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Recruitment, Retention, and Wellbeing of LGBTQ-Serving Child Psychiatrists and Mental Health Providers

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Authors

Ramos, Natalia
Jones, Skylar A
Bitterman, Moshe
et al.

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Recruitment, retention, and wellbeing of LGBTQ-serving child psychiatrists and mental health providers

Authors

Natalia Ramos, MD, MPH (she/her) - https://orcid.org/0000-0001-8688-9426
Department of Psychiatry and Biobehavioral Sciences, University of California, Los Angeles David Geffen School of Medicine, Los Angeles, California, USA.
nramos@mednet.ucla.edu

Skylar A. Jones, BA (she/her)
The Jane and Terry Semel Institute for Neuroscience and Biobehavioral Sciences, University of California, Los Angeles, Los Angeles, California, USA.

Moshe Bitterman, MD (he/him)
Ann and Robert H. Lurie Children's Hospital of Chicago, Chicago, Illinois, USA.

Aron Janssen, MD (he/him)
Pritzker Department of Psychiatry and Behavioral Health, Ann and Robert H. Lurie Children's Hospital of Chicago, Chicago, Illinois, USA.

Corresponding Author

Natalia Ramos, MD, MPH - nramos@mednet.ucla.edu

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Key Words (4-8 words to direct and optimize search results)

- LGBTQ youth
- Youth mental health
- Medical education
- Mental health workforce

Key Points (3-5 bulleted sentences indicating the main takeaways/defining elements of the article)

- LGBTQ+ youth experience higher rates of psychological distress than cisgender heterosexual peers due to social discrimination and stress.

- Health systems in the United States are woefully unprepared to provide mental health services for LGBTQ+ youth, in part due to the politicization of LGBTQ+ health services.
- Standardized, more robust LGBTQ+ training and education initiatives in both undergraduate and graduate medical education programs are needed.
- The presence of LGBTQ+ clinician educators improves the quality and quantity of LGBTQ+ health training.
- LGBTQ+ trainees report that mentoring from LGBTQ-identified mentors benefits their wellbeing and career development.

Synopsis (100 words or less)

The workforce of mental health providers serving lesbian, gay, bisexual, transgender, queer, and/or questioning (LGBTQ+) youth lags far behind the demand for LGBTQ-focused mental health care. Unsatisfactory training and a lack of standardized training metrics for accredited programs perpetuate the lack of preparedness among providers. The presence of LGBTQ+ faculty and mentors in medical education increases the amount of LGBTQ+ content taught to trainees and improves professional development for LGBTQ+ trainees. Inclusive workplace practices and affirming care policies may also improve retention and recruitment of LGBTQ-serving mental health providers.

INTRODUCTION

Approximately 10% of United States (U.S.) youth aged 13-17 identify as lesbian, gay, bisexual, transgender, queer, and/or questioning (LGBTQ+[a]).[1] The rate of youth identifying as LGBTQ+ is increasing; younger Americans are more likely to identify as LGBTQ+ than older generations.[2] Despite their significant prevalence across the country and social visibility,[1] LGBTQ+ youth remain highly marginalized and face many harmful stressors linked to their LGBTQ+ identities. LGBTQ+ youth thus experience more psychological distress and mental health symptoms than their cisgender heterosexual peers, including disproportionate rates of depression, suicidality, and substance use.[3] [4] Almost half of LGBTQ+ teenagers considered suicide in the past year, and 18% attempted suicide at least once within the past year.[5]

The lack of mental health services for LGBTQ+ youth is a pressing crisis occurring within the broader U.S. youth mental health crisis.[6] More than half of LGBTQ+ youth ages 13-24 (54%) desired mental health care in the last year but were unable to receive it.[7] Racially minoritized LGBTQ+ youth, including Black, Latinx/e, and Asian American youth, were even less likely to receive desired mental health care than White LGBTQ+ youth.[7] Geographic differences are also apparent, with LGBTQ+ youth residing in the South experiencing the highest unmet mental health needs.[7]

Nationwide, the supply of youth mental health providers serving LGBTQ+ youth remains woefully insufficient. According to data from the Substance Abuse and Mental Health Services Administration (SAMHSA)

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[a] *In this article, we utilize the term LGBTQ+, which stands for Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, to refer to patients minoritized on the basis of gender and/or sexual orientation. Some of these specific terms represent gender identities, while some represent sexual orientations. It is also worth emphasizing that different LGBTQ+ patients use different terms to describe themselves and their identities, and the acronym used by the authors encapsulates a limited number of identities. For example, many youth identify with non-binary, genderfluid, and/or genderqueer identities. A best practice for the clinician is to always ask the youth what term(s) best describe them and what terms they would like the clinician to use.*

National Mental Health Services Survey (N-MHSS)[8]—one of the few datasets to examine LGBTQ+ mental health services across facilities, including psychiatric inpatient units, residential treatment centers, day programs, and outpatient services—only 28% of youth mental health facilities offer any LGBTQ-specific mental health services.[9] The percentage of youth mental health facilities offering LGBTQ-specific services remained virtually static from 2014 (25%) to 2020 (28%), despite the increasing demand for services.[9] LGBTQ+ community health centers, often sources of support and community activities, report limited capacity for mental health services as well. Among a sample of 60 U.S. LGBTQ+ community centers, 51% had five or fewer mental health providers, and only half provided any evidence-based mental health treatments.[10]

Workforce shortages and the lack of available high-quality mental health services compound well-established mental health and social inequities facing LGBTQ+ youth. To effectively serve LGBTQ+ youth with mental health needs, we must expand the workforce of well-trained providers offering evidence-based mental health services through an identity-affirming lens (i.e., supportive of all gender identities and sexual orientations). In this article, we explore underlying etiologies of the workforce gaps and propose practical approaches to expand the workforce of LGBTQ-serving youth mental health providers.

BACKGROUND

Mental health inequities among LGBTQ+ youth facing discrimination

LGBTQ+ youth experience numerous socially-embedded stressors across home, school, and community systems that may negatively impact their mental health. Common social stressors include family rejection or non-acceptance, exclusion and bullying in school settings, and exposure to anti-LGBTQ initiatives—including bans on health care for transgender youth, exclusions of transgender youth in sports activities, and laws forcing the compulsory outing of LGBTQ+ students to their families. Due to pervasive

discrimination, marginalization, and harassment across social settings, LGBTQ+ youth experience disproportionate rates of mental health conditions, including depression, suicidality, and substance use.[11] Peer victimization and family rejection have lasting impacts on self-esteem, substance use, and health outcomes.[12,13] Negative self-image or self-regard corresponds with higher rates of risk-taking behaviors among LGBTQ+ adolescents, including escalating substance use,[14] earlier substance use,[15] and higher risk sexual behaviors.[16,17]

LGBTQ+ youth also face identity-linked stressors within health care settings, including fears around identity disclosure to caregivers and providers and invalidation of their identities. Experiences of discrimination, prejudice, stigma, and rejection increase internalized stigma, stress related to concealment of identity, and anticipation of discrimination.[18] Discriminatory experiences in health care settings (and/or the expectation of encountering discrimination) may result in future avoidance of care, non-disclosure of identity and/or health behaviors to providers, and fewer health-promoting behaviors. LGBTQ+ individuals who do attempt to access health care report discriminatory experiences with inadequately trained clinicians and feeling as though they must educate their clinician on LGBTQ+ content.[19] These experiences further push LGBTQ+ individuals out of health settings and reduce trust.

Like other marginalized groups, LGBTQ+ youth also navigate complex external structural barriers to receiving high-quality mental health care, including a lack of insurance coverage for LGBTQ-specific services, legal barriers to LGBTQ-related care, and unprepared and/or biased providers.[20] In addition to the low availability of LGBTQ-serving mental health facilities and providers, complex psychosocial issues impede care for LGBTQ+ youth. Many LGBTQ+ youth face difficulties related to parental disclosure and/or permission requirements that may prevent accessing care in the first place.[7] LGBTQ+ youth also experience concerns about being treated poorly by

providers on the basis of identity.[7] For Black, Latinx, and other LGBTQ+ youth of color, minoritized sexual and/or gender identities intersect with racial marginalization and discrimination, further compounding the inequities faced.[19]

Sociopolitical context of LGBTQ+ mental health care shortage

Since 2016, the U.S. has experienced a monumental rise in anti-LGBTQ+ political initiatives—particularly state bills and laws that target the rights of transgender youth and their families. Currently, almost 500 bills across the U.S. target the rights of LGBTQ+ Americans across health care, school, workplace, and public settings.[21] As of this writing, 19 states have enacted bans on gender affirming care for youth,[22] and over 100,000 U.S. transgender youth ages 13-17 reside in states that have passed bans on gender affirming care.[2] Other active anti-LGBTQ+ initiatives aim to force teachers to disclose students' LGBTQ+ identities to their parents, regardless of home safety; prevent transgender girls from playing on girls teams; and restrict instruction related to gender identity and sexual orientation, to name a few.

The detrimental effects of these anti-LGBTQ+ political initiatives on LGBTQ+ youths' mental health are three-fold: (1) LGBTQ+ youth internalize stigma and negativity about their own identities, which increases their psychological distress;[18,23,24] (2) anti-LGBTQ+ initiatives promote discrimination and harassment of LGBTQ+ individuals in society, thereby increasing rates of traumatic experiences and threats to personal safety for LGBTQ+ youth; and (3) LGBTQ+ youth and their families—especially transgender youth and youth of color—face even greater structural barriers to obtaining the medical and mental health services in line with standards of care supported by mainstream medical associations including the World Professional Association of Transgender Health, the American Academy of Pediatrics, the American Medical Association, and the American Academy of Child and Adolescent Psychiatry. The effects of anti-LGBTQ+ messaging on

youths' psychological distress and poor self-image are hard to fully capture. Youths have broad access to media, with 90% of teenagers online at least several times per day and almost half reporting they are online "almost constantly."[25] LGBTQ+ youth may spend even more time online than their cisgender heterosexual counterparts.[26]

Meanwhile, clinicians, community clinics, and health systems face *increasing* barriers to providing mental health care for LGBTQ+ youth. Some states threaten providers with penalties, including criminal charges, licensure revocation, fines, and/or civil action for providing affirming care.[27] The health care bans have also led to multiple closures of well-regarded programs across the U.S., leaving fewer families with access to LGBTQ+ affirming medical and mental health care.

Clinical gaps in mental health care for LGBTQ+ youth

LGBTQ+ patients report better treatment outcomes when they receive care that is inclusive of LGBTQ-identities and/or tailored to LGBTQ+ needs.[28] On the other hand, LGBTQ+ patients report lower levels of satisfaction in general mental health and substance use programs (e.g., those not tailored to LGBTQ+ individuals) than cisgender heterosexual peers, and, consequently, are more likely to drop out of treatment due to unmet needs.[28,29] Yet care gaps for LGBTQ+ patients exist across both general mental health[9] and substance use[30] programming across all service levels (e.g., outpatient, residential, inpatient) and health care settings (e.g., community clinics, academic centers, hospital systems).

Many clinicians in various treatment settings may have the desire to serve LGBTQ+ patients but lack the requisite training and clinical experience to provide high quality, nuanced care around stressors and stigma related to gender and/or sexual orientation. Families of LGBTQ+ youth may present with additional needs pertaining to family dynamics, child and adolescent development, and specific educational needs and supports. Intersectional complexities that vary case-by-case act as a learning curve that requires

more than “good intentions” to be adequately addressed.[31] In addition to knowledge and fluency in LGBTQ+ content, providers must learn to build trust with LGBTQ+ youth and their caregivers, which often requires comprehensive knowledge of cultural and identity-specific issues. Mental health providers can improve care for LGBTQ+ youth by supporting healthy exploration of identities, providing referrals and linkage to medical and additional mental health resources, when appropriate, and working with families and caregivers to promote family support and decrease non-accepting behaviors.[32]

DISCUSSION

As discussed above, LGBTQ+ youth present to care settings with unique mental health needs related to social stigma and discrimination. Formal evidence-based interventions for LGBTQ+ youth remain limited, though an increasing number of LGBTQ-affirming cognitive behavioral therapy (CBT) protocols exist.[33] [34] Further trials of specific psychotherapeutic interventions specifically tailored to LGBTQ+ youth and their families are needed; data remain limited by the lack of research and clinical resources dedicated to LGBTQ+ mental health. The lack of large-scale comparison trials on LGBTQ-affirming CBT also reflects the dearth of providers and programs providing these services in community settings; data on these interventions stem largely from smaller pilots and randomized trials conducted in academic settings.

The aphorism *measure what you value, and you value what you measure* speaks to the action items in regards to the child psychiatry and broader mental health workforce serving LGBTQ+ youth and their families. We propose a multi-faceted approach to building the workforce of LGBTQ+ youth serving mental health providers characterized by the following: (1) Education and clinical training in social stressors experienced by LGBTQ+ patients and focused clinical strategies for supporting LGBTQ+ youth exploring and/or disclosing their identities; (2) Mentorship and professional

development support for LGBTQ-identified mental health providers; and (3) LGBTQ-inclusive work environments and employment practices to support and retain LGBTQ+ providers. We explore each of these *action items* in greater detail below.

Clinics care points

- Create a strong, inclusive non-discrimination policy. This policy should clearly state that all employees are protected from discrimination on the basis of sexual orientation and gender identity. It should also include information about how employees can report discrimination and what steps the organization will take to investigate and address it.
- Use inclusive language. This means avoiding gendered terms and using language that is respectful of all identities.
- Create support programs for LGBTQ+ faculty, staff and trainees, and use participatory practices to measure presence of LGBTQ+ faculty, staff and trainees.
- Offer LGBTQ+ inclusive benefits. These may include domestic partner benefits, transgender-inclusive health insurance, and parental leave, fertility treatment, and adoption support for same-sex couples.
- Provide LGBTQ+ inclusion training and educational resources on LGBTQ+ health and mental health to all trainees and staff, and measure the impact of this training and education.
- Include inclusive hiring practices. This means ensuring that all job postings are gender-inclusive and that all candidates are evaluated fairly, regardless of their sexual orientation or gender identity.

Education and clinical training

Literature on the quantity and quality of LGBTQ+ health content in medical education is underdeveloped but gradually growing. In a 2011 study, the median total hours of LGBTQ-related health education across U.S. and

Canadian medical schools was only 5 hours. Nearly 7% of medical students received 0 hours during their preclinical years, and 33% received 0 hours during their clinical years. Furthermore, the quality and effectiveness of the education varied widely by institution.[35] Graduate medical education fared no better, with over half of psychiatry residencies (55.6%) reporting fewer than 5 hours of LGBTQ-specific training.[36] Unfortunately, there are no published studies on LGBTQ-specific training in child psychiatry fellowship training.

Since 2010, LGBTQ-focused topics have received increased focus at the undergraduate medical education (i.e., medical school) level, though these curricula updates are variable and lack effective evaluation.[37] In 2014, the Association of American Medical Colleges (AAMC) published guidelines for LGBTQ+ competencies "across learning modalities, including didactic instruction, case-based and active learning, and in clinical rotations."[38] The AAMC also made recommendations for trainees, faculty, and administrators to create an inclusive learning environment. In 2020, the Accreditation Council for Graduate Medical Education (ACGME) revised its Common Program Requirements to include a competency in "respect and responsiveness to diverse patient populations," including "gender and sexual orientation."[39] The ACGME requires psychiatry residency programs to expose residents to patients of different genders but does not specify any LGBTQ-specific competency requirements. These writers support clinician-researchers who have called for formal review and reform of LGBTQ-focused content at the Graduate Medical Education (GME) level to include LGBTQ-specific topics tailored to each medical specialty—psychiatry, in particular, given the pivotal roles of communication, empathy, and sensitivity in mental health treatment.

Psychiatry training programs on the whole lack a centralized curriculum or specific training requirements on LGBTQ+ mental health. Within the American Association of Directors of Psychiatric Residency Training (AADPRT), the Curriculum Committee offers peer review and promotion of "model curricula" submitted by members and outside

organizations.[40] Currently, AADPRT recommends one model curriculum on LGBTQ+ mental health: the Association of LGBTQ+ Psychiatrists (AGLP) and the Group for the Advancement of Psychiatry (GAP) curriculum for general psychiatry training.[b] This online curriculum outlines specific areas of training where LGBTQ+ content should be incorporated and provides a concise review of pertinent literature. This curriculum falls short of providing specific reading lists, sample cases, or materials to use directly with psychiatry trainees. Educators may also utilize reputable free online education resource centers like the Center of Excellence on LGBTQ+ Behavioral Health Equity[c] funded by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) and the National LGBTQIA+ Health Education Center[d] led by Fenway Health, a Federally Qualified Health Center. Separately, there have also been efforts to develop formal LGBTQ-specific fellowship programs in psychiatry, but these programs have not yet published on their development or impact.

A review of existing LGBTQ-focused content in psychiatry training programs revealed that the presence of LGBTQ+ faculty increased both the amount and the variety of LGBTQ-specific educational content in psychiatry residency training.[36] Similarly, the presence of LGBTQ+ faculty in medical schools increased the hours of LGBTQ+ specific content in undergraduate medical education and raised the likelihood of educational opportunities highlighting the needs of LGBTQ+ youth.[41] Given these benefits, it is important to consider approaches to support and retain LGBTQ+ clinicians in academic medicine. The presence of LGBTQ+ faculty contributes to a virtuous cycle in which students and trainees receive education on LGBTQ+

[b] *Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) Mental Health: A Curriculum for Psychiatry Residents* from the Association of LGBTQ+ Psychiatrists and the LGBTQ Committee of the Group for the Advancement of Psychiatry (GAP) is available at: https://www.gap-lgbtq.org.

[c] The Center of Excellence for LGBTQ+ Behavioral Health Equity provides live sessions, recorded trainings, and consultation opportunities. For more information, please visit https://lgbtqequity.org.

[d] The National LGBTQIA+ Health Education Center provides over dozens of webinars and publications on a variety of LGBTQ+ health topics online at https://www.lgbtqiahealtheducation.org.

health care topics and clinical care strategies, as well as relevant career mentorship. As these students and trainees enter the mental health workforce themselves, a new generation of clinicians sustains and builds on these gains.

Mentorship and professional development

Seventy-two percent of LGBTQ+ health care trainees reported that having an LGBTQ-identified mentor was important for their personal development.[41] However, less than half of them have had the opportunity to work with an “out” LGBTQ+ mentor during their education and training. LGBTQ+ trainees with an LGBTQ+ mentor benefited from positive role modeling and a shared understanding of experiences. Participants also valued LGBTQ+ peer networking and LGBTQ-related professional advice as unique benefits of having an LGBTQ-identified mentor.[41] These findings capture how LGBTQ+ identity-matched mentors can play an important role in the wellbeing and career development of LGBTQ+ trainees. Mentors can provide support, guidance, role modeling, and access to a network of allies, resources that may be especially beneficial to LGBTQ+ trainees who face discrimination and stress in health care settings not experienced by their cisgender heterosexual colleagues.

Should LGBTQ-identified child psychiatrists and mental health providers prioritize training, clinical education, and research in LGBTQ+ mental health? Currently, LGBTQ+ health care professionals disproportionally contribute to LGBTQ+ health research and education.[41] Some LGBTQ+ care advocates suggest that “lived experience” (e.g., the provider sharing the same identity in their own life) is the best way to truly understand how to navigate similar experiences and advocate across systems and environments.[31] Along with the shared identity may come a feeling of sameness, relatability, and shared experiences.[42] Still, LGBTQ+ mental health clinicians may have limited experience with gender diversity and/or have limited experience with patients’ cultural backgrounds. For

example, a cisgender gay psychiatrist may not understand the nuances of life experiences related to transgender identity, not to mention different cultural and racial identities not shared with their client.

Many might agree that sharing a common identity can help clinicians better understand and serve minoritized patients who experience stigma and social alienation. On the other hand, LGBTQ+ providers—like the LGBTQ+ patients they serve—may experience social stigma and discrimination that interfere in their wellbeing and/or professional achievement. Furthermore, LGBTQ+ professionals are underrepresented in medicine and mental health fields and may experience an increased burden from uncompensated identity-related work efforts—a phenomenon often referred to as the "minority tax" in academic settings.[42] Practical strategies for minimizing the minority tax are detailed elsewhere.[43]

Professional medical and mental health organizations, such as the American Academy of Child and Adolescent Psychiatry (AACAP), the American Psychological Association, the American Psychiatric Association, the Association of LGBTQ+ Psychiatrists (AGLP), and the Group for the Advancement of Psychiatry (GAP), offer additional mentorship and training opportunities across career stages. LGBTQ-focused committees within these organizations often serve as safe spaces for LGBTQ+ providers to connect with colleagues around the country, engage in advocacy work, and contribute to national initiatives on LGBTQ+ mental health. Engagement may also help LGBTQ+ providers find a community and feel less isolated, particularly when working in professional settings that are not supportive.

To build a sustainable workforce of identity-matched providers, LGBTQ+ providers would benefit from supportive services and mentoring at all career levels, even beyond their formal training years. Inclusive practices at the institution and health system level can also contribute to mental wellbeing, stress reduction, and retention for LGBTQ+ providers.

LGBTQ-inclusive work environments

The legal landscape for LGBTQ+ workplace protections has historically been convoluted and variable depending on the state of residency and medical practice.[44] At the federal level, Title VII of the Civil Rights Act of 1964 (Title VII) was passed to protect historically persecuted minoritized individuals in important employment decisions like hiring and firing. However, Title VII did not explicitly protect individuals on the basis of gender or sexual minority status, and Congress has failed to enact a federal law to protect LGBTQ+ individuals in employment settings for decades. Technically, the U.S. Supreme Court's historic rulings in several employment discrimination cases in 2020—including the most famous case *Bostock v. Clayton County*—extended Title VII's employment non-discrimination protections to LGBTQ+ status.[45] As the Supreme Court determined, Title VII's existing prohibition of discrimination "on the basis of sex" must be interpreted to include discrimination on the basis of sexual orientation or gender identity, with which biological "sex" is necessarily intertwined. Still, in practice, LGBTQ+ professionals experience varying support and protections based on the state in which they practice, as well as the type of work setting (e.g., federal settings like Veterans Affairs facilities, state-funded settings like public universities, private health care corporations or hospitals). Furthermore, the *Bostock* ruling was limited to the employment protections of Title VII and does not extend legal protections to other key resources like housing or health care, which are necessary for the LGBTQ+ patient and provider, alike. Discriminatory policies at the state level still serve as significant detractors for LGBTQ+ providers considering working in less LGBTQ-friendly jurisdictions. The Human Rights Campaign's *Healthcare Equality Index* may assist mental health professionals in locating health care facilities with LGBTQ-inclusive employment and patient care policies.[46]

Indeed, as discussed previously, laws pertaining to medical care access for LGBTQ+ patients, especially transgender and gender diverse individuals, vary widely by state and have been the subject of intense political discourse in recent years. Whether a health insurance plan has to cover LGBTQ-

affirming care or not is also largely determined at the state level. As such, psychiatrists and mental health providers selecting an internship, residency, or fellowship must weigh their ability to access LGBTQ-affirming care for themselves *and* for their patients. These state-based limitations further bifurcate and consolidate where clinical care, mentorship, education and research are offered.

SUMMARY

Though the demand for mental health care among LGBTQ+ youth continues to grow, the workforce of LGBTQ-serving mental health providers lags behind. Provider shortages and care gaps unevenly affect racially-minoritized Americans, particularly those who reside in Southern states. The lack of effective, sensitive mental health services for LGBTQ+ youth compounds social and psychological stressors faced by LGBTQ+ youth. The current sociopolitical landscape in the U.S.—particularly the initiatives banning gender affirming care and threatening providers and families with harsh penalties—pose a serious challenge to addressing workforce needs. Generally, literature on LGBTQ+ content in undergraduate and graduate medical education are limited, but existing data show that the presence of LGBTQ+ faculty and mentors increases the amount of LGBTQ+ content taught to trainees and benefits LGBTQ-identified trainees. Relatedly, professional development and mentoring initiatives may help LGBTQ-identified faculty and clinicians, as do inclusive workplace protocols and practices.

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