainings resulting in significant improvements in these outcomes, and others showing no difference (Benuto et al., 2018). A handful of reviews have also identified improvements in client satisfaction and improved client outcomes associated with provider cultural competence training (Lie et al., 2011; Truong et al., 2014). Additionally, provider higher levels of provider cultural competence has been linked to decreased client perceptions of microaggressions in treatment (Hook et al., 2016) and lower client-initiated termination of care (Owen et al., 2017).

For those working in community MBHO settings, a therapist's cultural awareness of and clinical practice with LGBTQ+ persons may also be undermined by their service organization's lack of sensitivity or awareness. For example, clients who encounter unaffirming marketing communications, reception staff, intake forms, billing language, educational materials, or office signage may feel uncomfortable while engaging with an organization's services (Israel & Selvidge, 2003; McGeorge et al., 2020; Skaistis et al., 2018). Thus, in addition to therapists, MBHO administrators would also benefit from training that help guide their systems of care to be more affirmative and sensitive to the needs of LGBTQ+ clients.

Organizational Readiness for Adoption and Change

Organizations face frequent challenges when confronting the adoption and implementation of new approaches, particularly when they require the involvement of employees. A systematic literature review of the organizational features that influence the adoption and implementation of evidence-based best practices in healthcare organizations indicated that there is no standard theoretical framework that has been consistently applied to understand the adoption of new approaches and change in such organizations (Li et al., 2018). Nevertheless, organizational culture, networks of communication, leadership, financial resources, staffing and workload, time, education and training, quality assurance processes, and champions of the new approach were identified as critical components of healthcare organization adoption of evidence-based practices (Lie et al., 2018).

For the current study, we relied on the Consolidation Framework for Implementation Research (CFIR; Damschroder et al., 2009) to explore what factors might impact MBHO and their therapists' adoption and implementation of our LGBTQ+ cultural competency training and technical assistance programs. CFIR is a meta-theoretical framework that integrates and organizes a myriad of trans-theoretical concepts and factors that facilitate or hinder the effective implementation of health services into five domains (Damscrhoder, et al., 2009). These domains help researchers to assess potential facilitators and barriers of implementing programs and include: (1) *intervention characteristics*, or the features of the intervention, such as evidence supporting the quality of the intervention, the intervention's complexity, or cost; (2) outer or external factors, which reflect broader social and contextual factors within which the organization resides and can include pressure from competing organizations, external policies, and the organizational network; (3) inner factors are those related to the internal workings of the organization, which include organizational size, turnover, culture, and implementation climate

(e.g., readiness for change); (4) individual characteristics are specific to the individuals within an organization and can be assessed through an individual's beliefs about a given program, their self-efficacy in being able to learn or implement new skills, among other, and (5) the process of implementation, which characterize different stages of the implementation process including planning, the engagement of internal leaders and champions, or the reliance on external facilitators. Exploration of these factors is essential to help support the effective dissemination and implementation of the program. For example, findings can be used to ensure alignment with various mental health care settings, the refinement of protocols and training strategies, and considerations for scalability and replication.

Informed by the extant literature on LGBTQ+-sensitive mental health practice and CFIR, the current study examined the organizational- and individual-level factors that motivate community MBHOs and their therapists to participate in an LGBTQ+ training program and adopt LGBTQ+ affirming policies and practices in their everyday operations. We also explored various factors that would facilitate or inhibit implementing these practices within the organization and in therapeutic practice.

Methods

Sample

Focus groups (*N*=8, 20 participants total) were conducted with three independent community mental and behavioral health centers in a major city in the mid-Atlantic region of the United States. Centers were recruited from a compiled waitlist of organizations wanting to participate in a local LGBTQ+ cultural competency training for community MBHOs. Organizations on the waitlist (n=14) were contacted via email and were asked to complete a screening survey to assess eligibility. Centers were eligible to participate in the focus groups if

they (1) had the authority to make organizational policy changes related to data collection, hiring policies, employee benefits, training requirements for therapists and staff, and quality improvement practices; (2) had six[1] or more full or part-time licensed therapists (e.g., clinical social workers, clinical psychologists, couple/marriage and family therapists); and (3) were not exclusively focused on substance use rehabilitation. These eligibility criteria were imposed to align this study with the eligibility characteristics of our subsequent randomized controlled trial. The trial's purpose – which followed this particular study – was to assess the feasibility and effectiveness of our developed LGBTQ+ cultural competency training program. Six of the 14 centers filled out the screening eligibility survey, and three MBHOs met the criteria for inclusion and were enrolled in the study.

Within each of the three organizations, researchers purposively recruited focus groups to include either administrators (e.g., directors, clinical directors/supervisors, CFOs/COOs; n=3 focus groups with a total of 8 participants) or licensed therapists (e.g., licensed clinical social workers, clinical psychologists, couple and family therapists; n=5 focus groups with a total of 12 participants). Each provider and therapist individually consented to participate before participating in virtual groups via Zoom. Each participant was assigned a pseudonym to protect their identity.

Procedures

At the start of each focus group, the facilitators provided a brief PowerPoint slide overview of the training program components and objectives and answered any questions from participants. The proposed LGBTQ+ training incorporated several elements: a one-day seven-hour virtual synchronous training addressing foundational competencies (e.g., understanding

[1] The number of therapists per organization targeted for the trial was based on study design feasibility, as well as validity and power of statistical analysis in which therapists were nested within organizations.

LGBTQ+ terminology, LGBTQ+ mental health challenges, LGBTQ+ mental health disparities, and characteristics of affirmative therapeutic practice), six bi-monthly one-hour virtual clinical consultations in which mentors problem-solved and advised therapists regarding their affirmative practice challenges, and four monthly two-hour virtual organization technical assistance sessions in which MBHO administrators examined employee and client policies, billing and other procedures, appointment and reception staff, forms, as well as the physical and therapeutic environment. Following the program's introduction, facilitators asked a series of questions regarding the participants' perceptions of their organizational- and individual-level motivations and readiness to adopt and implement the multi-component LGBTQ+- training on affirmative practices in their workplace.

Interview protocols were developed using the CFIR interview guide tool (see cfirguide.org/tools), which is designed to assist researchers in developing qualitative interview guides that explore various factors related to program implementation. The guide includes pre-developed questions that tap into each of the constructs outlined by the CFIR model. The research team worked to consolidate the interview guide to include questions that were most relevant to the factors that may influence early decisions to engage with and implement our multi-component LGBTQ+ training program for mental and behavioral health centers. The administrators and therapist focus group interview protocols had a parallel structure but were slightly altered to reflect their unique perspectives on engagement and implementation within the organization. All focus groups were recorded and the audio was transcribed verbatim prior to analysis. This study was approved by the University of Maryland Institutional Review Board (#1548762-7).

Analytic Approach

Given that the focus group interview guide was closely aligned to the CFIR framework, we utilized template analysis, a structured approach to thematic analysis. Following guidelines for qualitative research (Creswell, 2009; Fereday & Muir-Cochraine, 2006) and template analysis (King, 2012), the coding team approached analysis via the following steps: 1) organized and prepared data for analysis, 2) read through all transcripts, 3) memoed on salient themes, 4) defined an initial coding template, 5) coded transcripts, 6) modified the template as needed, and 7) finalized the coding template.

Data were analyzed using primary CFIR aligned codes: *characteristics of individuals* (i.e., personal bias, general interest, improved skills, knowledge and beliefs, and self-efficacy); *inner setting* (i.e., culture, barriers to implementation, implementation climate, readiness for implementation, and structural characteristics); *outer setting* (i.e., external policy and incentives, needs and resources, other motivating factors, peer pressure); and *process* (i.e., planning). Additional codes arose during data analysis, including *reactions to the curriculum* (i.e., content, structure), *marketing*, and *other/previous training opportunities*.

Results

Reactions to Curriculum

One of the primary goals of the study was to investigate MBHO administrators' and therapists' reactions to our specified LGBTQ+ training program in terms of training content (e.g., topic and competencies) and structure (e.g., delivery logistics such as length and format). Regarding content, administrators and therapists both described an interest in the proposed program content and frequently mentioned the importance of learning LGBTQ+-related language and terminology. "Maybe it's a language... in order to be sensitive to someone else we need information" (Margarita, administrator, organization #2). Some described the lack of training in

this area and the importance of being up to date, “I’ve had a few trainings before, mostly around terminology, but they’re old... I actually am excited because I want to know more. I want to use the correct terminology” (Alexandra, therapist, organization #2). Jeanine, a therapist (organization #1), reflected on the challenges of correct terminology, even with their current and former clients.

> To me, I think it’s good 'cause I’ve had a lot of exposure, just various clients that I’ve had come through. I think understanding terminology, or appropriate terminology to use for patients to feel comfortable and not make 'em. If I don’t use the appropriate gender term…that I don’t make anyone feel uncomfortable in a situation.

These challenges in terminology and cultural competence were also illustrated through the language used in our conversation with participants, Some people just don’t know. They don’t know how to—they don’t understand the language. Quite frankly, I don’t either. Um, so the his, her—there’s already a his and a her. Again, I don’t know the language. I don’t know when it’s appropriate (Tammy, administrator, organization #3). Tammy went on to express the need for additional training “Of course, staff needs to be educated if we’re gonna practice gender inclusivity or whatever it’s called. You hear me? I don’t even know what words to use as I’m talking.”

We received feedback on the structure, sequence, components, and incentives to participate in the training program (e.g., workshop, technical assistance, clinical consultations). Administrators and therapists consistently commented on the importance of Continuing Education Units (CEUs), which are required to maintain therapists’ professional licenses, and mentioned a preference for programs that offer CEUs for practicing therapists. Reflected by

Agnes, an administrator (Organization #2), “I also said that CEUs are very good, that’s why I originally asked about the certification process, ‘cause I know that’s always very attractive to therapists.”

Comments regarding time commitments and sequencing were common among therapists but less so among organization administrators. Therapists inquired about the length of the training (one full day vs. two half-days). They shared the implication for contractual therapists who bill hourly under a 1099 tax code relative to therapists who were salaried appointments in the organization. Others inquired about the time commitment of the training program, postulating on long-term commitment.

> I think that when you have a lot of people and you have something that is in increments over a period of time is probably expected to lose some people”. Charlotte goes on to inquire on the length of the training, “I do have a question though. One hour per month for six months. One hour per month for four months. Are we talking 10 months or are we talking [something else]…(Charlotte, therapist, organization #2)

Lastly, in response to the organizational-level training components (e.g., changes to medical records system, patient forms, and building signage), administrators spoke to the importance of a tiered approach to technical assistance to ensure administrative and clinical programs staff are included, for example, potentially separate training based on how they interact with clients.

Readiness to Change

Characteristics of the Individual

Participants commonly mentioned throughout the discussions that general interest in the topic was a crucial factor in facilitating the implementation of the training program in their work setting. Administrators and therapists' reported interest in the topic, the desire to know more, the importance of LGBTQ+-related knowledge for their profession, and the need of the clients they serve. One administrator said, "I can't stress enough that there's a difference between tolerance and inclusivity. For me, [inclusivity is] necessary" (Lisa, Administrator, Organization #2). Manisha (therapist, organization #1) described,

> I just feel like education is important. We -- our society -- is made up of all different types of people and we do need to be informed about best practices as it relates to specific communities...I don't work directly with the [LBGTQ+] population, but I would never want to disservice the population.

The CFIR constructs of self-efficacy, knowledge and beliefs, and improved skills were also identified throughout the transcripts. Most of the therapists shared that they felt the need to improve their confidence and comfort with discussing LGBTQ+ topics and integrating LGBTQ+ perspectives in their clinical practice; several mentioned a need for more depth in knowledge about the LGBTQ+ community and recommended practices for addressing LGBTQ+ experiences in practice. With the training components in mind, many therapists suggested that the program might improve their self-efficacy and knowledge of the population, "it's like 'oh, am I saying the right thing? Am I ripping up on my words?' I think this would help relax people and [help them] feel more comfortable working with this population" (Kalina, therapist, organization #2). Kalina goes on to think through how the program could help therapists improve "I think just the way that we interact with clients and our confidence in sessions and just making other people feel comfortable and like this is a non-judgement space. Yeah. I think it would be

nice to already have that knowledge." Specific to knowledge and improved skills, administrators spoke about a desire to acquire training for their team "as it relates to educating my team with what to expect [and] new terminology so as to bridge the gap" (Heidi, administrator, organization #2) between team members' training and current client needs for accurate, affirming terminology. Similarly, therapists described the need for increased knowledge to help identify gaps and improve direct services, sharing that "the program helps us ...to be able to identify better what is in front of us so we can better service who is in the room, however they identify [with regard to clients' gender identity and expression or sexual orientation]" (Celia, therapist, organization #1).

Inner Settings

Within the CFIR model, inner settings reflect structural characteristics, culture, and the climate for readiness and implementation. Specific to inner settings, we coded data relevant to barriers to implementation, culture, implementation climate, readiness for implementation and other structural characteristics.

Although not a dominant theme of conversation, both administrators and therapists described some potential barriers to implementing the proposed training program components. Administrators expressed logistical concerns such as resource allocation and costs, time, space, personnel, and the process of instituting procedural and paperwork updates. For example, an administrator spoke of potential controversy that may accompany specific changes such as all-gender bathrooms.

> I think discussions around people's private areas, maybe, being exposed if you're all using the same bathroom. What does that feel like? That kind of thing. I don't know. I would think that that would be a sensitive topic for discussion just before

> we did something like this, I would think. The training program is one thing, but bringing it into our agency [would involve sensitive topics of discussion] (Tammy, administrator, organization #3).

Therapists also described the logistics of changing electronic medical records systems and patient forms as a potential barrier to implementation and that it would be critical to have organizational administrators supporting the implementation of these new procedures. Charlotte, a therapist with organization #2, listed "administrative staff, the owners, the clinical director per" - to make those changes to medical records procedures.

However, administrators and therapists alike suggested that their organizational culture would support the implementation of training and programmatic changes and discussed their work environments as having an atmosphere that fostered collaboration, flexibility, commitment to patient care, and solution-oriented staff. One of the administrators's described,

> Historically, we've been very flexible. Like I said, when we brought the trauma-informed training in, [staff and therapists] were really on board. We've been able to do a lot of changes, and people have been really accommodating and flexible to that (Agnes, administrator, organization #2).

Therapists described their leadership team as being instrumental in focusing on patient care and introducing training that serves the greater community. For example, as one therapist explained,

> I would say the leaders…are clearly out there on the front line of seriously trying to impact the lives of communities that are affected by so many different things that they're just out there really just trying to give them a hand (Manisha, therapist, organization #1).

Another stated,

> Just my day-to-day encounters, and what we say, and just how we treat one another, and how we treat the ladies in the program. From my perspective, I enjoy what I do. I love working with the ladies. From the executive director on to my boss, I would think that they would embrace it. At least from my perspective, I think so. (Lisa, therapist, organization #3).

Participants further acknowledged factors that primed organizations to adopt change; for example, one therapist noted, "we are also informed enough to know that this is a community that on some level, in some way, shape, or form we will have to provide services for" (Jeanine, therapist, organization #1).

Outer Settings

In CFIR, outer settings reflect external pressures and resources that encourage or inhibit the adoption and implementation of new programs and practices. Within this theme, participants shared the importance of client needs, the therapist's need for CEUs, program completion certificates, and data on the program's success, such as statistics and testimonials. Testimonials, data, and resources were referenced most often to encourage adoption. For example, therapists shared that "it would be great to hear from the programs implemented in other agencies, or other settings similar to ours, how it has supported their client base" Xandria, Therapist, organization #1). Another therapist stated

> If we can all get sent a PDF or a printout or a poster, I think that would be really helpful. Something we could put in our offices when we're back in our offices. Something that we can say, "Okay. We can refer to this." I know one time that I did a training in school actually, and I got a safe space little certificate that you

> can put on your wall. It's like, "Okay. This is a safe space." That would signal that I'm educated in this capacity (Kalina, therapist, organization #2).

Administrators also mentioned that they would be motivated to participate in a training that had some level of efficacy or proven track record,

> I guess just showing the benefits of how they're gonna have success with their clients, how the sessions are gonna go more smoothly, how they're gonna feel less of that frustration that they sometimes feel, and how it could just ease the—and not even just this population. I'm sure a lot of these principles can be widespread throughout everything... I would assume whatever statistics you guys have from your—I would imagine that you have some literature that you use to reference and to work from to show how effective the intervention is or the training would be (Kalina, therapist, organization #2).

When asked, organizational administrators could not identify external policies or state requirements that would motivate or influence participation in an LGBTQ+ cultural competence training program. All the administrators also mentioned the benefit of the competitive advantage that they would yield if they could tout their program as being LGBTQ+ sensitive and gaining a reputation for providing competent and affirmative clinical care for the LGBTQ+ community. For example, an administrator noted the potential for the training to be a point of service promotional.

> That way, we can differentiate, like if somebody's asking for a specific clinician or just has a specific need, or even as we're promoting our agency online, that we can show something like, these clinicians are specifically trained to work with this

> population, or just whatever. No problem. That's cool (Agnes, Administrator, Organization #2).

Lastly, as referenced earlier, the importance of CEUs was consistent throughout all organizations among therapists and administrators. “Above and beyond just doing well for the people you serve, certainly, CEUs are a nice incentive” (Chandra, Administrator, Organization #1).

Discussion

Given the need to address gaps in mental and behavioral health care for LGBTQ+ populations (APA, 2021; Rees et al., 2021; Shelton & Delgado-Romero, 2011), we sought to assess the implementation factors that might influence the adoption of a multi-level, multi-component LGBTQ+ cultural competency training program designed to elevate the cultural competence of mental and behavioral health therapists and the organizations that they work for. Results from our focus groups show why therapists and MBHO administrators are interested in LGBTQ+ training programs; motivations included a multitude of personal, organizational, and external factors. In addition to highlighting implementation factors that facilitate engagement and uptake, focus group participants also mentioned potential barriers to implementing LGBTQ+ affirmative practices in their MBHO.

Among the most prevalent findings were that therapists and organizational administrators recognized their current limitations in serving the LGBTQ+ community. These reflections on service constraints are not unique to our sample (Graham, Carney, & Kluck, 2012) and emphasize the importance of leveraging implementation science to address LGBTQ+ mental health service deficits (Perry & Elwy, 2021). The therapists in our study shared that they felt unsure of themselves when working therapeutically with LGBTQ+ clients, discussing a lack of

knowledge of LGBTQ+-related language, and hesitance about their ability to speak with the population in a way that reflected basic knowledge and understanding. Indeed, many therapists and organizational administrators stumbled in their attempts to use LGBTQ+-related language and often misgendered clients in describing their experiences working with transgender and gender-diverse communities (e.g., not sure which pronouns to use). Overall, the focus group's conversation demonstrated therapists' internal motivations to increase their comfort in working with LGBTQ+ clients and feel more efficacious in their clinical practice with this population. Many discussed that they were motivated to participate in LGBTQ+-related training to be a better therapist and to feel better equipped to address the clinical needs of a potentially increasing LGBTQ+ client caseload.

It was notable that administrators and therapists focused so heavily on the concept of language and it being instrumental to elevating the clinical practice with LGBTQ+ populations. Overwhelmingly, focus group participants were most concerned about proper language and indicated a cursory understanding of how issues related to LGBTQ+ identities, such as development, acceptance, disclosure, and resilience against societal marginalization, might be important to address in therapeutic practice. These conversations reflect perhaps an oversimplification of what it takes to develop LGBTQ+ affirmative therapeutic approaches; that LGBTQ+ sensitivity demonstrates an understanding of how LGBTQ+ identity and related experiences need to be considered at all levels and stages of the therapeutic process, from the most preliminary to deep therapeutic discussions, and from the initial screening phone call through case termination. These findings suggest that a barrier to engaging community mental health centers may be related to their view of what constitutes LGBTQ+ affirmative services and whether they are willing to engage in more comprehensive training that requires greater

commitment from staff and administration (e.g., knowing up-to-date community terminology vs. understanding how to do case conceptualization that is sensitive to LGBTQ+ experiences). Our observations also suggest a great deal of variability in the baseline knowledge of those who would potentially participate in the program. For example, some mental health therapists seek out training and materials for their edification in working with the LGBTQ+ population (APA, 2021; Holt et al., 2020). As such, many therapists are starting with different sets of initial knowledge of the community and clinical skills related to working with LGBTQ+ clients. This requires that facilitators acknowledge this variability in knowledge and create of a safe and supportive training environment that does not assume specific knowledge of the LGBTQ+ community. This also requires that trainers facilitate authentic and sometimes difficult conversations around understandings of sexual and gender diversity that are designed for exploration and growth toward more affirmative practice for those across the continuum of LGBTQ-related knowledge and skills.

Although therapists were personally motivated to participate in LGBTQ+-related continuing education, the data suggest that external or outer setting characteristics did not reinforce this desire. Focus group participants were unaware of state or professional expectations regarding LGBTQ+ competence – of which there are none based on the location of our sample (Williams et al., 2020) – and commented on the dearth of available training opportunities to increase knowledge and skills in working with LGBTQ+ clients, which is not atypical in surveys of mental health providers (Graham, 2012; Nowaskie, 2020). Although therapists who had recently graduated from accredited training programs appeared to show more comfort and knowledge about the LGBTQ+ community, these therapists were clear that their education about the LGBTQ+ community and their comfort with language about sexuality and gender identity

inadequately prepared them to work with the LGBTQ+ population in clinical practice. Together, these narratives emphasize the importance of utilizing implementation science to develop and implement efficacious training programs to increase the LGBTQ+ cultural competency of mental and behavioral health care therapists (Perry & Elwy, 2021).

Of note, there were some instances where focus group participants insinuated that there might be some staff in their organization who might be resistant to adopting and implementing LGBTQ+-sensitive practices. For example, resistance to all-gender bathrooms was discussed. Given the unique characteristics of marginalization for LGBTQ+ communities, particularly in mental health care (e.g., the previous designation of "homosexuality" as a mental disorder, religious freedom, and consciousness clauses that allow for refusal of care), it must be acknowledged that bias may likely be a barrier to engagement and implementation of training related to LGBTQ+-affirmative practice that needs to be addressed as part of the program. Unfortunately, most professional mental health organizations (e.g., American Psychological Association [APA], American Association for Marriage and Family Therapy [AAMFT]) and bodies that accredit graduate programs (e.g., Commission on Accreditation for Marriage and Family Therapy Education [COAMFTA]; Council for Accreditation of Counseling and Related Educational Programs [CACREP]) do not require that students in training meet specific training requirements or benchmarks regarding their work with LGBTQ+ clients (Williams et al., 2020). This extends to state licensing boards; licensed mental and behavioral health therapists are generally not required to receive training or continuing education in this area to receive or maintain their licensure. Therefore, there may be benefits to implementing external factors that incentivize therapists to participate in LGBTQ+-specific continuing education. For example, in Washington, DC, licensed mental and behavioral health therapists must participate in LGBTQ+-

related continuing education to maintain active licensure. Still, these mandates are not standard in other states. Such educational requirements would likely increase the LGBTQ+-related knowledge of the mental and behavioral health workforce and increase the demand for LGBTQ+-specific graduate training and continuing education opportunities. Absent these external motivating factors, MBHOs and therapists will have to self-select into the LGBTQ+-specific training—this remains an insufficient strategy to drive the widespread adoption of affirmative practices to the degree necessary to address the current services gaps experienced by LGBTQ+ people. That said, MBHOs can motivate their therapists to participate by offering the training at no cost, covering therapists time for participation, offering to cover the cost of continuing education units (CEUs), and emphasizing the priority of the population for their organization.

Compared to therapists, administrators (e.g., owners, directors, and administrative and clinical supervisors) were more likely to name external motivating factors for program adoption and implementation; namely that training in how to provide more LGBTQ+-inclusive services and building a favorable reputation with the local LGBTQ+ community would give their organization a competitive advantage over other MBHOs in their region. At the same time, administrators were more concerned than therapists about the cost and logistics of adopting and implementing the components of the training program. Organizational administrators reflected that a full-day training and ongoing technical assistance would include a loss of billable hours. Many of the participants in our administrator focus group also mentioned that implementing the suggested structural and policy changes (e.g., updating electronic medical health records and paperwork) would be complicated, time-consuming, and require coordinated efforts from staff, administrators, human resources, and therapists. That said, administrators, many of whom were

owners of these organizations, still believed that the benefits of imparting better clinical care for LGBTQ+ clients far outweighed the potential costs—particularly if the training program had tangible metrics of efficacy and success. In all instances, administrators and therapists agreed that their decisions about adoption and implementation largely fell on the organizational administrators. They also mentioned that the program would most likely succeed if there was a designated person or team to help champion these institutional and programmatic changes. These findings reflect the importance of engaging a broader set of stakeholders when investigating the implementation process (Hamilton & Finley, 2019; Perry & Elwy, 2021). These reflections provide essential insights for disseminating and scalability of programs to address LGBTQ+ mental health.

There is an overall scarcity of research on opportunities and challenges for mental health providers' acquisition of competence in serving LGBTQ+ clients. Gaps in care for LGBTQ+ persons are well recognized, and a shortage and maldistribution of qualified mental health providers have contributed to these gaps (Mongelli et al., 2020; Williams & Fish, 2020). Implementation science is a vehicle to identify how to expand LGBTQ+ mental health care services to those most in need (Perry, 2021). As our data suggest, mental health providers want to provide competent care for LGBTQ+ persons but cite a lack of coursework and training on LGBTQ+ competency. In the absence of institutionalized requirements and widespread opportunities for education in this area, many mental health providers take the initiative to teach themselves to be better providers of LGBTQ+ clients through experience and information gathering (APA, 2021; Holt et al., 2020). Many directors of MBHOs, including those who advertise services to LGBTQ+ people, perceive a high need for LGBTQ+ mental healthcare and report the need for more LGBTQ+ affirmative staff and related resources (Pachankis, 2021). In

particular, mental health services and related implementation research are needed to affirmatively address the needs of LGBTQ+ subpopulations such as Latino/a/x/e sexual minority men at high risk for HIV (Harkness, 2021), older adults (Holman, Landry, & Fish, 2020; Goldhammer, 2019), persons in rural areas (Willging, 2016), and veterans (Valelntine, 2021). Our results illuminate both opportunities and challenges in strategies to improving LGBTQ+ affirming care in community MBHOs.

Our findings reflect participants' expressed enthusiasm and self-perceived and researcher-observed need for LGBTQ+-specific training programs for MBHOs and their therapists. The dissemination and implementation of these programs are critical in addressing the current service gap for LGBTQ+ clients (Williams & Fish, 2020). The scale-up and dissemination of these programs need to be sensitive to the barriers and facilitators that influence organizational and therapist adoption and implementation of these practices. Our results suggest that a multi-level, multi-component sustained approach to training that includes CEUs and tangible deliverables (e.g., testimonials of success, evidence of positive changes in practice) are necessary to engage therapists. For successful organization adoption and implementation, training and technical assistance programs must be designed and offered in ways that are sensitive to the constrained resources, including time, of community MBHO therapists and administrators. Given the scarcity of implementation research on LGBTQ+ mental health services (Perry & Elwy, 2021), this research provides a valuable window into what motivates MBHO administrators and therapists to participate in programs designed to accelerate the research to practice timeline and educate the mental health workforce in providing affirmative and effective services for the LGBTQ+ population. The scant existing research suggests that the primary barrier to mental health provider participation in such training is not a perceived lack of

need but rather a lack of access (Smith et al., 2019; Holt et al., 2020). Hence, the administrators and therapists in this study who wanted to participate in LGBTQ+ training are likely to have similar barriers to participation as those in other community mental health services.

Limitations and Areas of Future Research

There are some limitations to note. First, focus groups were recruited from a small number of organizations on a waiting list to receive our LGBTQ+ training program. Thus, participants were likely unique in their motivation to participate in LGBTQ+ training, and their perceived barriers and facilitators of implementing the resources and skills learned in these programs. Future research should consider a larger and more generalized sample of MBHO, notably those organizations that are not actively looking for these opportunities, to get a better sense of what factors may inhibit or facilitate engagement with LGBTQ+ training programs. Second, the interview protocol provided a brief verbal and visual overview of the training program components but did not include extensive discussion about the specific content and format (e.g., objectives). This likely limited focus group participants' ability to foresee which factors might play a role in facilitating or hindering the uptake and implementation of the entire program and specific program components. Additional interviews with participants following the delivery of the program or shortly after that would yield additional perspective on how individual characteristics, inner/outer settings, and processes may influence the adoption and implementation of the program. Third, our sample is geographically limited to organizations in one state of the mid-Atlantic region of the United States. Given the potential for outer factors to influence organizational adoption and implementation, there are likely unique facilitators and barriers across diverse geographic contexts, including state and urban/rural settings.

Conclusion

The mental and behavioral health workforce continues to lag in its ability to meet the needs of the LGBTQ+ community effectively. The current study identified several factors that motivate community MBHOs to participate in an LGBTQ+ training program and adopt LGBTQ+ sensitive policies and practices. Overall, therapists are motivated by opportunities to feel more efficacious in their therapeutic practice with LGBTQ+ clients, and administrators see benefits for marketing and meeting clients' needs. Both administrators and therapists recognize that there may be some barriers to engaging and implementing comprehensive training but indicate that these barriers can be overcome, and that the benefits far outweigh the barriers. The ability to engage and train these organizations and therapists is necessary for the effort to shrink mental and behavioral health services gaps for LGBTQ+ people in the United States.

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