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Assessing LGBTQ youth cultural competency in direct-care behavioral health workers: Development and validation of a measure.

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Assessing LGBTQ youth cultural competency in direct-care behavioral health workers:
Development and validation of a measure.

A dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy at Virginia Commonwealth University.

by

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Abstract

ASSESSING LGBTQ YOUTH CULTURAL COMPETENCY IN DIRECT-CARE
BEHAVIORAL HEALTH WORKERS: DEVELOPMENT AND VALIDATION OF A
MEASURE.

By Megan Elizabeth Gandy, Ph.D.

A dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of
Philosophy at Virginia Commonwealth University.

Virginia Commonwealth University, 2015.

Chair: Elizabeth M. Z. Farmer, Ph.D.
Professor and Associate Dean for Research, School of Social Work

Direct-care workers can provide an array of service types to children, adolescents, and

their families in behavioral health treatment. They may also work in a variety of settings (*e.g.*,

group homes, inpatient units/hospitals, residential treatment, treatment foster care, day treatment,

in-home treatment, *etc.*). Direct-care workers typically are involved in the supervision of youth

and in the implementation of a treatment plan developed by the youth's treatment team. For

youth who are lesbian, gay, bisexual, transgender, and queer or questioning (LGBTQ) and are

receiving behavioral health services, such workers form a critical part of their therapeutic

experience. However, little is known about these workers' competencies related to working with

LGBTQ youth. This study begins to fill that gap by developing and testing a measure that

assessed LGBTQ cultural competencies related to behavioral health practice with youth and a

measure that was relevant to the roles and responsibilities of direct-care (*e.g.*, paraprofessional,

front-line) workers.

In order for direct-care workers to use LGBTQ cultural competency in their practice,

more understanding is needed about their current level of LGBTQ-related cultural competency.

The LGBTQ Youth Cultural Competency scale (abbreviated as LGBTQY-CC) provides a means to measure those competencies. An exploratory factor analysis found that the new scale consists of one primary factor which represents knowledge, attitudes, skill, and awareness of LGBTQ cultural competency. Cronbach's alpha, correlations with other measures for concurrent validity, and correlation with a measure of social desirability all resulted in evidence that the LGBTQY-CC has good validity.

Analyses examined how the new measure was related to constructs associated with training and competency in direct-care workers. Multiple regression analyses showed that higher levels of LGBTQ cultural competency (as measured by the LGBTQY-CC) were significantly related to age (younger), political ideology (more liberal), more social contact with LGBTQ individuals, and degree of religious belief about LGBTQ being a sin. A model including these factors explained 60% of the variance in LGBTQY-CC scores.

The LGBTQY-CC was created with the long-term goal of creating training interventions for direct-care workers to improve their practice with LGBTQ youth. The measure could be used to assess training participants' knowledge, attitudes, skills, and awareness and to evaluate the effectiveness of varying types and styles of training programs. Federal and state regulatory bodies have begun to require service providers to identify how they will address disparities faced by LGBTQ individuals, so service providers need to demonstrate how they are improving access to and quality of care for LGBTQ individuals. Therefore, the LGBTQY-CC may provide a means to gather data on efforts made by service providers to improve their behavioral health workforce's capacity to serve LGBTQ youth.

Chapter 1: Introduction

Background

      This study was designed to investigate the views of direct-care behavioral health workers regarding lesbian, gay, bisexual, transgender, and queer or questioning (LGBTQ) issues in youth. During my experience working as a direct-care worker in many different settings (such as in-home therapy, case management, group homes, and an inpatient psychiatric unit), I saw the important role that direct-care workers can play in a youth's course of treatment. Direct-care workers often spend the most amount of time with youth in treatment, and their roles are vital to overall treatment success. Beyond the typical struggles of adolescence, LGBTQ youth face additional obstacles and need unique kinds of support in order to achieve healthy development. While working as a direct-care worker, I observed things that both were and were not supportive for LGBTQ youth. I came to wonder about how direct-care workers could be more supportive of LGBTQ youth in treatment. As I began to explore research in this area, I discovered that there were no measures that were directly relevant to direct-care workers' roles and practice competencies related to LGBTQ youth. I found that there were measures for therapists or counselors, but none that captured the broad range of activities of a direct-care worker. Therefore, that led me to create such a measure for my dissertation research. I view the current work as a foundation for a career in which I expect to focus on improving training and treatment around issues related to LGBTQ youth for a broad range of staff members who work with youth in behavioral health treatment settings. The current study is designed to help launch this work by developing an instrument that can assess workers' views and practices and begin to understand what factors might be related to variations in LGBTQ-focused competencies.

Statement of the Problem

LGBTQ youth are likely to be disproportionately represented in behavioral healthcare settings, and face disparities in treatment experiences and outcomes (Block & Matthews, 2008; LeFrançois, 2013; Semp, 2006; Wilson, Cooper, Kastsanis, & Nezhad, 2014). Prior research has demonstrated how a safe and supportive environment facilitates positive outcomes for LGBTQ youth (Hatzenbuehler, Birkett, Wagenen, & Meyer, 2014). Furthermore, a systematic review of literature on counseling LGBTQ clients found that a therapist's attitude, knowledge, and skill are important in the treatment milieu (King, Semlyen, Killaspy, Nazareth, & Osborn, 2007). However, there is a dearth of research on the capacity of direct-care workers to create and maintain such an environment (Gandy, McCarter, & Portwood, 2013).

Although a limited number of studies have investigated LGBTQ-related competency among professionals within the disciplines of social work, psychology, and counseling (Crisp, 2006; Eliason & Hughes, 2004), virtually no literature addresses the unique practice role of direct-care behavioral health workers (as opposed to graduate-level/licensed therapists) who provide daily services to youth. Not only is little known about the level of competency of these workers, there is also little known about training them in either the area of cultural competency in general, or in LGBTQ-related competency specifically. There are known efforts to improve the practice ethics of graduate-level mental health professionals around LGBTQ issues, but few studies exist that examine trainings for other types of workers involved in the field of children's mental health (Christensen & Sorensen, 1994; Clark, Landers, Linde, & Sperber, 2001; Finkel, Storaasli, Bandele, & Schaefer, 2003; Rudolph, 1989; Whitman, Horn, & Boyd, 2007; Worthen, 2011).

This is particularly important in many behavioral health settings because contemporary paradigms of care recognize the importance of multi-disciplinary, team-based interventions that include a continuum of care to meet the varied and changing needs of youth with emotional and behavioral health problems (Miller, Blau, Christopher, & Jordan, 2012; Stroul & Friedman, 1986). Therefore, multiple types of workers interface within the field of children's mental health. These workers are individuals who deliver treatment services directly to the child and/or family, and they have a wide variety of educational backgrounds. This includes not only licensed mental health professionals (*e.g.*, licensed clinical social workers, licensed professional counselors, licensed psychologists), but also medical professionals (*e.g.*, psychiatrist, nurse practitioner, physician's assistant, nurse, nurse's assistant), special education teachers and other school-based staff, case managers (who may or may not have a human services related bachelor's degree), paraprofessionals (who have less than a bachelor's degree), administrative and support staff (*e.g.*, receptionists, food service providers, groundskeepers, *etc.*), and managerial/leadership staff. Within a given treatment setting, many workers engage in a variety of tasks and activities that the counseling or therapy relationship alone does not capture. Such tasks can be labeled as direct-care roles. Typically, in treatment settings direct-care workers are responsible for contact with the youth not just for therapeutic intervention but also for supervision, implementing behavioral treatment plans, assisting with activities of daily living, and collateral contact with family members and community stakeholders who also play a role in providing treatment to youth.

Given their extended contact with youth (beyond a one-hour therapy session), this range of direct-care workers play an important role in creating and maintaining a safe environment for LGBTQ youth (Mallon, 1998; Ragg, Patrick, & Ziefert, 2006). Therefore it is imperative to address their level of preparedness to work in a culturally competent manner with LGBTQ

youth. Measuring outcomes of training interventions for direct-care workers is an important part of improving practice, and such measurement involves assessing the level of cultural competency in the individual provider.

Relevance to Social Work. LGBTQ youth are a vulnerable and historically oppressed population, and social workers are called to work to end the oppressions faced by such populations (National Association of Social Workers, 2008). LGBTQ youth who are dealing with a serious emotional or behavioral disorder face unique challenges to their well-being and are in need of support by the service providers who are charged with their care. Therefore, social workers should play a leadership role in improving the quality of care received by LGBTQ youth, and one way to achieve that is by addressing the competency of direct-care workers.

Aim of Present Study

In order to deliver effective LGBTQ-related training for direct-care behavioral health workers, more understanding is needed about their current level of LGBTQ-related cultural competency. A valid and reliable measurement tool is needed to investigate the level of LGBTQ cultural competency. Therefore, this dissertation aimed to develop and test a measure that assesses the level of cultural competency of direct-care workers as it relates to LGBTQ youth in behavioral health care.

Research Questions

To advance knowledge in this field, the current work is organized around two primary aims and a nested set of specific research questions.

Aim 1: To what extent can a measure capture the variability of cultural competence in direct-care behavioral health workers as it is related to LGBTQ issues in youth?

1. What is the internal consistency of the measure?

2. What is the underlying factor structure of the measure?

    a. Does the factor structure support a multi-dimensional model that aligns with the conceptual model of cultural competency?

3. Are items significantly influenced by social desirability?

4. Does the new measure correlate as expected with existing measures of gay affirmative practice and attitudes towards LGBTQ persons?

Aim 2: How is this measure related to concepts associated with behavioral health workforce competence and development?

5. Does the measure vary systematically with characteristics of workers and organizations?

    a. Personal factors: sexual orientation, sex, age, race, level of education, political ideology, social distance to an LGBTQ person, and personally held sin belief about LGBTQ individuals.

    b. Organizational factors: perceived organizational climate related to LGBTQ individuals; policies in place related to LGBTQ individuals.

6. Is the measure related to other measures concerning training or competency in workers or the work environment?

    a. General cultural competency.

    b. Worker willingness to adopt evidence-based practice.

    c. Organizational culture and climate.

    d. Job autonomy.

Organization of Chapters

Chapter 2 identifies and explains the conceptual framework for this study as well as theories that guide an understanding of the issues involved. Chapter 3 includes a literature review

of empirical and conceptual literature related to providing culturally competent care to LGBTQ youth who are in behavioral health treatment settings. Chapter 4 describes the methodology used for the study, including details about the development of the measure and an explanation of the analyses used to test the new measure. Chapter 5 presents findings based on the study aims and research questions outlined above. Finally, Chapter 6 offers a discussion of the findings and explores the implications of the findings to theory, research, policy, and practice. It also covers limitations of the study and concludes with a discussion of next steps for future research on this topic.

Chapter 2: Conceptual and Theoretical Frameworks

Introduction

This chapter offers a discussion of the cultural competency framework used to guide the present study. The chapter will begin by providing some background on the behavioral health system of care, the workers of interest in this study, and a discussion of why this issue is important for LGBTQ youth. Then, it will define the conceptual framework of cultural competence and associated concepts. In order to put the discussion in context of behavioral health services, a brief history of cultural competency in the field of children's mental health services will be reviewed. Criticisms of the conceptual framework will be examined. Then a conceptual model, which informed the development of the proposed measure, will be presented. The chapter will then discuss the theories that help explain the nature of the problem faced by LGBTQ youth. Lastly, it will discuss philosophical social science assumptions that underlie the framework in the context of the present study.

Background

Behavioral Health Care. Today's behavioral health services for children and adolescents are often delivered in a systems-of-care framework. This framework is defined by Miller and colleagues (2012) as:

> A spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life. (p. 567)

While this definition provides an idealized version of how a system will work, the underlying ideas are built on concepts that have formed the dominant paradigm of children's mental health service delivery since the 1980's (Stroul & Friedman, 1986). The framework was developed to address serious concerns with prevailing multi-system approaches to serving children with mental health problems and their families (*e.g.*, lack of coordination among providers, lack of a continuum of services, duplication of services, lack of community-based options, *etc.*)(Knitzer, 1993). As opposed to a fragmented system where a youth could interface with multiple entities just to get the basics of treatment (*i.e.*, case management, therapy, medication management, residential treatment, *etc.*), the system-of-care approach is intended to enable a youth and his/her family to interface within a network of service providers who are working together toward mutually agreed upon goals.

This paradigm assumes that multiple service provider stakeholders interact within this system of care. There are many roles that behavioral health workers take on in a youth's course of treatment. Indeed, the discussion of how to address LGBTQ cultural competency has evolved from a singular focus on a therapist's role (Ryan & Futterman, 1998) to discussions that include organizations and communities involved in providing behavioral health care (Clark et al., 2001). Yet one aspect of this discussion has yet to be explored: direct-care roles. Workers in these roles do more than just counseling with their youth and therefore need skills and training that expand beyond just a counseling role. There is no literature or measures to address these unique roles and responsibilities.

Youth who have emotional and/or behavioral disorders often present in behavioral health services with symptoms as well as certain needs due to problems functioning in life domains such as school, family, and community. The problems addressed in treatment by these service

providers are not limited to just psychiatric disorders, but rather encompass both the disorders diagnosable by the DSM-5 and "the problem behaviors associated with them, such as violence, aggression, and antisocial behavior" (O'Connell, Boat, & Warner, 2009, p. xv). Child welfare systems sometimes include behavioral health care, yet not all youth who are in a behavioral health system-of-care are involved in the child welfare system. The child welfare system is defined for this study as the system that is involved in legal custody related to abuse or neglect cases, and traditional foster care services. The same is true for the juvenile justice system – not all youth in behavioral health care have interfaced with the juvenile justice system, although many have. Thus, this study focuses on youth in the behavioral health system, not the child welfare system or the juvenile justice system. This distinction is important because there are studies that addressed LGBTQ youth in the child welfare and juvenile justice systems, but I propose that the studies do not adequately relate to youth in the behavioral health system.

Direct-Care Workers. Typically the labels that encompass the workers of focus for the present study are paraprofessional, direct-care, or front-line. This study will use the term direct-care, although the terms are interchangeable. Direct-care workers can provide an array of service types to children and adolescents in behavioral health treatment. They may also work in a variety of settings (*e.g.*, group homes, inpatient units/hospitals, residential treatment, treatment foster care, day treatment, *etc.*). There is no single rule or definition for exactly what kinds of services direct-care workers can and cannot deliver; however, Medicaid service definitions specify what kind of license, certification, level of education, or amount of experience is required to deliver a service. For instance, a high-school-educated worker cannot provide a service that requires a license such as an L.C.S.W. or R.N. Direct-care workers typically are involved in the supervision of youth and in the implementation of a treatment plan set out by the youth's treatment team

(Buchbinder, 2003). A definition of direct-care workers offered by Hodas (2012) captures the intent of this label well:

> Direct care workers, sometimes referred to within Mental Health as "mental health workers" and "mental health techs" and by other terms in other systems, are typically individuals with a high school diploma, although some may have a higher terminal degree, and a specified amount of experience working with children in human services. Despite their limited formal training (and, at times, limited clinical experience), direct care workers typically have the most frequent contact with children and, often, the greatest influence. … No program can effectively meet the needs of its children without an effective, well-trained cadre of direct care staff. This, in turn, requires a strong commitment by program leadership to promote the professional development of its workforce. (p. 1)

Ultimately, it takes the entire staff of an agency in order to be successful in treating youth. From the groundskeeper to the CEO, everyone has a part to play. This was underscored in a prior study I conducted in which staff members of a children's mental health agency were assessed for their attitudes towards LGBTQ youth (Gandy et al., 2013). In that study it was found that attitudes differed by job category, most significantly between the leadership staff and the front-line/support staff. Thus it is important to address all staff members in an agency, not just the ones with advanced degrees or clinical licenses.

In contemporary behavioral health treatment settings, direct-care activities are not only limited to direct-care workers. The reality is that licensed clinicians do not just sit in their offices and see patients. They also interact within the therapeutic milieu. For instance, a day treatment therapist might go out of her office to help with a group activity. Or an inpatient clinical social

worker may step on to the floor to help de-escalate a patient. A licensed clinician may be part of an in-home treatment team who interact with the youth and other supports in the community setting. These are activities that direct-care workers traditionally engage in, but in today's behavioral health context, licensed clinicians are asked to do more than just sit in their office and 'do therapy.' This reflects the team-based and interdisciplinary nature of today's behavioral health treatment. So, a measure focused on direct-care workers could also be relevant to other types of workers in these therapeutic settings.

LGBTQ Youth. Although LGBTQ youth comprise 5% to 20% of the general adolescent population (Savin-Williams, 2005), LGBTQ youth are likely to be disproportionately represented in behavioral health treatment settings (Block & Matthews, 2008; Williams & Chapman, 2014; Wilson et al., 2014). Population-based studies and systematic reviews have found that LGBTQ youth report higher rates of suicidality and depression (Marshal et al., 2011), anxiety (Williams & Chapman, 2011), post-traumatic stress disorder or symptoms (D'Augelli, Grossman, & Starks, 2006; Dragowski, Halkitis, Grossman, & D'Augelli, 2011), substance abuse (Newcomb, Birkett, Corliss, & Mustanski, 2014), and psychological distress (Birkett, Newcomb, & Mustanski, 2015). The exact prevalence of LGBTQ youth in behavioral health treatment settings is unknown; however, Williams and Chapman (2011) found that there was a statistically significant difference in the amount of service access for sexual minority youth (lesbian, gay, bisexual) and heterosexual youth (19.8% versus 12.1%). The lack of data on the number of LGBTQ youth in treatment is likely due to the invisible nature of the early stages of developing an LGBTQ identity. According to stage models of identity development (Cass, 1984; Morgan & Stevens, 2012; Troiden, 1989), disclosure of LGBTQ status does not occur until later in an individual's developmental process. The nature of identity development suggests that earlier stages of

development occur in childhood and adolescence, thus marking those early stages as times when the person does not outwardly identify as LGBTQ (Morrow, 2004). Therefore, data may not exist on LGBTQ youth because of the difficulty in identifying the population.

The topic of LGBTQ competency is relevant not just for workers who interact with adolescents, but those who work with younger children as well. In terms of age range, LGBTQ issues are important for youth as young as age 5 because youth can begin the identity development process at a very young age even if they do not outwardly identify as LGBTQ (D'Augelli, Grossman, & Starks, 2008). Retrospective studies of LGBTQ identity development have found that young people reported feeling different as early as age 5, sometimes younger (D'Augelli et al., 2008; Rosario, Schrimshaw, Hunter, & Braun, 2006). Studies have addressed some treatment professionals' competencies with adolescents (Block & Matthews, 2008; Mallon, 2006; Ragg et al., 2006), but no studies to date have addressed the topic to include workers with younger children.

One reason LGBTQ youth are in need of support is because of the vulnerabilities associated with the invisible nature of their LGBTQ identity (Uribe, 1994) – there are no inherent outward signs of LGBTQ status. Even if a youth readily identifies inwardly as LGBTQ, disclosure of one's LGBTQ identity can be tricky. A study by Semp and Read (2014) found that even when it was relevant to their treatment, participants found "considerable difficulty" (p. 1) in reporting their sexual orientation to their practitioner, which supports the assumption that LGBTQ issues can easily go unaddressed. If a youth is ready to come out as LGBTQ, he/she has no assurance that there will be a support system available if he/she encounters bullying, prejudice, or discrimination. LGBTQ youth have no inherent physical manifestations to identify others who are similar to them, can relate to their struggles, or have some reasonable chance that

someone would provide support. This is an issue that manifests itself in unique ways for sexual and gender minorities, as illustrated by Sullivan and Wodarski (2008):

> The homosexual is unique among minorities in facing hatred and discrimination in that (s)he usually has no role model, no positive example in their family and no loving parent who has gone through the same experience, to offer support or understanding. Youth discriminated against because they are (for instance) Jewish or African-American usually have families or communities for which this is a common problem, and have familial support, but gay youth often experience rejection from their families in addition to the larger community and they seldom have yet identified any supportive peers and/or communities (Savin-Williams, 1994). (p. 5)

Their unique needs are emphasized by Sherriff and colleagues' discussion of their findings from a study of mental health service providers and LGBTQ youth, stating: "our findings indicate that many LGBTQ young people's needs are not being adequately met by existing services across Sussex, and that this is compounded in part both by their invisibility and the normalization of homophobic language and bullying" (Sherriff, Hamilton, Wigmore, & Giambrone, 2011, p. 951).

Youth who are still forming their identify or are in a stage of questioning their identity pose an even greater need for workers to be competent in LGBTQ issues, as the following literature demonstrates. A study of 1,856 high school students in Montréal, Québec, found that youth who reported being unsure of their identity had a greater risk of suicidality than those who identified as heterosexual, and more than youth who reported same-sex attraction but self-identified as heterosexual (Zhao, Montoro, Igartua, & Thombs, 2010). Youth who are in a

questioning phase and do not identify outwardly or inwardly as LGBTQ need support. This is underscored by Sherriff and colleagues' (2011) discussion:

> As Williams, Connolly, Pepler, and Craig (2005) found, Questioning youth tend to report higher rates of truancy, depression, suicidal feelings, and substance misuse than both heterosexual and LGB young people. Such findings suggest that the experiences of Questioning youth are equally or even more important to consider than LGB(T) youth in terms of risk for potential negative outcomes. (p. 952)

LGBTQ youth often have fewer places to turn to for support because of the hostility and rejection that can be present in their families, in school settings, or in the community (Mcconnell, Birkett, & Mustanski, 2015; Nesmith, Burton, & Cosgrove, 1999; Reisner, Greytak, Parsons, & Ybarra, 2014; Sullivan & Wodarski, 2008). Therefore, if LGBTQ youth are to be successful in behavioral health treatment, service providers and organizations must attend to their unique stressors and needs.

Conceptual Framework

This section will introduce the framework of cultural competence and explain how it will be used in the present study. A conceptual framework is understood in the present study to be "a general perspective of organizing and classifying concepts into a relevant structure" (Kim, 1997, p. 32, as cited in Fawcett, 1999, p. 2). A concept is understood here as "a word or phrase that summarizes the essential characteristics or properties of a phenomenon" (Fawcett, 1999, p. 1). This section will start with defining cultural competency and associated concepts and then provide a brief discussion of the history of the cultural competency framework. It will address

critiques of the framework and end with a brief discussion of the applicability of this study to social justice.

Cultural Competency Definition and History. Although there are many definitions of cultural competency, the one guiding this dissertation was proposed by Cross (1988) in a monograph on cultural competency with minorities in children's mental health care: "a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or amongst professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations" (Cross, Bazron, Dennis, Isaacs, & Benjamin, 1989, p. iv). There are several reasons for choosing this definition over others. First, it is the definition used across federal and state entities that regulate and influence behavioral health service providers' standards for cultural competency (National Center for Cultural Competence at Georgetown University Center for Child and Human Development, 2014; Office of Minority Health, 2001; SAMHSA Prevention Training and Technical Assistsance, 2014). Second, it is most commonly viewed as the cornerstone for cultural competency standards in the field of children's mental health (Mancoske, Lewis, Bowers-Stephens, & Ford, 2012). Third, many helping professions, including social work, base their definitions of cultural competence on this one. For instance, although the National Association of Social Workers offers a definition in their *Standards for Cultural Competence in Social Work Practice*, stating "the process by which individuals and systems respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, religions, and other diversity factors in a manner that recognizes, affirms, and values the worth of individuals" (National Association of Social Workers, 2007, p. 12), this definition is followed by several other definitions in the same publication, one of which includes Cross and colleagues' definition established in 1989.

Two additional definitions are needed for clarity of this conceptual framework. One is culture, defined as "the integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group" (Cross et al., 1989, p. iv). This definition is useful because it does not limit culture to only racial/ethnic minorities, which is important when considering the application of cultural competency to practice with LGBTQ youth. Secondly, the working definition of competence is "having the capacity to function effectively" (Cross et al., 1989, p. iv). An important distinction must be made regarding the concept of competence. Competence in this sense is understood as a lifelong commitment to learning about other cultures and becoming more able to work effectively with other cultures, rather than an arrival point that one can achieve in a prescribed series of steps. Competence and competency are used interchangeably in this dissertation and are understood to be the same for the purposes of this study.

History in Mental Health Services. Relevance of cultural competency to children's mental health is commonly traced back to 1988 with Cross' landmark monograph on cultural competency with minorities in children's mental health care (Cross et al., 1989; Cross, 1988). In it, the author described what cultural competency was, which marked a shift from ideas like ethnic-sensitive practice, cross-cultural awareness practice, and others. In this work, Cross and colleagues moved the field towards an understanding that cultural competence is something that begins with awareness, but becoming culturally competent involves an iterative process through several phases, and involves a lifetime commitment to learning. They also extended cultural competency to the agency and system level, which was important because it acknowledged the systemic limitations on practitioners who may have already been practicing in a culturally competent way, but had no higher level support for the work they were doing.

Beginning in the 1990's, disciplines related to mental health services such as psychiatry, social work, psychology, and counseling began adopting formal statements that called for culturally competent standards of care (Mancoske et al., 2012). The first cultural competency standards were adopted by the American Psychological Association (APA) in 1992 (Kohli, Huber, & Faul, 2010). The National Association for Social Work (NASW) created a policy statement in regards to cultural competency in 2000 (National Association of Social Workers [NASW], 2000), and the first standards of practice were published in 2001 (National Association of Social Workers, 2001). In 2001, the Office of Minority Health, a Division of the U.S. Department of Health and Human Services, published a set of standards called the Culturally and Linguistically Appropriate Services (CLAS) (Office of Minority Health, 2001). This policy provided 14 standards for health care provider organizations and individuals who receive federal funds, four of which are mandates, nine are guidelines, and one is a recommendation. None of the CLAS standards contained any mention of sexual orientation or gender identity, and all focused primarily on differences according to race, ethnicity, and language spoken.

Following the CLAS policy, cultural competency emerged in the field of health care in the early 2000's, and focused mainly on racial, ethnic, and language differences between patients and providers, with the goal of providing healthcare solutions that were more likely to be adopted by disparate sociocultural groups (Betancourt, Green, Carrillo, & Park, 2005). However, this notion of culturally competent healthcare does not extend to certain characteristics such as sexual orientation or gender identity. The motivation behind the adoption of cultural competency policies in healthcare settings was an effort to reduce health disparities experienced by minority groups (Betancourt et al., 2005). Therefore, it is understandable that the inclusion of LGBTQ issues in cultural competency policies is still in the infancy stages, given that research on

disparities faced by LGBTQ persons has gained attention only recently (Bradford & Mustanski, 2014).

  Criticisms of Cultural Competency. A major criticism of culturally competent practice standards and policies is that there are few instances of empirical evidence to support the assumption that such policies are effective in creating better outcomes for clients (Beach et al., 2005; Bhui, Warfa, Edonya, McKenzie, & Bhugra, 2007). Another major criticism is that cultural competency is seen by some as a problematic concept in the academic and theoretical literature. Some scholars have dismissed the concept of cultural competency, and opted instead for theories on cultural humility (Ortega & Faller, 2011) or cultural responsiveness (Aisenberg, 2008), to name only a few. In order to investigate the meaning and semantic relation between the terms cultural competency and cultural sensitivity, a study was conducted which involved an extensive literature search in counseling and psychotherapy literature to identify frequency and co-occurrence of these terms in the literature, and then the use of multivariate analyses such as multidimensional scaling and cluster analysis to examine the relationship between the terms (Whaley, 2008). The author found that most theoretical discussions of cultural competency and cultural sensitivity were tapping the same dimension. The same study came to the conclusion that scholars who dismissed the use of the term 'cultural competency' and opted instead for 'cultural sensitivity' most likely did so in an effort to clarify that one can never become fully 'competent' in another culture. This distinction is important in considering the relative utility of theories on cultural competence versus other theories like cultural sensitivity, cultural humility, and cultural responsiveness. In the present study, the use of the term cultural competence does not dismiss the importance of humility, sensitivity, and awareness. Rather, with a careful reading of the theories on cultural competency, it becomes apparent that without personal and

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professional characteristics of humility, sensitivity, and awareness, cultural competency is impossible to achieve. However, this does not dismiss the fact that these varying theories are set in different paradigms and therefore bring different strengths and weaknesses to the present conceptualization of practice with LGBTQ youth. These different theoretical orientations can be used to approach the area of practice with LGBTQ youth in differing manners and would very likely produce different results and conclusions. For the present study, the framework and concepts underlying cultural competency seemed to most fully align with the positivist paradigm and the goals of establishing a measure that, potentially, could be beneficial in future work to assess changes associated with training. Philosophical assumptions of this underlying framework will be further explored later in this chapter.

Social Justice. Social work is concerned with social and economic justice, so how does the present study relate to a social justice context? Today's cultural competency efforts fall in the realm of endeavors for social and economic justice because they come from "an empowerment approach for oppressed and vulnerable client populations" (Mancoske et al., 2012, p. 196). Social justice in its most basic form can be defined as "the fair distribution of society's benefits and responsibilities" (Morris, 2002, p. 365). The conceptualization of social justice that the present study uses is based in the Rawlsian distributive justice perspective, which states that "the greatest benefits are required to go to the least advantaged in cases of unequal distribution" (Rawls, 1971, as cited in Morris, 2002, p. 366). This is appropriate for the present study because LGBTQ youth experience higher rates of clinically diagnosable mental health disorders (Mustanski, Emerson, & Garofalo, 2010) and have 31% higher odds of having an unmet mental health need as compared to non-LGBTQ youth (Williams & Chapman, 2012), even though they

access services at a higher rate than their non-LGBTQ peers (Williams & Chapman, 2011). Thus, there is an unequal distribution of resources.

Conceptual Model

This section explains the conceptual model that will be used to guide the creation of the measure. Models are "typically used to guide decision making or to understand how decisions are made" (Flynn, 1992, as cited in Hardina, 2002, p. 45). The conceptual model for this study will be used in a prescriptive way so as to guide decisions for the creating of the new measure (Netting, O'Connor, & Fauri, 2008). This section will start by explaining the individual level model of cultural competency. It will then discuss organizational level factors that influence the individual practitioner.

Individual Practitioner Level. There are as many models of cultural competency as there are definitions. However, the model selected for use in this study was chosen because of the frequency of its use in practice settings in the field of children's mental health. Written by Sue and colleagues (1992) for the American Psychological Association, cultural competency was framed as consisting of three dimensions: (1) attitudes/beliefs held by the practitioner about different cultural groups; (2) knowledge, or information that the clinician knows about different cultural groups; and, (3) skill, which is the skill set and ability of the practitioner to work with different cultural groups. Although many researchers and practitioners have since developed and tested models that sometimes collapsed the three dimensions or expanded them, this tripartite model seems most useful because of what I consider an important distinction: a practitioner can have LGBTQ-affirming knowledge, and LGBTQ-affirming attitudes, yet still practice in a way that is harmful to LGBTQ youth. This is explored further below in the conceptual model, but is also explained by microaggressions theory as discussed next.

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Figure 1: Conceptual model of a service provider's culturally competent practice (Sue et al., 1992)

Figure 1 represents the model of culturally competent practice in a mental health service provider. It is my assumption the best level of cultural competency is to be in the middle intersection of all three circles. The concepts overlap because often a practitioner can be stronger in one area than another, resulting in a lack of full cultural competency. This can be the case in regards to culturally competent practice about LGBTQ youth. Direct-care workers could have affirming attitudes and some knowledge about LGBTQ issues, yet lack the skill to effectively interact with youth about those issues.

A useful addition to the tripartite model is the dimension of awareness, which represents an understanding of one's own cultural biases and knowledge/skill limitations, and the degree to which one is willing to learn more about other cultures and groups (Cross et al., 1989). Awareness is important because without it, the practitioner could unknowingly be engaging in culturally destructive practice behaviors. Awareness permeates and impacts all three dimensions, thus in this model it is overlaid around all three, as in Figure 2.

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Figure 2: Addition of awareness dimension to the cultural competency model.

LGBTQ-specific. Van Den Berg and Crisp (Van Den Bergh & Crisp, 2004) wrote what is now a cornerstone piece of literature on culturally competent practice with sexual minorities. This piece helped to fill the gap on what cultural competency standards left out about LGBTQ persons. In it, the authors used the model of gay affirmative practice by Appleby and Anastas (1998) to specify themes that coincide with the tripartite model of cultural competency, as seen in Table 1. Added to this are themes related to transgender persons in order to align it with the present study's focus on both gender and sexual minorities.

Table 1: Themes for LGBTQ-affirming practice in a cultural competence framework (adapted from Appleby & Anastas, 1998).

Attitudes
1. Same gender sexual desires and behaviors are viewed as a normal variation in human sexuality.
2. Variations in gender identity and expression are viewed as a normal part of gender identity development.
3. The adoption of a LGBTQ identity is a positive outcome of any process in which an individual is developing a sexual or gender identity.

Knowledge
1. During the course of treatment, service providers should not automatically assume that a client is heterosexual or cisgender[1].
2. It is important to understand the coming out process and its variations.

Skills
1. Practitioners need to be able to deal with their own heterosexual and cisgender bias, and their own homophobia and transphobia.
2. When assessing a client, practitioners should not automatically assume that the individual is heterosexual or cisgender.

Youth specific. Later, Crisp and McCave (2007) specified how gay affirmative practice can be useful for working with lesbian, gay, and bisexual youth. In addition to discussing specific knowledge and skills that would be helpful for working with youth, the authors described characteristics of gay affirmative practice that make it an ideal match for working with LGB youth in treatment settings, as described below (Crisp & McCave, 2007):

Characteristics: (1) focuses on affirming youths' identities; (2) empowers youth; (3) supports youth in self-identifying in whatever way they feel is appropriate; (4) supports youth in identifying homophobic forces in their lives; (5) considers problems in the context of the homophobia and discrimination that youth experience; and (6) can be used in the variety of settings in which GLB youth interact and receive social work services including schools, residential facilities, and outpatient treatment settings. (p. 405)

Bisexual, transgender, and queer. As support for gay affirming practice grew, it became apparent that the experiences of bisexual, transgender, and queer identified youth were not adequately captured by a model that focused only on individuals who identified exclusively as

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[1] Cisgender is defined as an individual whose gender identity matches the sex they were assigned at birth (*e.g.*, a female-identified person whose sex was assigned as female at birth). It is often used to distinguish between transgender and non-transgender individuals.

gay or lesbian. Thus, in recent years, literature has been written to expand cultural competency to persons outside of a homonormative identity, and inclusive of the diversity in gender identity and expression.

Bisexual. Bisexual individuals have historically been marginalized in the lesbian and gay community (Eady, Dobinson, & Ross, 2011). Many assumed that bisexuality was just a premature step towards identifying fully as lesbian or gay, and this assumption is most commonly linked to stage models of homosexual identity development such as that by Cass (1984). However, now bisexuality is understood better as a distinct identity from gay or lesbian, and brings with it its own set of unique challenges such as biphobia, a unique identity development model, and stigma from old assumptions about sexuality. A study by Scherrer (2013) examined the unique needs of bisexual persons by interviewing 45 bisexual-identified individuals, and found 5 salient issues relevant to clinical practice with bisexual persons: (1) biphobia, (2) practitioner attitudes about bisexuality, (3) identity development, (4) social relationships, and (5) sexual health. These themes must be considered in the context of culturally competent practice with LGBTQ individuals.

Transgender. Transgender youth face additional factors that make them even more vulnerable than lesbian, gay, or bisexual youth (Grossman & D'Augelli, 2006). Finding specifications for working with gender variant youth is difficult because inevitably the issue arises of how to clinically work with the youth on their gender identity development, which should only be done by highly trained and specialized professionals. However, direct-care workers are very likely to encounter gender variant youth in the course of their careers, so recommendations for how to help them develop their transgender identity in a clinical sense are not necessarily applicable. The recommendations by Advocates for Youth seem most appropriate

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to the roles that direct-care workers will take with transgender youth because of the depth and

breadth of the responsibilities that are addressed (see Table 2).

Table 2: Tips and strategies for meeting the needs of transgender youth (Girl's Best Friend Foundation and Advocates for Youth, 2005, p. 23-24)

- "Don't make assumptions" about the youth's gender, or whether or not the youth has gender identity issues.
- "Create a safe space for open discussion", including using gender-neutral language.
- "Be informed and don't be afraid to examine your own beliefs." We've all been influenced by a genderist and transphobic society, so checking your own belief system is okay.
- "Seek to fully understand gender identity." Attain knowledge about the continuum of gender identity, and balancing gender identity with the multifaceted aspects of a person's overall identity.
- "Respect confidentiality." Youth trust workers who they come out to about their gender identity issues, so don't break their trust by sharing their issues without their permission.
- "Know when and where to seek help." "Transgender youth are often subject to abuse, homelessness, suicide, harassment, and physical violence."
- "Provide training for staff, board, volunteers, and youth."
- "Protect from harassment." "Immediately protect transgender youth from harassment in any form."
- "Provide single occupancy bathrooms, if possible."

Agency/Institution/System Level. Practitioners do not operate in a vacuum. They are

influenced by factors related to their work environment, which includes not only their agency or

institution, but also the system in which their agency functions. Thus, there are aspects of a

system that impact cultural competency (see Table 3). In the same monograph written by Cross

and colleagues that set the course for individual cultural competency models, the authors framed

cultural competency as a system, agency, and individual level issue. They asserted that the

individual practitioner cannot fully realize cultural competency in their practice without an

agency and a system that also follows cultural competency guidelines.

Table 3: Essential elements of cultural competency at the agency, institution, or system level (Cross et al., 1989, p. 19-21).

1. Values diversity: "A system of care is strengthened when it accepts that the people it serves are from very different backgrounds and will make different choices based on culture" (p. 19)
2. Have the capacity for cultural self-assessment: "When planners and administrators understand how that system is shaped by culture, then it is easier for them to assess how the system interfaces with other cultures." (p. 19)
3. Be conscious of the dynamics inherent when cultures interact: "When a system of one culture interacts with a population from another, both may misjudge the others' actions based on learned expectations." (p. 20) – it is a two-way street.
4. Have institutionalized cultural knowledge: "The system of care must sanction and in some cases mandate the incorporation of cultural knowledge into the service delivery framework." (p. 20)
5. Have developed adaptations to diversity: "The system's approach may be adapted to create a better fit between the needs of minority groups and services available." (p. 21)

LGBTQ-specific agency/institution context. The GLBT Health Access Project, funded by the Massachusetts Department of Public Health, conducted a needs assessment study of community-based agencies to address how such agencies could best address the needs of GLBT youth (Clark et al., 2001). The project resulted in a list of recommended standards of care for community based agencies, including issues for personnel, clients' rights, intake and assessment, service planning and delivery, confidentiality, and community relations and health promotion. Salient recommendations for the present study included visibility of LGBTQ employees, policies to protect LGBTQ employees and clients, inclusion of LGBTQ clients' voices into service evaluation and planning, and ensuring all staff of an agency are familiar with LGBTQ issues.

These agency and institutional contexts are not a part of the conceptual model that makes up the new measure, but rather are anticipated covariates of the new measure. They are not included in the measure because they are not variables that are traditionally under the control of the direct-care worker. That is not to say that direct-care workers never have control over such

factors; but in a traditional top-down style of management, direct-care workers are often left with the least amount of influence over an organization's operations. However, the organizational factors are important aspects of the contextual influences of an individual direct-care worker's LGBTQ-related cultural competency.

Cultural Competency Measurement Practices and Issues

The issues that this section will address include the need for psychometrically tested instruments, method of assessment (self-report, external observer, client report, performance-based), impact of social desirability, and the lack of specificity to direct-care workers.

Need For Instruments. The need for rigorously tested measures of cultural competency cannot be overstated (Harris-Haywood et al., 2012). Because of the rise in culturally competent standards, and the expectation that agencies and systems comply with regulatory bodies that require demonstrated cultural competence in their service delivery, the ability to accurately measure cultural competency is needed. However, not many psychometrically tested measures exist in the literature. A systematic review examined available self-assessment measures of cultural competency in the medical literature, and found that out of 50 different measures, only 6 provided both reliability and validity psychometric properties, and 15 provided either reliability or validity but not both (Gozu et al., 2007).

Assessment Method. There is concern that self-assessment is not sufficient for accurately capturing levels of cultural competency (Cartwright, Daniels, & Zhang, 2008). Since it requires a certain level of awareness to accurately self-assess, if one does not have awareness then it is easy to be over-confident about how culturally competent one is. Furthermore, many culturally destructive practices happen without overt awareness on the part of the practitioner, as in the case of microaggressions, which will be discussed later. A study by Cartwright and

colleagues (2008) examined the relationship between counseling students' self-reported level of cultural competency versus an independent observer's assessment and found that self-report was significantly higher than observed behavior. Thus, even when self-report measures are the only practical method for measuring cultural competency, the actual behavior of service providers may be less positive than self-reports suggest.

Other ways to assess cultural competency include evaluator observation (Lafromboise, Coleman, & Hernandez, 1991; Stanhope, Solomon, Pernell-Arnold, Sands, & Bourjolly, 2005), anticipated practice behavior (Oles, Black, & Cramer, 1999), performance measures of cultural competency (Siegel et al., 2000), and consumer/client assessment of their service provider (Mancoske et al., 2012). These methods may be feasible in small-scale studies or in quality improvement efforts by some providers. However, many times these measures require more resources than agencies or training facilitators can afford. Thus, self-report measures remain the most time and cost effective.

Impact of Social Desirability. There is a concern about the influence of social desirability on the validity of self-assessment measures of cultural competency (Constantine & Ladany, 2000). Interestingly, when in the context of training on cultural competency issues, trainees who complete social desirability measures along with self-assessment cultural competency measures sometimes score lower than expected on social desirability measures, meaning that they more readily admit to their own racial and cultural biases (Constantine & Ladany, 2000). This is thought to occur because of the increased awareness that training on cultural competency can create. So, comparing the new measure for the present study to a measure of social desirability is important.

Relevance to Direct-Care Workers. Existing measures have been limited to the scope of the counseling/therapist relationship, yet behavioral health agencies employ a wide spectrum of professionals and paraprofessionals from many disciplines; therefore, not every direct-care worker can reliably say that they have the same function as a counselor or therapist (Stanhope et al., 2005). Stanhope and colleagues explored the validity and reliability of cultural competency measures of behavioral health service providers, and found that the measures available at that time did not provide particular relevance to workers who do not have a direct counseling role (which applies to the direct-care workers who are a focus of this present study). In the study conducted by Gandy, McCarter, and Portwood (2013), one conclusion was that the instruments available for measuring concepts related to providing behavioral health services to LGBTQ youth did not capture the full array of activities involved in today's children's behavioral health field. In an agency where multiple types of services are delivered in a comprehensive format, it is inadequate to measure only the competencies of counseling and therapy related activities. Thus, the need for measures relevant to direct-care workers was highlighted.

Conclusion. Cultural competency is a suitable framework to use when addressing behavioral health treatment settings because it is the standard set by state and federal regulatory bodies (National Center for Cultural Competence at Georgetown University Center for Child and Human Development, 2014; Office of Minority Health, 2001; SAMHSA Prevention Training and Technical Assistsance, 2014). LGBTQ youth's treatment needs can be addressed under the umbrella of cultural competency by addressing relevant practices that are associated with the four domains of cultural competency (knowledge, attitude, skill, and awareness)(Van Den Bergh & Crisp, 2004). Next, theories that explain problems faced by LGBTQ youth will be presented.

The conceptual framework interacts with the theoretical framework because the theories explain the problems that cultural competency is meant to solve.

Theoretical Framework

This section summarizes theories that describe an understanding of the problems addressed by LGBTQ cultural competency. A theory is defined for the present study as "an abstract generalization that serves to define and give structure to human experience" (Witkin & Gottschalk, 1988, p. 218). A theoretical framework, then, can be understood as a way to "corral assumptions" into "some form for understanding" (O'Connor & Netting, 2011, p. 29). This section will start with heterosexism and genderism to explain the phenomena that comprise the problem. Then microaggressions theory will be used to explain how the problem is manifested in the lives of those affected by the problem. It will conclude by linking these theories to the importance of culturally competent practice standards in the context of LGBTQ youth who are in behavioral health treatment.

Heterosexism. Heterosexism, akin to homophobia, can be defined as "an ideological system that denies, denigrates, and stigmatizes any non-heterosexual form of behavior, identity, relationship, or community" (Herek, 1990, p. 316). Heterosexism impacts the well-being of all youth regardless of sexual orientation, as demonstrated by the tragedy of youth ending their lives due to anti-gay bullying, even when the youth does not identify as LGBTQ but was bullied because of someone else's perception of his/her identity being LGBTQ (Avery, 2012; Presgraves, 2009). However, lesbian, gay, bisexual, and queer youth face additional challenges as compared to their heterosexual peers due to the victimization, discrimination, isolation, and loneliness faced while developing a non-heterosexual identity (Bontempo & D'Augelli, 2002; Mustanski et al., 2010). When heterosexism influences the practice behaviors of service

providers, LGBQ youth may receive less effective care due to the negative impacts heterosexism can have (LeFrançois, 2013; Pallotta-Chiarolli & Martin, 2009).

Bowers, Plummer, and Minnichiello (2005) conducted an in-depth qualitative inquiry into the ways that homophobia impacts outcomes in counseling and found through client and counselor narratives that homophobia was expressed during sessions. Homophobia is defined by the authors as "the socialisation of heterosexuals against homosexuals and concomitant conditioning of gays and lesbians against themselves" (Bowers et al., 2005, p. 472). While homophobia is conceptually differentiated from heterosexism, it is believed that they both share similarly negative effects on LGBQ persons (Neely, 1999). Bowers and colleagues argue that homophobic influences on counseling can cause clients to experience re-traumatization and that homophobia in counseling must be addressed in order to alter the current trajectory of therapy away from the re-traumatization present in it today.

Internalized homophobia is also a concept that explains the impact of homophobia on lesbian, gay, bisexual, and queer individuals. It is defined as "the extent to which LGB individuals internalize negative attitudes toward homosexuality that exist in society" (Cox, Dewaele, van Houtte, & Vincke, 2011, p. 118). It has been linked to several unwanted outcomes such as depression and psychological distress (Cox et al., 2011).

Genderism. Broadly referred to as anti-trans prejudice, genderism is the set of attitudes, beliefs, and behaviors that contribute to the marginalization of gender-nonconforming people. It can be broken down into three constructs: transphobia, genderism, and gender-bashing (Hill & Willoughby, 2005). Transphobia is defined as "an emotional disgust toward individuals who do not conform to society's gender expectations" (Hill & Willoughby, 2005, p. 533). Though not a true phobia, transphobia is considered an underlying fear of gender non-conforming people.

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Genderism is defined as "an ideology that reinforces the negative evaluation of gender non-conformity or an incongruence between sex and gender" (Hill & Willoughby, 2005, p. 534). Genderism is associated with the belief that gender non-conforming people are pathological (Hill & Willoughby, 2005). Gender-bashing is defined as "the assault and/or harassment of persons who do not conform to gender norms" (Hill & Willoughby, 2005, p. 534).

Heterosexism and genderism are abstract interpersonal concepts that are not easily identifiable in an objective way because of their covert manifestation. Thus, how do youth know for sure that a service provider is harboring heterosexism/genderism if it is not expressed overtly? Microaggressions can help to answer this question by understanding the covert manifestation and impact of heterosexism and genderism.

Microaggressions. Heterosexist and/or genderist influences in behavioral health services are likely difficult to empirically detect because of the way that such attitudes are communicated covertly. The complexity of covert prejudices is explained in part by the concept of microaggressions. Microaggressions can be defined as "brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative slights and insults toward members of oppressed groups" (Nadal, 2008, p. 23). Theorists break down the concept of microaggressions even further, into three different types: microassaults, microinsults, and microinvalidations (Sue et al., 2007). Microassaults are defined as "conscious and deliberate forms of discriminatory practice, biased attitudes, or behaviors that are intended to harm or oppress a marginalized group" (Shelton & Delgado-Romero, 2011, p. 211). These are what are traditionally known as discrimination in an overt form. An example is when someone uses a derogatory slur, like "you're so gay." Microinsults are defined as being "laden with demeaning and insulting properties. Snubs,

gestures, and verbal slights, typically outside of one's awareness, communicate rudeness and insensitivity to a marginalized group" (Shelton & Delgado-Romero, 2011, p. 211). An example of this would be to suggest that a black man 'speaks well' for a person of his race (Shelton & Delgado-Romero, 2011). Finally, microinvalidations are "characterized by communications that exclude, negate, or nullify the psychological thoughts, feelings, or experiential reality of a [marginalized] person" (Sue et al., 2007, p. 274). Microinvalidations are considered the hardest to deal with because they are difficult to confirm, leaving people instead with a denial of their own reality (Shelton & Delgado-Romero, 2011). An example is "someone assuming a woman is lesbian because of the perceived lack of effort the woman put into her appearance, which communicates the message that lesbians are not concerned with being attractive or are less attractive than heterosexual women" (Shelton & Delgado-Romero, 2011, p. 211).

Nadal describes the impact of microaggressions on LGBTQ youth as "death by a thousand cuts" (Nadal et al., 2011, p. 234) and supports his assertion through the qualitative inquiry he and colleagues conducted with LGB youth. The findings suggested that LGBTQ youth experience both conscious and unconscious microaggressions that negatively impacted their mental health. Nadal and colleagues found eight themes that emerged from the data that described how the youth experienced microaggressions:

> Use of heterosexist or transphobic terminology, endorsing heteronormative
>
> behaviors, assumption of a universal LGBT experience, exoticization [or
>
> dehumanization] of LGBT persons, discomfort or disapproval of LGBT
>
> experience [such as a lesbian couple holding hands], denial of societal
>
> heterosexism or transphobia, assumption of sexual pathology, and LGBT

individuals who deny their own heterosexist and transphobic beliefs or actions. (p. 237–38)

Microaggressions theory helps to explain how heterosexism and genderism influence mental health practice, because it is not always the case that a service provider is openly hostile towards an LGBTQ youth. In fact, covert hostilities are believed to be more difficult for marginalized populations to deal with because of the lack of certainty involved – there is room to question whether or not the experience was real, whether or not the intended message was the same that was received (Shelton & Delgado-Romero, 2011).

Connection to Cultural Competency. Microaggressions are an important part of understanding cultural competency as it relates to LGBTQ issues because they help to explain the subtle yet crucial differences in what creates a safe environment in which LGBTQ youth can succeed. It is quite easy to deny the existence or the importance of microaggressions for people who are not a part of the associated minority. This is especially true for professionals who interact with youth. One study examined heteronormativity in schools, and found that when educators denied the presence of heteronormativity and claimed that they had a neutral environment when it came to LGBTQ issues, the reality for LGBTQ students was that it was an un-affirming environment (Atkinson & DePalma, 2008). What this means is that a neutral environment is just as incompetent as an overtly negative environment (McCabe, Dragowski, & Rubinson, 2013). This point is especially important for mental health professionals who are tasked with the job of creating an environment where youth can address behavioral and emotional problems. One study illustrates the importance. A study examined school psychologists' recognition of verbal microaggressions in their place of work (school settings) and compared that to their report of how often verbal microaggressions occur in their workplace

(McCabe, Dragowski, et al., 2013). The findings showed that only 16% of school psychologists reported that LGBTQ discrimination occurs at their school workplace, yet 43% of them reported that they hear verbal microaggressions such as "that's so gay" among students and coworkers (McCabe, Dragowski, et al., 2013). The findings from this study illustrate the idea that even when asked to identify discrimination against LGBTQ students, the participants did not consider microaggressions to be a part of that discrimination. This suggests that these professionals lack sufficient competence in LGBTQ-related issues and are therefore unprepared to create a safe and successful environment for LGBTQ youth.

Heterosexual and cisgender youth are also impacted by these same problems. There are now several sources of empirical evidence to support the hypothesis that homophobic-related bullying and victimization have negative effects on heterosexual youth (Collier, Bos, & Sandfort, 2013; Poteat, Scheer, DiGiovanni, & Mereish, 2013; Ybarra, Mitchell, Kosciw, & Korchmaros, 2014). A study of 572 heterosexual adolescents over a 7-month time period found that homophobic victimization increased anxiety and depression for heterosexual youth (Poteat et al., 2013). Data from the Teen Health and Technology study were examined to address how bullying and peer harassment affects suicidal ideation for both LGB and heterosexual youth (Ybarra et al., 2014). Findings from this study indicate that there is an increase in odds for suicidal ideation for all youth who are victims of bullying and peer harassment, and there was a particularly elevated rate of suicidal ideation for bisexual youth (Ybarra et al., 2014). No such studies have examined the effect of bullying or discrimination based on gender identity or expression. These studies can be used to support the assumption that LGBTQ cultural competency would benefit all youth – not just LGBTQ youth – because of how LGBTQ cultural competency is aimed at eliminating such problems from the therapeutic milieu.

Philosophical Assumptions

All scientific endeavors are situated within a set of assumptions about ontology (the nature of truth), epistemology (the nature of knowledge and how persons come to attain that knowledge), human nature (the relationship between humans and their environment), and methodology (ways to investigate and obtain knowledge) (Burrell & Morgan, 1979). These sets of assumptions make up the philosophy that underlies any scientific endeavor. The sets of assumptions that underlie the cultural competency framework used in this study will be explored next.

The assumption about ontology in cultural competency is both nominal and realist in nature. Nominalism refers to the idea that there is no 'real' physical world outside of individual cognition, so names are used only for convenience (Burrell & Morgan, 1979). An example of this in cultural competency is that sexual orientation and gender identity are understood in a contemporary sense as fluid and changing; thus, labels put on individuals are used simply for convenience but do not represent the actual nature of those identities. Realism is the assumption that the social world is made up of relatively tangible and unchangeable structures (Burrell & Morgan, 1979). An example of this in cultural competency is the assumption that everyone has an object of desire, and the object of that desire can be used to classify one's sexual orientation. Similarly, a person has a sense of their gender identity which is informed by the social world around them, so gender identity can be classified using relatively immutable and unchangeable gender roles and expectations. The cultural competency framework used in the present study is mostly influenced by realism.

The assumption about epistemology that applies to the cultural competency framework is mostly positivistic rather than anti-positivistic. Positivism is the assumption that knowledge can

be attained by seeking to explain it and predict what will happen in the social world by searching

for commonalities and causal relationships (Burrell & Morgan, 1979). Cultural competency is

positivistic because it seeks to explain commonalities in the experiences of different cultural

groups, and seeks to predict what will happen in behavioral health treatment if a set of cultural

competencies is used in practice. Anti-positivism is the assumption that the social world is

relativistic and can only be understood by individuals who are directly involved in a

phenomenon (Burrell & Morgan, 1979). This represents the idea that you can only understand an

experience if you have had it yourself. The present model of cultural competency is only slightly

influenced by anti-positivism because it does assume that the individual consumer is the best

source of knowledge on their own preferences in treatment. However, the cultural competency

model used in this study is mostly positivistic because it is assumed that knowledge about

LGBTQ youth can be attained by an 'outsider' for the purpose of applying that knowledge to

practices with LGBTQ youth.

In the realm of human nature, cultural competency is mostly influenced by determinism

rather than voluntarism. Determinism is the assumption that humans and their activities are

completely determined by their situation and their environment (Burrell & Morgan, 1979).

Voluntarism is the assumption that humans are completely autonomous and free of influences by

the outside world (Burrell & Morgan, 1979). Cultural competency is influenced mostly by

determinism because it assumes that LGBTQ youth, to a large extent, have been shaped and

developed by their social environment. Indeed, the present study is built on the assumption that

the needs, desires, and characteristics of LGBTQ youth can be explained by external trends and

events in a deterministic fashion.

Lastly, cultural competency's assumption about methodology is both ideographic and nomothetic. Ideographic methodology assumes that knowledge is attainable only by first-hand knowledge and is iterative because knowledge unfolds as the individual explores their detailed background and life history (Burrell & Morgan, 1979). Nomothetic methodology assumes that systemic protocol and techniques are the only true way to attain knowledge (Burrell & Morgan, 1979). The cultural competency model used in this study taps into both assumptions because it includes both knowledge from individuals and uses an iterative process for understanding the meaning of direct-care workers. But it also uses a systematic approach to answering the main research questions. Thus the present study is influenced fairly equally by both assumptions.

Conclusion

Heterosexism and genderism pose challenges to the well-being of LGBTQ and non-LGBTQ youth. Microaggressions theory explains how heterosexism and genderism manifest themselves, because the latter are abstract concepts not easily identified. The goal of LGBTQ cultural competency is to help practitioners become more able to reduce or eliminate heterosexist and genderist influences in behavioral health treatment settings. The next chapter will review literature that addresses LGBTQ youth in behavioral health care, best practices for service providers, and measures that are similar to but not sufficient for assessing LGBTQ cultural competence.

<center>**Chapter 3: Literature Review**</center>

Introduction

      This chapter will review and synthesize literature about LGBTQ youth in behavioral health care and what is known about direct-care workers' level of competency in LGBTQ issues. It will examine the strengths and weaknesses of the extant empirical literature on the experiences of LGBTQ youth in mental health treatment settings. The chapter will be organized in such a way as to answer several questions, starting with, "what are the expressed needs and desires of LGBTQ youth in treatment settings?" Then it will move on to, "what conceptual professional guidelines and theories have been created with regard to best practices with LGBTQ youth in treatment settings?" It will end with, "what instruments exist to measure cultural competency in direct-care workers as it relates to LGBTQ youth?"

Empirical Literature on LGBTQ Youth in Behavioral Health Care

      Residential and Inpatient Care. Four studies were found that address LGBTQ youth in residential and inpatient treatment settings. LeFrançois (2013) offered an ethnographic case study from an adolescent inpatient unit. A study by Nolan (2006) evaluated the outcome data of 40 youth who discharged from a transitional living program in New York City, which serves LGBTQ youth specifically. In 1998, Mallon published a book based on in-depth qualitative inquiry into the experiences of LGBT youth who were in the foster care system (Mallon, 1998). A more recent study examined the experiences of LGBTQ youth who were in foster care in Los Angeles County (Wilson et al., 2014). Although foster care is not inherently a behavioral health treatment setting, findings from these foster care studies can be translated to a behavioral health context because it addressed issues with LGBTQ youth who are in out-of-home care.

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Foster care youth. Mallon collected data by interviewing 54 lesbian or gay youth between the ages of 17 to 21 who were in foster care at the time of the study (late 1990's). The main message from the youth was that they constantly questioned their own safety, and Mallon explains that they may have done so because of the way hostility towards gays and lesbians was acceptable or legitimized in society and in treatment settings. The salient message from this study for providers in this new era of systems-of-care is that it takes the entire team of professionals to be on the same page about LGBTQ issues in order for youth to feel like they are understood and can trust the professionals in their lives.

A more recent study examined the experiences of LGBTQ youth who were in foster care in Los Angeles County (Wilson et al., 2014). The study involved a telephone survey with a random sample of 765 youth in foster care in Los Angeles, ages 12-21. The key findings of this report by The Williams Institute were that LGBTQ youth are disproportionately represented in foster care (approximately 19.1% in foster care versus approximately 9.45% in the general population) , and that LGBTQ youth faced disparities in their foster care experience as compared to non-LGBTQ youth. These disparities included higher proportion of LGBTQ youth are in a group home placement (25.7% versus 10.1%, $p<.001$ ($F_{(1,682)}=23.84$)), higher number of different foster care placements (mean 2.85 (SD 1.1) versus mean 2.43 (SD 1.03), $p<.05$ ($t_{(682)}=2.19$)), greater proportion of being treated poorly in the foster care system (12.93% versus 5.78%, $p<.05$ ($F_{(3.00, 2044.44)}=3.57$)), higher proportion being hospitalized for emotional reasons (13.47% versus 4.25%, $p<.001$ ($F_{(3.99, 2724.52)}=7.81$)), and a higher proportion ever having been homeless (21.09% versus 13.90%, $p<.05$ ($F_{(2.00, 1362.72)}=4.57$)). The study highlights the fact that LGBTQ youth are a population that has unique challenges and needs.

Transitional living. A transitional living program specifically for LGBTQ youth was evaluated on outcomes for the program's goals related to successful independent living (Nolan, 2006). The program was not a behavioral health treatment program, but it was provided by an organization that provides behavioral health services to youth with emotional and behavioral disorders, so it has findings that may be relevant for a focus on direct-care behavioral health workers. However, it was never specified in the article whether or not the youth in this particular program had emotional or behavioral disorders, or had experience in mental health treatment. Using chart review methods and in-depth interviews with former and current residents, the authors found that the youth learned valuable lessons in budgeting and money management, interpersonal skills, and independence and responsibility. The author claimed that the study showed evidence of the need for an LGBTQ specific organization for homeless youth. However, the author reported no data to support this claim. The basis for the author's claim was on previous literature, but not on the actual data that were reported. Furthermore, the author reported on themes from staff members, but the article did not identify who those staff members were or how data were collected from them. The only subjects identified in the methodology section were the 40 youth files from the program's records.

Inpatient unit. In this study, LeFrançois discusses two girls on an inpatient psychiatric adolescent unit who were repeatedly called upon to stop holding hands and to stop being near one another (LeFrançois, 2013). The contact was not sexual in nature or intent, but the staff members identified it as inappropriate same-sex behavior. The author recorded multiple instances of heteronormativity imposed on the girls by the staff members. They received public admonishment that relayed to the young people on the unit "that same-sex relationships are not the norm and should be avoided" (LeFrançois, 2013, p. 4). These girls did not self-identify as

lesbians, but rather were seeking support from one another while in treatment. The author interpreted this public admonition of same-sex affection to be evidence that paternalistic environments, such as an inpatient psychiatric unit, demoralize any non-heterosexual behavior because it threatens the power that the providers hold over the patients.

In addition, the author described a boy on the unit who was struggling with openly admitting his own sexuality during the time that the two girls were having such backlash from the staff members in regards to their so-called lesbian behavior. The boy had multiple readmissions and struggles in therapy until he came out as gay. In retrospect, a psychiatrist reported that the boy's coming out seemed to be a positive turning point in his treatment and that coming out was a struggle for the boy even though he had very "liberal parents" (LeFrançois, 2013, p. 7). This boy's experience speaks to the important impact that service providers can have on youth who are in treatment. Even though the boy's parents were liberal (as interpreted by the psychiatrist) and were therefore assumingly accepting of LGBT people, the boy struggled in the treatment context. The service providers set an environment that was openly hostile towards non-heterosexuality, and the boy struggled to thrive in that treatment atmosphere.

In addition to the findings that heteronormativity was enforced in this inpatient unit, this article also gives an example of how heterosexist influences might be harmful to all patients and not just LGBTQ patients. The author reported that the girls who continued to display so-called lesbian behavior did so as an act of defiance that they knew would get a reaction from the staff. Doing so likely led to more disruptions in the therapeutic milieu, which could have been avoided if the staff of the unit responded more appropriately to the girls' hand-holding behavior. The findings of this study lead to more questions, such as: if the staff were not so reactive to the girls' behavior, could the experience of these girls (and the boy) in treatment have been improved? In

order to better understand the service providers' behavior, it would be helpful to find out why staff felt it necessary to publically demean the girls' behavior. If the staff members had ignored it, or treated it as normal, would the treatment process have gone any differently?

 Outpatient and Community-Based Settings. Given the paucity of studies on residential/inpatient settings and the range of settings in which direct care staff work, data from the broader network of outpatient and community-based mental health settings were explored. Five relevant studies in such settings were identified. Tate & Ross (2003) described the efforts of an LGBTQ Resource Center staff, psychiatric services staff, and student representatives in their work to effect change in the service experience of LGBTQ students who sought treatment at the University psychiatric center. One study addressed the gap in literature on the use of evidence-based practice interventions with LGBTQ youth by examining the adaptation of an evidence-based substance abuse program with LGBTQ youth (Goldbach & Holleran Steiker, 2011). Pallotta-Chiarolli & Martin (2009) conducted semi-structured, in-depth interviews with bisexual-identified youth and community health service providers in order to better understand the challenges and opportunities in intervening with bisexual youth for health and mental health issues. King (2008) examined LGB college students' retrospective experiences of receiving support in high school from their high school counselor. A study published in 2006 investigated child welfare worker competencies for working with gay and lesbian youth by interviewing gay and lesbian youth who were in out-of-home care (Ragg et al., 2006). As was the case in the previous section on residential and inpatient settings, although the study by Ragg and colleagues does not address behavioral health direct-care workers, the findings can translate to a behavioral health context because of the nature of the child welfare workers' interactions with the youth.

University outpatient counseling. The article by Tate and Ross (2003) described the effort that came about in response to a student who made a public call to action after a particularly demoralizing experience at a university outpatient counseling center. Actions that resulted from the call included the formation of a committee charged with identifying steps to improve services and acting on those steps. Initial priorities of the committee included having an anonymous feedback form for students to be able to report positive or negative experiences; professional development series on LGBTQ issues for all staff of the center; inclusion of LGBTQ concerns in a pre-existing client satisfaction survey; improving student access to LGBTQ-positive psychiatrists; drawing up a client bill of rights to address issues inclusive but not limited to LGBTQ issues; and resource, information, and referral sources. These initial goals were met and the committee dissolved after two years.

Tate and Ross (2003) described an environment where there was some willingness on the part of the psychiatric center to admit that they had areas to improve upon in terms of meeting the needs of LGBTQ students in particular. However, there were several instances in the two-year span of the effort wherein the psychiatric center staff were unwilling or resistant to changing the center and the staff members' approaches to be more inclusive and approachable for LGBTQ clients. The authors reported that there was a tone of defensiveness from the psychiatric professionals, which they interpreted to be a result of medical professionals' tendencies to problematize the client's behavior rather than attend to their own behavior as practitioners. Although there was evidence of improvement in services for LGBTQ students as a result of the committee's efforts, it was clear that there were still critical areas that were left untouched – one included putting a visible sign of LGBTQ affirming care, such as a rainbow or upside-down pink triangle. This is a simple effort yet can have a profound effect on the way that

LGBTQ students feel welcomed in an environment. This work points to the fact that scholars are identifying a need to address the treatment experiences of LGBTQ youth (or young people) and the related practice behaviors of service providers.

Outpatient substance abuse treatment. The need to address substance use issues is particularly important because LGBTQ individuals experience unique stressors, such as sexuality-related stigma, which has been found to have an influence on substance use behavior (Needham, 2012; Reisner et al., 2014). The study by Goldbach, Holleran, and Steiker (2011) involved inviting youth from an LGBT drop-in center to review the treatment protocol for a substance abuse treatment program that was found to be effective with African-American and Hispanic youth. The youth in this study were solicited to provide input during a focus group on what changes they would make to the treatment program to make it more culturally relevant to LGBTQ youth. The authors focused specifically on the importance of cultural adaptations performed by the LGBTQ youth as they reviewed the treatment protocol. Through the interpretation of these adaptations, meaning would be made to understand the cultural implications for treatment interventions with LGBTQ youth.

The first change suggested by the youth was to change scenarios to use gender-neutral names and pronouns. Although the youth stated that they face the same stressors as heterosexual youth, they did acknowledge that being LGBT introduced unique stressors that could contribute to drug use. Another change recommended by the youth was to incorporate sex and sexuality more into the scenarios, such as: "a refusal skills scenario that initially read 'Let's ditch math class' was changed to 'Let's ditch math class and have sex'" (Goldbach, Holleran, & Steiker, 2011, p. 199). Also, youths suggested incorporating physical locations unique to the LGBT community, such as a gay bar instead of just a bar.

An insight gained in this study for substance abuse prevention was that the youth wanted to be treated with respect and believed that their problems were no different than their heterosexual peers. Also, the authors observed that youths had a preoccupation with sex and with the assumed lifestyle that adult LGBT people live, and the LGBT youths connected sex with substance use more often than heterosexual youth did (in other focus groups). These findings help to better understand that there may be unique cultural issues for LGBTQ youth substance use prevention interventions.

Community-based services. Pallotta-Chiarolli & Martin (2009) sought to better understand the challenges and opportunities in intervening with bisexual youth for health and mental health issues. Using thematic analysis, the researchers found the following themes to be salient for their sample: underrepresentation and misrepresentation of issues related to bisexuality in education and health programs, and outdated and homogenized representation. There was a disparity between the realities of the bisexual adolescents and the knowledge and competence of mental health workers. Many of the participants shared how clinicians viewed their sexuality as pathological and connected to clinical issues that may not necessarily be related.

The researchers explored the ways that youth who identified outside of the binary homo/hetero-sexual divide were marginalized even by those who purported to be gay-affirming. They use the term homonormativity to reflect the ways that sexual identity is forced into a homosexual identity if the person is not heterosexual, and if a person is bisexual then they are seen as pathological because they do not fit either of the norms. The main criticism of this research is that the findings section contained very little actual data collected from the study and

instead offered an in-depth literature review, and the authors offered little evidence from the data to support the conclusions that they draw back to the literature.

High school counselors. The major theme that emerged from King's (2008) qualitative study of LGB students' support from high school counselors was that perceived homophobia and heterosexism posed a significant barrier to LGB students receiving support from their counselor or social worker. Not only did the school climate contribute to that barrier, but also counselors' interactions with the students. One student described it in this way: "It's not like saying you know they're gay friendly, and they weren't, or saying we hate gay people, and they were friendly, it was just almost like an aggressive neutrality" (King, 2008, p. 367). Microaggressions theory helps to understand what the girl described as 'aggressive neutrality' – the underlying message of hostility that was expressed by her counselor is an example of a microaggression. Another major theme that emerged from the data was the importance of breaking the silence about LGBTQ issues. Students reported that they wished their counselors would make a physical or verbal sign that showed their affirmation and openness to LGBTQ issues. This study gives insight into the experiences of LGB youth and their interface with supportive services in a school setting.

Child welfare workers. Ragg and colleagues (2006) used a content analysis of data collected on child welfare worker competencies in working with gay and lesbian youth in out-of-home care. The researchers identified three major themes, the first of which was vulnerability versus empowerment. This theme spoke to the way that workers had a great deal of power when they were aware of the youth's orientation, and could use that information against the youth. The second theme was stigmatization versus validation, in which certain worker responses to learning about a youth's orientation led to either a positive or negative interaction, which either supported

or denigrated a trusting therapeutic relationship. The third and final theme from these youths'
experience was acceptance versus rejection. The youth told stories of how they would go to
extensive efforts to avoid rejection if they felt it was a possibility, and that the power of
acceptance extended to those workers who were even just neutral or open-minded but not
necessarily affirming of the youth's orientation. The lessons learned from this study point to the
importance of going beyond worker knowledge about LGBTQ issues, to directly addressing the
actual practice behavior of those service providers. Increasing knowledge is a good place to
begin, but if the worker does not use the knowledge by translating it to more competent practice
with LGBTQ youth, then there is likely little impact on the youth's experience in treatment.

     Synthesis. From these studies, the main message that becomes apparent is that LGBTQ
youth desire certain characteristics in their treatment professionals and certain qualities in their
treatment environment. LGBTQ youth value non-judgmental attitudes, they want workers to not
assume heterosexuality or cisgender status, maintain confidentiality, and be actively involved in
creating an environment that is free from threats to physical safety. The question that evolves
from this set of literature is, "how well are behavioral health workers delivering services in a
way that mirrors what LGBTQ youth want and need?" It is a question that highlights a gap in the
current literature, and is the question that led to the purpose of the present study.

Conceptual Literature on Professional Guidelines and Best Practices

     There are many reasons why empirical studies on LGBTQ competencies with a
representative sample of direct-care workers are hard to conduct. First, the population is difficult
to access because it is difficult to identify – workers may claim that they have never worked with
an LGBTQ youth nor do they intend to. Youth who are developing an LGBTQ identity may not
outwardly identify as such, or may not even identify as "questioning," therefore a direct-care

worker may claim that LGBTQ issues are not relevant to their work because they have never

knowingly interacted with an LGBTQ youth. So, finding workers to participate in such a study

may prove difficult. Second, the sensitive nature of the information being gathered makes it

difficult to examine the direct-care workers' actual behavior with this group. It is unlikely that a

direct-care worker will openly admit to hostile behavior towards a minority group, so measuring

microaggressions and using indicator constructs would be needed for this sort of research. Third,

researchers often have difficulty gaining IRB approval to conduct studies related to LGBTQ

youth due to many IRBs' lack of understanding about the nature of sexual orientation and gender

identity (Fisher & Mustanski, 2014; Mustanski, 2011). Despite the dearth of empirical literature

on this subject, conceptual and theoretical literature does exist on providing mental health

services to LGBTQ youth. This next section will explore a few exemplars.

The Model Standards Project. The Model Standards Project was created out of a

partnership between Legal Services for Children and the National Center for Lesbian Rights with

the goal of creating standards for care of LGBTQ youth in out-of-home care (Wilber, Reyes, &

Marksamer, 2006). This project was created out of both prior research literature and a national

advisory board of academics, researchers, professionals (in child welfare, juvenile justice, health,

and mental health), youth service users, and community advocates, and was revised after piloting

at national conferences and meetings. The first area addressed was creating an inclusive

organizational culture. This included prohibiting derogatory terms based on sexual orientation or

gender identity or any other individual difference, displaying visible signs of affirmation (such as

posters and/or symbols), using respectful and inclusive language (not gender specific or

assumptive of the youth's sexual or gender identity), prompt intervention when youth harass or

tease their peers as it relates to LGBTQ issues, and welcoming regular discussions about

diversity. Other standards included mandated training on LGBTQ issues and written policies prohibiting discrimination on the basis of sexual orientation or gender identity. The remaining themes included: recruiting and supporting competent caregivers and staff, promoting healthy adolescent development, respecting privacy and confidentiality, providing appropriate placements, and providing sensitive support services. This article provides a solid beginning for understanding how to make systems-of-care more accessible and affirming to LGBTQ youth.

Assessment Phase of Treatment. Block and Matthews (2008) give a vivid description of a hypothetical case study wherein a boy who is questioning his sexual orientation experiences struggles in mental health treatment. Although the focus of the boy's treatment was anger management and aggressive behaviors, the boy experienced a turning point when he interacted with an assessing clinician who was open-minded and non-judgmentally opened the door for him to talk about his sexual orientation. The boy had experienced harassment from other peers about their perception of his sexual orientation as gay, and until his work with that particular clinician, no service provider had linked the harassment to his aggressive behavior. Through this case study, one can see that the application of gay-affirming practice extends beyond the one-on-one therapy session, and applies to every setting of treatment for children and youth, because any staff member could have intervened on behalf of this boy.

Transgender Youth. Mallon and DeCrescenzo (2006) offer a discussion of the developmental needs of gender variant children and recommendations to service providers for best practices as it relates to supporting these youth. The authors first address the challenges faced by gender non-conforming youth which harkens back to the concept of societal norms, but goes further into the specific issues faced by youth who are labeled with gender identity disorder (GID). The authors also discuss the importance of recognizing the difference between gender

identity, gender expression, and gender non-conforming behavior such as cross-dressing which may not be related to a youth identifying as transgender. The authors address hormone replacement therapy and surgical sex reassignment, and point out that most social work students are ill prepared to practice proficiently around such issues. The article concludes with implications for practice, which follow a familiar pattern of education, non-judgmental affirmation, prohibition of reparative therapies, and support for families of transgender youth.

Guides for Professionals. Books and articles abound on recommendations for service providers working with LGBTQ youth in behavioral health care. A partial list of examples include: *Improving Emotional & Behavioral Outcomes for LGBTQ Youth: A Guide For Professionals* (Fisher, Poirier, & Blau, 2012), *Lesbian & Gay Youth: Care & Counseling* (Ryan & Futterman, 1998), and *Serving LGBT Youth in Out of Home Care: CLWA Best Practice Guidelines* (Wilber, Ryan, & Marksamer, 2006). These are interdisciplinary, including counseling, psychiatry, social work, psychology, and child welfare, but the major themes are similar throughout all the works. They first address the developmental needs of LGBTQ youth by reviewing current and classic literature. Often this includes a theory on sexual identity development and newer books have included theories on gender identity development. Next, the books discuss various risk factors and disparities faced by LGBTQ youth. Then, the books address ways that individual practitioners and agencies as a whole can make changes to their service delivery so that they are more LGBTQ-affirming.

Critical Analysis. There is a plethora of books and articles written on recommendations for practitioners working with LGBTQ youth in behavioral health care. Yet, there are few instances of empirical literature examining exactly what direct-care workers are *doing* with LGBTQ youth in practice settings. Without knowledge on the current state of practice,

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researchers and policy makers are left to extrapolate from related research on licensed mental health professionals. This body of research is not sufficient to inform the current system of care for children's mental health treatment because direct-care workers' roles extend beyond that single category of licensed or graduate-level behavioral health professionals. Actual direct-care workers differ by educational background, demographics, amount of time spent with the youth during care, and the role played in the youth's care. Therefore, a major gap in the literature is that there are no empirical studies examining heterosexist/genderist influences on all stakeholders in the system of care.

One study that began to give insight into the issue of direct-care workers competencies found that attitudes towards LGBTQ youth differed by job category (which included licensed professionals, direct-care workers, administrative/clerical/support staff, and managerial/supervisory staff) (Gandy et al., 2013). This finding supports the idea that service providers' learning needs may differ by their job type because their attitudes vary. Therefore, training efforts should take into consideration the varying learning needs of the array of service providers involved in mental health care.

Measurement Instruments

What instruments exist that measure cultural competency of direct-care workers as it relates to LGBTQ youth? Several scales measure aspects of clinical practice as it relates to LGBTQ individuals (not youth specifically): Gay, Lesbian, & Bisexual Working Alliance (Burkard, Pruitt, Medler, & Stark-Booth, 2009), Gay Affirmative Practice scale (Crisp, 2002), Sexual Orientation Counselor Competency Scale (Bidell, 2005), to name a few. However none of these use a cultural competency framework (and are therefore not relevant to the present study's framework), and do not address practice specific to youth. They also do not address

bisexual, transgender, queer, or questioning issues (with the exception of the Gay, Lesbian, & Bisexual Working Alliance which does address bisexuality). An instrument available in the grey literature, the Personal Comfort Scale (Health Care of Southeastern Massachusetts (HCSM), 2008), addresses practice with LGBTQ youth specifically, but does not cover all domains of a cultural competency framework (attitudes, knowledge, skill, and awareness). One instrument exists that was created out of a cultural competency framework and attempts to cover several different worker roles, called the *Self-Assessment Checklist for Personnel Providing Services and Supports to LGBTQ Youth and Their Families* (Goode & Fisher, 2009). It does a good job of describing roles outside of a strict counseling or therapy role and it follows guidelines established by cultural competency literature that were reviewed in Chapter 2. However, it has not been psychometrically tested, is repetitive and long, and there are no documented cases of its use in empirical research. Considering that previous research demonstrates the constraints of self-assessment in measuring cultural competency (mentioned in Chapter 2), it was determined that this measure is not adequate to capture the construct of interest in the present study.

Synthesis. This review of the measurement literature leads to several implications. First, there is a clear dearth of instruments to measure the specific cultural competencies that are relevant both to serving LGBTQ youth and to direct-care behavioral health workers. Some measures exist to address cultural competency but do not address LGBTQ-specific cultures, some measures exist to address practice with LGBTQ individuals but not specific to children and adolescents, and some measures exist to address culturally competent practice with LGBTQ youth but do not fully capture the roles and responsibilities of a non-graduate level direct-care worker. Thus, the field of children's mental health is in need of a measurement tool specifically tailored to fill these gaps. Second, it is important to have appropriate measurement tools to assess

the level of cultural competency in this area. It is important to capture the competencies of direct-care workers because they can play unique roles in the treatment of LGBTQ youth, which expand beyond the traditional counseling role or a one-on-one session.

Conclusions and Implications

This chapter explored the extant context of addressing competencies in workers to meet the service needs of LGBTQ youth. It began by exploring the existing empirical literature on experiences of LGBTQ youth in various behavioral health treatment settings, including residential, foster care, inpatient hospitalization, outpatient therapy, community-based substance abuse intervention, and school-based services. It then presented conceptual literature on best practices for working with LGBTQ youth. The chapter ended with a discussion of the measurement issues relevant to the study of LGBTQ-related cultural competency in direct-care behavioral health workers.

Upon reviewing the extant empirical and conceptual literature, it is evident that scholars concur on the importance of addressing the unique needs of LGBTQ youth in behavioral health treatment settings. However, the apparent shortcomings in the rigor of the available literature as well as the inherent challenges of conducting research with this population have left much to be desired. Research involving youth from the entire spectrum of behavioral health services is absent – this involves not just inpatient or residential treatment, but also outpatient therapy, medication management, case management, day treatment programs, therapeutic foster homes, in-home therapy, and other newly emerging treatment milieus. Also, research using rigorous qualitative and quantitative methods is needed in order to support the abundance of conceptual literature on best practices with these youth. There is a dearth of quantitative studies in this area, which is important because of the generalizability of studies conducted with large, representative

sample sizes and the reliability and validity of studies which use quantitative measurement tools that have been previously tested to have adequate psychometric properties. Additionally, there is no empirical research on the treatment experiences of transgender identified youth, which is a population that faces unique challenges apart from sexual minorities (those who identify as lesbian, gay, bisexual, or queer). Some researchers have gathered information about the licensed professionals that work with LGBTQ youth in treatment settings. Rather than extrapolate from data collected on a small segment of service providers, researchers should examine the practice behaviors of the entire spectrum of service providers because they each play unique roles in treatment, have differing educational backgrounds, and are likely to have different learning needs in training. The measures available do not adequately address a direct-care worker's roles and responsibilities, and they do not address issues specific to the age group of youth. The next chapter will provide details about the methodology that was used in the present study.

Chapter 4: Methodology

Introduction

The goal of the present study was to develop and test a measure to assess cultural competency as a means to better understand the level of competency in LGBTQ youth issues of direct-care workers. The study involved two phases. Phase one encompassed the development of the measurement tool and phase two involved administration of the measure to assess for validity and reliability and to test the proposed model of cultural competency. IRB approval for human subjects protection was obtained from the author's institution and the study was approved as exempt.

Research Design

The study used a nonexperimental, correlational design, which was chosen based on the purpose of the study (to create and validate a new measure). In order to validate a new measure, data need to be collected, but it is not necessary for the data to be collected in any particular relationship to time and there is often no need to use control or comparison groups. The study was nonexperimental because it had only one group of subjects and all respondents were given the same measures at only one point in time. A correlational design uses data to test a theoretical model, and the goal is "to test relationships as predicted by theory" (Drake & Jonson-Reid, 2008, p. 109). Thus, a correlational design matches the goal of this study which was to test the relationship between the measure created from the conceptual model of cultural competency to other measures of concepts that were thought to be related due to theory and findings from prior studies.

Research Questions

Aim 1: To what extent can a measure capture the variability of cultural competence in direct-care behavioral health workers as it is related to LGBTQ issues in youth?

1. What is the internal consistency of the measure?

2. What is the underlying factor structure of the measure?

   a. Does the factor structure support a multi-dimensional model that aligns with the conceptual model of cultural competency?

3. Are items significantly influenced by social desirability?

4. Does the new measure correlate as expected with existing measures of gay affirmative practice and attitudes towards LGBTQ persons?

Aim 2: How is this measure related to concepts associated with behavioral health workforce competence and development?

5. Does the measure vary systematically with characteristics of workers and organizations?

   a. Personal factors: sexual orientation, gender, age, race, level of education, political ideology, social distance to an LGBTQ person, and personally held sin belief about LGBTQ individuals.

   b. Organizational factors: perceived organizational climate related to LGBTQ individuals; policies in place related to LGBTQ individuals.

6. Is the measure related to other measures concerning training or competency in workers or the work environment?

   a. General cultural competency

   b. Worker willingness to adopt evidence-based practice

c. Organizational culture and climate

d. Job autonomy

Phase 1: Measurement Tool Development and Stakeholder Feedback

The first phase of the study involved the development of the new measure. This section will describe how the items were developed, the process for stakeholder review of the items, and revision of the item pool.

Step 1: Item Pool. Items were developed using three sources: existing measures of similar constructs (Goode & Fisher, 2009; Health Care of Southeastern Massachusetts (HCSM), 2008), the pilot scale I created for a previous study (Gandy, 2014), and best practice literature on behavioral health cultural competency with LGBTQ youth (S. K. Fisher et al., 2012; Van Den Bergh & Crisp, 2004). Then the items developed from these sources were examined and considered for relevance to a direct-care worker's roles and responsibilities. This was completed by examining service definitions from several sources, which will be described later. Next, items were grouped by construct according to the cultural competency model that guided this study (knowledge, attitude, skill, and awareness). A total of 56 items were developed. Information about the sources for these items will be presented next.

Best practice literature. Fisher, Poirier, and Blau (2012) offer a thorough examination of issues relevant to providing and improving behavioral health services to LGBTQ youth. It covers issues such as measurement practices, general knowledge about identity development, and ideas for improving practice at the individual, organizational, community, and system levels. This book provided a guidepost for creating items relevant to domains of cultural competency. In addition, Van Den Bergh and Crisp (2004) provided examples of practice with gay and lesbian

youth in each cultural competency domain. These examples were helpful because they provided real-world examples of situations that are relevant to practice with this population.

Previous measures. Existing measures used for the development of items were: (1) a self-assessment check-list for personnel providing mental health services (Goode & Fisher, 2009), (2) a measure of personal comfort with LGBTQ youth (Health Care of Southeastern Massachusetts (HCSM), 2008), and (3) the items from a pilot study I conducted in 2013 (Gandy, 2014). Across the existing scales, some items were very similar, so duplicates were eliminated from the pool. These sources are each described next.

Self-Assessment Cultural Competency Checklist. The Self-Assessment Checklist for Personnel Providing Services and Supports to LGBTQ Youth and Their Families was developed by Goode and Fisher of the National Center for Cultural Competency at Georgetown University (2009). It is a self-assessment questionnaire that consists of forty-five items grouped into three dimensions: (1) physical environment, materials and resources (five items) (*e.g.*, "I ensure that printed/multimedia resources (*e.g.*, photos, posters, magazines, brochures, videos, films, CD's, Websites) are free of biased and negative content, language, or images about people who are LGBT"), (2) communication practices (nine items) (*e.g.*, "I attempt to learn and use key words and terms that reflect 'youth culture' or LGBTQ youth culture, so that I communicate more effectively with youth during assessment, treatment, or other interventions"), and (3) values and attitudes (thirty-one items) (*e.g.*, "I avoid imposing values that may conflict or be inconsistent with those of LGBTQ youth cultures or groups"). Responses are based on three choices: (A) "I do this frequently," or "the statement applies to me to a great degree;" (B) "I do this occasionally," or "the statement applies to me to a moderate degree;" or (C) "I do this rarely or never," or "the statement applies to me to a minimal degree or not at all." The measure includes

principles from cultural competency standards of practice as well as best practices specific to the LGBTQ population. It has good face validity but no psychometric testing. It is intended to increase awareness by personnel about LGBTQ issues in human service settings. The authors of this scale were contacted but did not respond to requests for any psychometric testing information available for this measure.

Personal Comfort Assessment Tool. The Personal Comfort Assessment Tool (Health Care of Southeastern Massachusetts [HCSM], 2008) was created by the Health Care of Southeastern Massachusetts GLBT Youth Support Project. It has 16 items and respondents answer by choosing agree, disagree, or not sure to each statement. Examples of items are: "I am comfortable addressing and talking about GLBT issues in general" and "I would be comfortable if a client came out to me as GLBT." It is scored by assigning values to response items: 1=agree, 0=disagree, 0=not sure. It has good face validity and was tested for initial internal consistency by Gandy, McCarter, and Portwood (2013) with a Cronbach's alpha coefficient of 0.81.

Pilot study. I developed and tested a pilot measure in 2013 that aimed to assess the practice behavior of mental health workers as it related to LGBTQ issues in youth (Gandy, 2014). The measure had 21 items with a variety of question and response formats, including some ranked order items (*e.g.*, read a vignette about a LGBTQ foster child and then rank order what type of foster home to place the child in, ranging from extremely religious and anti-LGBTQ to non-religious and LGBTQ-affirming), some Likert-type items (*e.g.*, "If a youth wanted to question his/her sexual orientation, I would [never/rarely/sometimes/often/always] encourage a youth to question his/her sexual orientation."), and some nominal level responses (*e.g.*, "A lesbian youth tells you that she wants her 'family of choice' to be included in her treatment. You respond by saying: [respondent has several non-ordered answers to choose from]."). The

measure was scored as an index rather than a scale, meaning that a number was assigned to each response item based on the level of practice competency that would be required for a respondent to select each answer, ranging from 0 - 2. Then scores were summed to result in a number that represented the amount of the respondent's level of competency in their practice behaviors with youth in treatment as it relates to LGBTQ issues. The pilot study was reviewed by field experts and reported to have good face validity, and from preliminary analysis in a pilot study had good internal consistency (α=.85).

Direct-care workers. Next the items were examined and considered for relevance to direct-care workers' roles and responsibilities. This was done by comparing descriptions of direct-care workers' educational requirements and job requirements to each item to judge whether or not the item described something for which a direct-care worker would be responsible. Items were eliminated or developed so as to cover the broad range of roles and responsibilities that are attributed to a direct-care role. This was achieved by comparing each item to the descriptions (listed below) to determine if the item would fall into the roles and responsibilities of a direct-care worker. If the item was not compatible, it was revised, or if there was another item that better captured the concept and was a better fit with the direct-care worker description, then it was eliminated. The sources used to interpret direct-care worker roles and responsibilities were: (1) Department of Health and Human Services staff definitions (North Carolina Administrative Code, 2009); (2) Department of Behavioral Health and Developmental Services Office of Licensing: Qualified ParaProfessional Mental Health (QPPMH) Definitions (Virginia Department of Behavioral Health and Developmental Services, 2012); (3) Psychiatric Rehabilitation Association's CPRP Credential (Psychiatric Rehabilitation Association, 2013); (4) Federal Department of Health and Human Services definitions of health professionals (U.S.

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Government Publishing Office, 2014); and (5) A report from California on the state of mental

health paraprofessional workers (Buchbinder, 2003).

      Item Pool. The final pool of items consisted of 56 items, grouped by the cultural

competency domain that each was constructed to represent. Table 4 includes all of these initial

items.

Table 4: Initial item pool

<u>Domain: Knowledge</u>

1. I understand that identifying as LGBTQ is a developmental process that involves many stages, and that youth can experience these stages in uniquely individual ways.

2. I understand and respect that LGBTQ youth may conceal their sexual orientation/gender identity or expression within their own racial, ethnic, or cultural group.

3. I understand that family members and others may believe that LGBTQ identity among youth is a mental illness, emotional disturbance/disability, or moral/character flaw.

4. I accept that religion, spirituality, and other beliefs may influence how families respond to a child or youth who identifies as LGBTQ.

5. I understand that even if LGBTQ issues are not addressed in a youth's treatment plan or goal, being LGBTQ-affirming is still an important part of how to provide good treatment.

6. I understand that a youth could be dealing with LGBTQ issues secretly without anyone else knowing about it.

7. If a youth "comes out" to me as LGBTQ, I avoid sharing that information without their permission.

8. The parents of LGBTQ youth should be made aware of their child's identity as LGBTQ, if they are not already aware.

9. I understand that LGBTQ youth can grow up to have children if they want to.

10. I understand that LGBTQ youth have the same typical goals and dreams for their future as do heterosexual/non-transgender youth.

<u>Domain: Attitudes</u>

11. I think it is okay for a youth to come out as LGBTQ.

12. I believe that LGBTQ youth are sinful.

13. I think it is best for boys to act like boys and girls to act like girls.

14. I do not believe that youth should be encouraged to identify as lesbian, gay, bisexual, or queer.

15. I do not believe that youth should be encouraged to identify as transgender or queer.

16. Youth should be allowed to explore their same-sex attraction feelings.

17. Youth should be allowed to explore their gender identity.

18. Youth should be allowed to spend time around people who identify as LGBTQ.

19. A youth's family should *not* encourage their child's decision to identify as LGBTQ.

20. I think a LGBTQ identified youth who needed foster care services would be best served in a highly religious foster home.

21. I do not assume that a lesbian, gay, bisexual, or queer client or co-worker is attracted to me.

22. I would be comfortable if a client came out to me as LGBTQ.

23. Being lesbian, gay, bisexual, or queer is a healthy expression of sexuality.

24. Being transgender or queer is a healthy expression of gender identity.

25. Bisexual identified youth are not sure whether they are gay or straight.

26. I believe that LGBTQ persons are mentally unstable, even though it is no longer a diagnosable mental disorder.

27. LGBTQ youth are sexually promiscuous.

Domain: Skills

28. I attempt to learn and use terms that reflect LGBTQ 'youth culture' so that I communicate more effectively with youth during treatment.

29. I screen books, movies, and other media resources for negative stereotypes about LGBTQ persons before sharing them with youth and their parents/families served by my program/agency.

30. I intervene when I observe others (*i.e.*, staff, parents, family members, children, youth) within my program/agency behave or speak about sexual orientation/gender identity in ways that are insensitive, biased, or prejudiced.

31. I intervene when a youth is being teased by being called LGBTQ-derogatory slurs (*e.g.*, "fag", "dyke", "tranny").

32. I have resources or literature relevant to LGBTQ issues readily available to give to a youth, or know where to get some.

33. I would put an LGBTQ-affirming sticker on my office or workspace if given the opportunity, or I do already.

34. I think any child or adolescent I work with should be allowed to engage in gender non-conforming play activities (for example, a boy painting his toenails).

35. If a youth wants to use a different gendered name than their given name, I agree to do what they ask (for example, a youth whose given name is James but wishes to be called Christina).

36. I use the preferred gender pronouns of a transgender or queer youth I work with (or might in the future work with), even when their preferred pronoun is different than what is in their record, chart, or notes (for example, if a youth's chart says that they are female, but the youth uses male pronouns such as he/him/his).

37. I know how I would respond if a youth came out to me as lesbian, gay, bisexual, or queer.

38. I know how I would respond if a youth came out to me as transgender or queer.

39. I intervene when youth tell me they have been bullied because of actual or perceived sexual orientation or gender identity.

40. I intervene when I hear co-workers use derogatory language or insinuations about LGBTQ persons.

41. When I am on shift, I make sure to create and/or maintain an affirming environment about LGBTQ issues.

42. When possible, I link (or would link) services between an LGBTQ identified youth and LGBTQ resources in the community.

43. I do not automatically assume that I know a youth's sexual orientation.

44. I do not automatically assume that I know a youth's gender identity.

45. When providing services (or if I were to provide services) to a transgender or queer identified youth, I ensure that they have access to a gender-neutral bathroom, or the bathroom of their preferred gender.

Domain: Awareness

46. I think about how my actions could be seen as homophobic.

47. I think about how my actions could be seen as transphobic.

48. I recognize that even when I have good intentions, I can still do or say things that may be hurtful to LGBTQ youth.

49. I avoid imposing values that may conflict or be inconsistent with those of LGBTQ youth cultures or groups.

50. I am comfortable using the words 'gay', 'lesbian', 'bisexual', and 'transgender'.

51. I am comfortable using the word 'queer' when a youth identifies as queer.

52. I am aware that being LGBTQ brings with it certain challenges that heterosexual and/or non-transgender people do not have to face.

53. I can identify my reactions that are based on stereotypical beliefs about LGBTQ people.

54. I witness co-workers saying homophobic things at my agency.

55. I witness co-workers saying transphobic things at my agency.

56. I witness co-workers allowing youth to display homophobic or transphobic behaviors.

After these items were developed, they were presented to stakeholder groups to evaluate them for face validity and suggested revisions or additions.

Step 2: Stakeholder Review. The pool of items was presented to stakeholders for the purpose of comparing the measure to their own respective experiences and knowledge. There were three groups of stakeholders involved in the review of the initial item pool: young adults who identify as LGBTQ and had experience receiving behavioral health treatment as adolescents, workers at a behavioral health agency who have or currently do provide direct-care services to youth, and researchers with substantive knowledge in the area of LGBTQ or youth practice and scale development.

Prior measurement design studies have started with an expert review panel and then solicited feedback from consumer/worker stakeholders later in the process. However, according to principles of cultural competency, consumers and/or those who work closely with them should have first priority in deciding how services should be designed for them. Therefore the review process started with feedback from young adults, then direct-care workers, and lastly from research experts. The mechanics presented by DeVellis (2012) were followed: (1) confirm or invalidate the definition of the phenomenon (the proposed model of cultural competency from Chapter 2): provide the reviewers with a working definition of the construct; (2) rate how relevant each item is to the phenomenon: the reviewers rate how relevant each item is to the definition of the construct; (3) evaluate the items' clarity and conciseness: stakeholders comment on items' wording and clarity, and suggest alternatives if they wish; and (4) point out ways of tapping the phenomenon that were not included: stakeholders invited to suggest additional items, or different approaches to measuring the concept.

The procedures for each stakeholder group will be explained below. Results of the groups and discussion of how their feedback was used to create the final items will also be explained.

Funds for the supplies and materials for this portion of the study were provided by the VCU Robin McKinney Dissertation Honor Fund.

Young adult stakeholder group. Young adults were recruited from an LGBTQ youth-serving organization via e-mail, posters, flyers, and in-person announcements at group meetings (recruitment materials are in Appendix A). Decisions about whom to recruit, how to respect the privacy and safety of youth who interacted with this agency, and logistical details were discussed and agreed upon with the agency's Executive Director and Program Manager prior to any direct contact with young adults from the organization. It was decided to recruit only young adults (defined as between ages 18 and 25) rather than youth under the age of 18 because it was believed that young adults would be capable of using retrospective knowledge of their prior experiences in behavioral health treatment to guide them in giving feedback on the item pool. Such a sampling frame also reduced concerns about consent, since respondents could legally consent for their own participation.

Demographics. A total of four young adults, between the ages of 19 and 23, participated. Gender identity included genderqueer, transgender, female, and male. Sexual orientation included gay and queer. Races were non-Hispanic white and non-Hispanic black. Types of behavioral health treatment received included counseling, psychiatric medication, group home, and case management.

There were two groups on separate days/times. Each lasted approximately 90 minutes each and was preceded by free pizza, drinks, and snacks. Participants received a $25 gift card as incentive for their participation. Two young adults attended each session. The sessions were audio recorded and a note-taker was present. Prior to agreeing to participate and again before the review group began the participants were given an information sheet that provided all elements

of informed consent (Appendix B), as well as a list of resources for different types and sources of mental health support in case a participant became distressed during or after the session (Appendix C). After initial introductions and setting group boundaries such as confidentiality, the participants were given a list of the pool of items (Table 4). The young adults were asked to read each of the items and then answer three questions about the item: (1) if I had a direct-care worker, I'd want them to do this / be like this; (2) if I were in treatment, how important would this be to me?; and (3) How important is this to providing quality treatment? Responses were in a 7-point Likert format from Extremely to Not at all, and respondents could also answer "do not know." Participants were given 30 minutes to complete this section. Then, a group discussion was facilitated and participants were asked to share about their answers for the three questions related to each item. During this time, clarification of meaning was asked from the participants, and discussion about the items occurred between participants and with the researcher. The sessions ended with a discussion of what participants thought might be missing from the pool of items.

Worker stakeholder group. Workers were recruited from a behavioral health agency that provided a variety of types of behavioral health services (*i.e.*, residential treatment, case management, day treatment, in-home intervention, *etc.*) to children, adolescents, and their families. Discussions were held with the agency's CEO and a Director about how best to reach the intended participants, how to avoid coercion in the recruitment process, how to protect the privacy of workers who decided to participate, and logistics issues such as time and day. Recruitment occurred via e-mail and posters in common staff areas on agency grounds (Appendix D).

Demographics. Four workers participated. Ages ranged from 23 – 49, all female, one individual who identified as gay, three were non-Hispanic white and one was non-Hispanic black. Three had master's degrees and one had a bachelor's degree. They had backgrounds in social work, education, and direct-care. Years in the field ranged from 3 to 20 years. Three reported that they had worked with a lesbian, gay, or bisexual youth. Only one reported having worked with a transgender youth; two reported never having worked with a transgender youth, and one was not sure.

Participants were given a $25 gift card and sandwiches, drinks, and snacks during the group. The session was audiotaped and there was also a note-taker present. Prior to the session and again at the session, participants were given an information document that presented all elements of informed consent (Appendix E). This session followed the same format as the young adult stakeholder group, except these participants were asked to answer questions that were relevant to them as workers: (1) does this item make sense?; (2) How much does this item apply to your role as a direct-care worker?; and (3) How important is this to providing quality treatment? Responses were in a 7-point Likert format from Extremely to Not at all, and respondents could also answer "do not know."

Researcher stakeholder review. Researcher stakeholders participated electronically on an individual basis. Researchers were selected on the basis of their knowledge in the area of practice with LGBTQ populations, children's mental health, and scale design. Four researchers were contacted and two researchers responded to the request for participation that was sent via e-mail.

Demographics. Disciplines represented were clinical psychology and social work. Both were in faculty roles. Experience in direct clinical practice was 1 and 26 years. Experience in social science research was 6 and 15 years. Both answered yes to ever having provided direct

services to a child or adolescent who identified as lesbian, gay, or bisexual. Both answered no to ever having provided direct services to a child or adolescent who identified as transgender.

Their input was gathered in a similar fashion to that of the previous two stakeholder groups, but were asked the following questions: (1) how relevant is this item to the construct?; (2) how important is this for providing quality treatment?; and (3) should this item be kept or dropped? Responses were in a 7-point Likert format from Extremely Relevant to Not at all Relevant, and respondents could also answer "do not know." The last item had response options of keep, maybe, drop, or don't know. Results from all stakeholder groups are presented next.

Step 3: Revision and Finalization of Items. This section will explain results of the item development and review phase. It will begin by explaining the sources of data. It will then present key results from each stakeholder group. Documentation of the entire analytic process used to add or eliminate items from the item pool is available in Appendix F. The final items that were included in the new measure are presented in Table 5. This section ends with a conclusion of the measurement development process.

Data sources. There were both qualitative and quantitative data available from the review groups. Qualitative data were in the form of notes that the participants wrote on the surveys and their comments during the discussion portion of the review sessions, which were captured both in audio recordings and on notes taken by a note-taker who was present in each of the sessions and by the researcher. Quantitative data were in the form of stakeholders' answers to the rating questions, which asked participants to rate each item based on how much the item made sense, was relevant to them, and whether or not the item was important to the delivery of quality care. These data were used to develop and refine the item pool for the new measure. First, the quantitative data were compiled to compare and contrast ratings to help the researcher determine

if each item was adequate as it was, needed to be revised, or needed to be dropped. Then the qualitative data for each item were added to the quantitative data to help further understand the justification for changes to each item. Based on these data, decisions were made about whether to keep, revise, or drop items. This analytic process was documented and is available in Appendix F. The original item pool and final items that were tested in the survey are included in that same Appendix.

Results from Young Adult Stakeholder Group. One of the most important pieces of feedback received from the young adult stakeholders was that they wanted adults to embrace their queer identities. This came up during a discussion about how sometimes adults are not comfortable using the word queer, typically because of the generational differences in the meaning of that word. But the young adults were quick to reply that it is very invalidating if a worker does not use the same word for the youth's identity as what the youth uses. The other way that feedback from this group was most helpful was in deciding whether to keep or drop certain items.

Results from Worker Stakeholder Group. The results from the stakeholder review groups that were most influential in the final decision making process are as follows. First, the direct-care workers highlighted the need to add more items about how workers deal with the ambiguity of some youths' identities; for example, if a youth declares that they identify as a lesbian but then later declares that they identify as transgender. According to the direct-care worker stakeholder group, such shifts and ambiguity in youth identities caused a worker to become more dismissive of a youth's LGBTQ identity and to become less supportive of when a youth "came out." This issue of dealing with ambiguities in identity became a recurring theme in the worker stakeholder group. On a similar note, stakeholders discussed how they observed

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workers having a lack of acceptance for youth who are in a questioning phase because the workers would not take it seriously when a youth made statements that suggested that the youth was questioning his/her sexual or gender identity. The reported lack of support for questioning youth is important because questioning youth have an even greater risk of negative outcomes than LGBT youth, such as suicide, depression, and substance abuse (Sherriff et al., 2011; Zhao et al., 2010). It is interesting that the workers reported a lack of tolerance for the questioning that youth naturally do during their childhood and adolescent years of development, particularly because a questioning stage is the one wherein workers will most likely encounter youth. This finding alone might shed light into how to improve care with LGBTQ youth who are in treatment settings – workers must learn how to tolerate ambiguity in youth's sexual orientation and/or gender identity. The stakeholders also reported that they heard fellow coworkers stating a belief that youth will come out as LGBTQ just because it is the latest trend or to copy other youth. Some stakeholders reported hearing coworkers state a belief that youth are only same-sex attracted temporarily if they are in a same-gender group home just because they are restricted from interacting with the opposite sex, but when they return to living quarters that do not involve restriction of interaction with youth of other genders, they become opposite-sex attracted once again. These pieces of input led me to add items to the item pool that addressed tolerance for ambiguity in identity, and items that addressed misconceptions about the development of an LGBTQ identity in youth.

Results from Researcher Stakeholder Group. The key findings from the researcher stakeholders were most helpful in providing justification for final decisions on whether or not to keep or drop an item. They were asked specifically about whether an item should be kept or dropped, so it was helpful to have a distinct question about that part of the item development

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process. These stakeholders also provided important information on how to word some items to make them more coherent. There were no major concerns expressed by the stakeholders about how the items fit into the constructs that they represented, so no major changes came from the stakeholders in that regard. If I was still undecided on whether or not to include an item after examining the input from the young adult stakeholder group and the worker stakeholder group, the researcher stakeholder input was used to make a final decision on such items.

Conclusion. Input from the stakeholder review groups was an important step in preparing the new measure for administration to the intended target respondents of direct-care workers. Input from stakeholder groups is relevant to a measure about cultural competency because tenants of cultural competency suggest that consumers and those who work closely with them should be involved in determining how services should be delivered.

Table 5: Final items after phase 1

Response categories: Very Untrue, Untrue, Neither True/ Untrue, True, Very true, Don't Know
1. Becoming LGBTQ is a process that unfolds over time.
4. A youth could be dealing with LGBTQ issues secretly without anyone else knowing about it.
6. LGBTQ youth have the same types of life goals and dreams for their future as do heterosexual/non-transgender youth.
7. Being LGBTQ brings with it certain challenges that heterosexual and/or non-transgender people do not have to face.
*8. LGBTQ youth are LGBTQ because of their childhood history of abuse/neglect/poor parenting.
*9. When youth think they might be gay/lesbian/bisexual, it is just a phase they will grow out of.
*10. When youth think they might be transgender, it is just a phase they will grow out of.
*11. Adolescents (ages 12-17) are not old enough to know whether they are gay/lesbian/bisexual or straight.
*12. Children (ages 5-11) are too young to be thinking about whether they are gay or straight.
*13. Adolescents (ages 12-17) are not old enough to know whether they are transgender or not.
*14. Children (ages 5-11) are too young to be thinking about whether they are transgender or not.
*15. Youth will come out as LGBTQ just to copy other youth who are coming out.
*16. Youth say they are LGBTQ to get attention.
*17. Youth act gay (feel attracted to the same-sex) when they are isolated from the opposite sex, like in an all-girls or all-boys group home.
Response categories: Strongly Disagree, Disagree, Neither Agree/ Disagree, Agree, Strongly Agree, Don't Know
2. Even if LGBTQ issues are not addressed in a youth's treatment plan or goal, acknowledging

their LGBTQ identity is still an important part of how to provide good treatment.

*3. In my job, I interact with youth because of their mental health problems not because of their sexual orientation/gender identity, so I do not talk about LGBTQ issues with youth I interact with.

*18. I believe that being LGBTQ is a sin.

*19. I think it is best for boys to act like boys and girls to act like girls.

*20. Youth should not be encouraged to be lesbian, gay, bisexual.

*21. Youth should not be encouraged to be transgender.

*22. A youth's family should discourage their child's decision to identify as LGBTQ.

*23. An LGBTQ youth who needed foster care services would be best served in a highly religious foster home so they can get set straight.

25. I would be comfortable if a client came out to me as LGBTQ.

*26. Bisexual youth are just not sure whether they are gay or straight.

*27. In general, LGBTQ people are mentally unstable.

*28. LGBTQ youth are sexually promiscuous.

*29. Questioning youth should just make up their mind, are they gay or straight?

*30. Youth who question their gender should just make up their mind, are they a boy or a girl?

31. I attempt to learn and use terms that reflect LGBTQ youth culture so that I communicate more effectively with youth that I interact with.

32. I screen books, movies, and other media resources for negative stereotypes about LGBTQ persons before sharing them with youth I interact with.

33. I would put an LGBTQ-affirming sticker on the space that I work in if given the opportunity, or I have already.

34. Any youth I interact with should be allowed to engage in gender non-conforming activities (for example, a boy painting his toenails, or a girl dressing in boy clothing).

38. When possible, I do or would connect an LGBTQ youth to LGBTQ resources in the community.

42. I recognize that even when I have good intentions, I can still do or say things that may be hurtful to LGBTQ youth.

43. I am comfortable using the words gay, lesbian, bisexual, and transgender.

44. I am comfortable using the word queer when a youth identifies as queer.

*45. In my job I do not talk to youth about sex or dating, so LGBTQ issues do not apply to my interactions with youth.

*50. I assume a youth is straight/heterosexual unless they tell me otherwise.

*51. I assume a youth is not transgender unless they tell me otherwise.

Response categories: Never, Rarely, Sometimes, Often, Always, Don't Know

5. If a youth tells me that they are LGBTQ, I avoid sharing that information without their permission.

*18a. If Yes: I tell youth that I interact with that being LGBTQ is a sin.

24. I do not assume that a lesbian, gay, or bisexual youth who is the same sex as me is attracted to me.

35. If a youth wants to use a different gendered name than their given name, I agree to do what they ask (for example, a youth whose given name is James but wishes to be called Christina).

36. I intervene when youth I interact with tell me they have been bullied because of actual or perceived sexual orientation or gender identity.

37. I intervene when I hear co-workers use derogatory language or insinuations about LGBTQ persons in front of youth I interact with.

39. If a transgender youth who was a boy and now identifies as a girl needs to use the bathroom, and asks to use the girls bathroom, I would allow them to use whichever bathroom is most comfortable for them.

40. I think about how my words/actions could be seen as discriminatory against lesbian, gay, and bisexual people.

41. I think about how my words/actions could be seen as discriminatory against transgender people.

46. I see/hear co-workers at my agency saying/doing prejudiced or discriminatory things about lesbian/gay/bisexual people.

46a. If Yes: I intervene when this happens.

47. I see/hear co-workers at my agency saying/doing prejudiced or discriminatory things about transgender people.

47a. If yes: I intervene when this happens.

48. I see/hear youth at my agency making fun of lesbian, gay, bisexual people or teasing other youth about being lesbian, gay, or bisexual.

48a. If Yes: I intervene when this happens.

49. I see/hear youth at my agency making fun of transgender people or teasing other youth about being transgender.

49a. If Yes: I intervene when this happens.

*=reverse coded

Phase 2: Administration of Survey

The next phase involved the administration of a survey that included the new measure as well as other variables, as described below.

Sample, Inclusion Criteria, and Recruitment. The sampling frame for this study was defined as direct-care workers who work at organizations that provide behavioral health services to children and adolescents ages 5 to 17 (referred to as "youth"). Direct-care workers were recruited through contact with these agencies. Initially, only agencies from North Carolina were solicited. North Carolina was chosen because of my familiarity with the state's behavioral health system and with agencies that operate in the state, which made it easier to reach out for initial contact, as described below. However, upon further contact with certain North Carolina agencies, recruitment expanded to some of their sites that were located across the mid-Atlantic region.

Recruitment also included a small number of sites in Virginia that took part in the pilot study that I conducted in 2013. The target sample size was 100-150, which is considered adequate for the primary analysis of this study, which is factor analysis of the newly created measure (Dattalo, 2013; Tabachnick & Fidell, 2007).

North Carolina agencies were first identified using a list of 175 Critical Access Behavioral Health Agencies (CABHAs) available at http://www.ncdhhs.gov/mhddsas/providers/cabha/cabha_certificationlist1-26-15.xlsx. Organizations that served children and adolescents were extracted from the list, resulting in 85 agencies total. Additionally, agencies were added that were CARF accredited for providing mental health services to children and adolescents, and each Local Management Entity of North Carolina was also contacted, resulting in 20 more entities contacted for a total of 105 agencies that made up the initial sampling frame.

A series of introductory e-mails (Appendix G) were sent to the Executive Director listed for each agency. The e-mails were written with the goal of being as un-burdensome as possible due to the reality that these agencies are already very busy with the activities involved in conducting their business. Organizations had a range of options for how to respond to the e-mail invitation, ranging from simply forwarding the invitation to their staff without informing me of their participation or contacting me and setting up specific logistics for how to recruit direct-care workers from their respective agencies. The least amount of involvement required for an agency to participate was simply to forward the e-mail invitation to staff members of their organization. Twelve agencies responded to the e-mail and confirmed their participation. Of those 12, six agencies agreed to simply forward the e-mail invitation to all of their staff members, and six agencies responded by inquiring how they could assist me in sending the invitation to direct-care

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workers from their agency. Their participation will be explained further, later. Five agencies responded saying that they could not participate either due to the timing of the study, or because they could not gain approval from the appropriate authority of their organization to authorize participation in a research study. Eight agencies' e-mails were returned due to an incorrect e-mail address, and investigation into these agencies resulted in no other ability to make contact (*i.e.*, no other e-mail listed on a website, no answer when calling the agency's main line for contact information). Agencies will not be identified because of confidentiality and anonymity to protect human subjects.

After the initial introduction e-mail, an e-mail invitation (Appendix H) was sent to all sites, and agency contacts were asked to simply forward the e-mail to staff members of their agency. The six agencies that responded with increased interest in assisting me with reaching their direct-care workers also posted fliers in common staff areas or put invitation flyers in staff mailboxes (Appendix I). Also, a public web blog was set up with recruitment information so that interested parties could go there to read the same information available in the recruitment materials (http://LGBTQCompetencyStudy.blogspot.com).

At first, the survey was set up so that respondents would self-identify in one of four agency roles, which are in Table 6.

Table 6: Agency roles and descriptions

Agency Role	Description
Direct-care, Front-line, or Paraprofessional	Responsible for directly interacting with youth and/or their families, but does NOT require a license or a graduate degree. If you personally have a graduate degree but your job does not require you to have one, you are still eligible. (Examples include but are not limited to: group home staff, treatment parents/foster parents, substitute caregiver, behavioral technician, case manager, day treatment behavioral counselor, mobile crisis associate, inpatient unit behavioral counselor, substance abuse counselor, recreational counselor, associate professional (AP), qualified professional (QP), qualified mental health professional (QMHP), *etc.*
Licensed clinician	Provides therapy, counseling, or other clinical treatment, and a license

	and/or graduate degree are required (*e.g.*, LCSW, LPC, MFT, Licensed Psychologist, *etc.*). This does NOT include "QP" or "QMHP." (Note: if this is describes your job role, you are ineligible to take the survey and you will be re-directed to end the survey)
Medical provider	(*e.g.*, MD, Nurse, NP, PA, *etc.*) (Note: if this is describes your job role, you are ineligible to take the survey and you will be re-directed to end the survey)
Support or administrative staff	No direct clinical contact with consumers/clients, or not responsible for directly interacting with youth related to their treatment plan. (Note: if this is describes your job role, you are ineligible to take the survey and you will be re-directed to end the survey)
Something else - Please specify	(user inputted data)

If a respondent chose anything except "Direct Care" or "Other", they were directed immediately to the end of the survey (they were screened out). I reconsidered this approach after a week of recruitment because I felt that respondents might not classify themselves as I would, and I would rather have the ability to decide how to classify direct-care respondents. Therefore, the survey programming was changed so that the respondent would still choose their agency role, but the item would no longer screen participants out. Then another field was added to the survey so that participants could enter their job title. I then could use both the job title information and the agency role information to decide whether to categorize the respondent as a direct-care worker.

In order to gain clarity about job titles and the roles they play in agencies, I contacted the 12 agencies and asked to speak to a representative regarding that information. From those agencies who were contacted, 3 agreed to be reached by phone. Through discussions with these agency contacts, it became clear that the agencies considered workers to be direct-care not based on their level of education or license requirements, but based on the types of contact their specific job or type of service required. For instance, a licensed MSW level worker could be

considered direct-care if she provided in-home therapy. Indeed, during many in-home therapy interventions, it is common for the worker to spend extended hours with the child and family. In-home therapy is typically provided in a team-based model, so it would not be uncommon for a graduate-level worker and a direct-care worker (as previously defined) to be working together in the same roles and responsibilities. What became evident after these conversations was that the new measure could be relevant and applicable not just to an apriori definition of direct-care workers but to other types of workers as well – essentially anyone who had direct contact with youth. Therefore, the final sample included workers who were categorized as direct-care, licensed clinician, or medical provider and excluded workers who were categorized as administrative/leadership/support, because those workers would not have any sort of therapeutic or intervention-related contact with youth.

After agencies were contacted, there was not as high a response to the invitations as was anticipated or needed, so I decided to expand the recruitment to sources that would reach several nationwide sites that relate to children's behavioral health services. Several listserv organizers were contacted for assistance in spreading the recruitment effort across the nation. One listserv that responded and agreed to share the recruitment information was the Children's Mental Health Network. Another listserv that agreed to participate was a SAMHSA workgroup on providing behavioral and emotional support to LGBTQ youth. The recruitment letter was also posted on my personal Facebook page because I have contacts through that medium with behavioral health workers from my prior work experience. These efforts expanded the recruitment across the country and internationally.

The survey was open for approximately 7 weeks, which started on November 12 and ended on December 31, 2015. The survey was administered online using REDCap software

(Harris et al., 2009). Participation was incentivized via a weekly drawing for a $50 Amazon.com gift card. Respondents provided contact information if they wished to be included in the drawings. This information was separated from their survey results.

Survey Design and Methods. The next section will describe how the survey was designed, implemented, and which analyses were chosen for each research question. All statistical analyses were conducted using IBM SPSS version 22.

Survey Administration. Participants were able to save their answers and come back to it later to finish the survey if they could not finish it in one sitting. The survey had 196 fields across 20 different web pages, and the respondent could see their progress towards completing the survey (*i.e.*, page 6 of 20). The beginning of the survey is in Appendix J. The entire survey cannot be attached due to copyright limitations for some scales used.

Research Aim #1. To what extent can a measure capture the variability of cultural competence in direct-care behavioral health workers as it is related to LGBTQ issues in youth?

Research Question #1: What is the internal consistency of the measure? The coefficient alpha test was used to assess internal consistency (reliability) of the new measure. Cronbach's alpha coefficient (Cronbach, 1951) is a statistic used to test for the internal consistency of a measure, and indicates the amount of covariance items in a measure share (Gardner, 1995). There is no steadfast rule as to the exact cutoff for alpha; however, Nunally (1978) suggests that an alpha of 0.70 or higher is sufficient. However, Gardner (1995) brings up the issue that if a scale is multi-dimensional, alpha may be deflated. The conceptual framework for this measure indicates that it is multi-dimensional. Therefore, a factor analysis was also utilized in the initial psychometric testing of this new measure.

Research Question #2: What is the underlying factor structure of the measure? Does the factor structure support a multi-dimensional model that aligns with the conceptual model of cultural competency? One goal of this study is to create a measure that can be used in future research, evaluation, and practice settings; therefore, creating a brief measure that reduces respondent fatigue is one purpose of these analyses. Factor analysis is a statistical method used to reduce or simplify data (Dattalo, 2013). It is frequently used in measure development because it can identify items that "form coherent subsets that are relatively independent of one another" and the factors are thought to reflect the underlying construct(s) that a group of variables claims to measure (Tabachnick & Fidell, 2007, p. 607). Factor analysis achieves this by combining variables that are correlated with one another and putting those variables into a factor (Tabachnick & Fidell, 2007). It can be used to reduce the number of items in a scale by identifying items that have greater representation of the factor to which they are connected.

Methods. The Principal Axis Factoring (PAF) method was used rather than Principle Components Analysis (PCA) because of the distribution of the items. PAF is the better choice with items that are mostly non-normally distributed (Costello & Osborne, 2005), which is the case for these data. A varimax rotation was used because it is an orthogonal rotation that produces factors that are uncorrelated, which aligns with the assumptions of this exploratory factor analysis. The method for retaining factors was a combination of the scree plot method and also based in the guiding conceptual framework of 4 domains (knowledge, attitude, skill, and awareness). Costello and Osborne (2005) suggest that the scree plot is the best way to determine the number of factors to retain.

Factor loadings. Factor loadings are the correlation between the item and the factor (Dattalo, 2013). These were examined to determine which items loaded on the factor and to

name the factor based on what item loaded the highest. Factor loadings of each item were also examined for the purpose of reducing the number of items in the new measure by using a cutoff score for the factor loadings. Items with a factor loading of greater than 0.5 were retained, which might seem like a high factor loading criterion (compared to 0.4 or 0.3 which is more commonly seen in exploratory factor analysis). However, with the goal of reducing the overall length of the instrument, and after looking at each item that would be eliminated using that criterion, it seemed that there was sufficient information retained in the items to use the 0.5 criterion based on the content of the items retained.

Research Question #3 & #4: Are items significantly influenced by social desirability? Does the new measure correlate as expected with existing measures of gay affirmative practice and attitudes towards LGBTQ persons? The new measure was assessed for construct validity by examining how it correlates with existing measures that are theoretically close to the construct explored in this new measure. Construct validity is achieved when the construct under investigation is measured properly, is accurately represented by the instruments used to measure them, and behaves the way it would be expected (Drake & Jonson-Reid, 2008). It is often tested by comparing it to other similar measures of the same construct (Drake & Jonson-Reid, 2008). Two constructs were used for this purpose: gay affirmative practice and attitudes toward LGBTQ persons. Three instruments to measure those constructs are described below. The new measure was compared to a measure of social desirability, also described below.

Gay affirmative practice. Gay affirmative practice is defined as practice that "affirms a lesbian, gay, or bisexual identity as equally positive human experience and expression to heterosexual identity" (Crisp, 2006, p. 25). This concept is relevant to the current study because it is theoretically similar to cultural competency, but specifies attitudes, knowledge, and skills

that are relevant to sexual minorities. It will be measured using a shortened version of the Gay Affirmative Practice Scale (GAP) (Crisp, 2002). The GAP has two subscales, a belief subscale and a behavior subscale. The short version (GAP-20) (Gandy & Crisp, 2015) consists of 20 items with answer responses in a 5-point Likert-type scale. Examples of items are "Practitioners should make an effort to learn about diversity within the gay/lesbian community" and "I demonstrate comfort about gay/lesbian issues to gay/lesbian clients." The short version had good internal consistency in a previous study (α=.85) (Gandy & Crisp, 2015).

Attitudes toward sexual minorities. The attitude dimension of the proposed measure in this study can be compared to measures on attitudes about LGBTQ individuals. Currently there are no available measures that include both sexual orientation and gender identity, thus attitudes about each respective construct were treated separately. Attitudes and beliefs are commonly thought to be conceptually similar in literature on cultural competency (Sue et al., 1992); therefore, attitudes towards lesbian, gay, and bisexual people were measured using the Beliefs about Sexual Minorities (BSM) scale (Eliason & Raheim, 1996; Eliason, 1997). The BSM measures attitudes about gays, lesbians, bisexual men, and bisexual women. This single item instrument asks respondents to choose a statement that best fits their own views, ranging from: Celebration ("I believe that (lesbians, gay men, bisexual women (BW), or bisexual men (BM) contribute in a positive and unique way to society), to Acceptance, Tolerance, Disapproval, Disgust, and Hatred ("I despise L/G/BW/BM people and believe that their lifestyle should be punished"). This measure has been used often in measures of attitudes about lesbians, gay men, and bisexual women and men, and has good test-retest reliability (Pearson r=.77) over a two-week period (Eliason & Raheim, 1996).

Attitudes toward gender minorities. A scale measuring transphobia attitudes was used called the Transphobia Scale (Nagoshi et al., 2008). This is a 9 item scale that measures attitudes about "key issue[s] of transgenderism, the fluidity of gender identity and how deviations from expected heteronormative manifestations of gender identity fundamentally challenge individuals' sense of self" (Nagoshi et al., 2008, p. 53). Answer responses are in a 7-point Likert-type scale ranging from 1=completely disagree to 7=completely agree. Examples of items include "I don't like it when someone is flirting with me, and I can't tell if they are a man or a woman," and "I think there is something wrong with a person who says that they are neither a man nor a woman." Overall Cronbach's Alpha coefficient for the scale was 0.82.

Social desirability. Social desirability is defined as "the need for social approval and tendency to respond in a socially desirable way" (Carpenter, 2006, p. 58). It is commonly used to assess social bias in self-report measures (Carpenter, 2006). Social desirability is important when assessing attitudes about LGBTQ individuals because researchers have found that the influence of social desirability on measures of heterosexist attitudes leads to severely underestimating the amount of anti-gay attitude (Coffman, Coffman, & Ericson, 2013). A four-item instrument was used that captures key elements of social desirability from the original 33 item Marlowe-Crown inventory that was first published in 1960 (Haghighat, 2007). Responses to the items are in a yes/no format where 1=yes and 0=no, and yes represented the socially desirable answer. The instrument is scored by simply adding all scores on the four items to reach the final respondent score. Examples of items in this scale are, "would you smile at people every time you meet them?" and "Do you always practice what you preach?" The scale was tested by Haghighat (2007) and found to have a Cronbach's alpha coefficient of 0.6, which is the lowest desirable level of alpha for this scale according to Marlowe and Crown (as cited in Haghighat, 2007).

Research Aim #2. How is this measure related to concepts associated with behavioral health workforce competence and development?

Research Question #5: Does the measure vary systematically with characteristics of workers and organizations? Research question #5 was analyzed using a multiple regression approach to assess the strength of relationships between relevant concepts and scores on the new measure. Multiple (ordinary least squares, or OLS) regression is used to predict values on a dependent variable (DV) based on linear combinations of several independent variables (IVs) (Dattalo, 2013). It can explain the amount of variance in a DV measured at an interval/ratio level that is accounted for by a set of IVs measured at interval/ratio, dichotomous, or dummy-coded nominal level (Tabachnick & Fidell, 2007). It achieves this by finding which combination of regression coefficients (*b* values, which are the amount that the value of each DV changes when the IV changes by one unit) best predict values of the DV as compared to observed values of the DV in the original data. OLS regression can also help the researcher to determine the importance of each IV in its ability to predict the value of the DV by comparing beta weights, which are standardized beta (β) coefficients (Dattalo, 2013). The R^2 statistic provides information on the overall model; it is a multiple correlation coefficient which tells the researcher the percent of variance explained in the DV by the IV's included in the model (Dattalo, 2013). Sequential regression is a technique used in exploratory research and is conducted by adding each IV or set of IV's into the regression model and examining the statistical results after each is added so as to evaluate the overall contribution of that IV or set of IV's to the model (Tabachnick & Fidell, 2007). The independent variables were grouped by personal factors and organizational factors, which will be explained next.

Personal factors. The relevance of personal factors to this measure were explored because an understanding of the relevance of such factors can contribute to a beginning understanding of the differing characteristics of workers that are related to LGBTQ attitudes, knowledge, skill, and/or awareness. The individual personal factors included in the regression analysis were: age, race, sexual orientation, sex, level of education, political ideology, personal social distance to LGBTQ individuals, and personally held beliefs about the nature of sin in relation to LGBTQ identities. Each variable and its associated measurement strategy are explained below. The personal factors were entered into the regression model first by basic demographic characteristics, including: age, race, sexual orientation, sex, and level of education. Next, political ideology was added, followed by personal social distance and personally held sin beliefs.

Age has been found to correlate with attitudes about LGBTQ individuals. Younger ages are correlated with more positive attitudes (Jones, Cox, & Navarro-Rivera, 2014). Age was measured by a single item in a numeric format. Race was included in the regression analysis because it has been found to be related to attitudes about LGBTQ individuals, with self-identity as non-white being associated with more negative attitudes (Lewis, 2003). Race was measured using a single item asking respondents to choose which racial category best fit how they identify, and responses included: American Indian or Alaska Native, Asian, Black or African-American, Hispanic or Latino/a, Mixed-race or Bi-racial, Native Hawaiian or Pacific Islander, White or Caucasian, Something else - please specify, and Prefer not to answer.

Sexual orientation is expected to be correlated with the new measure because lesbian, gay, and bisexual individuals have been found to have more positive attitudes towards LGBTQ issues (Pew Research Center, 2013). Sexual orientation was measured using a single item asking

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respondents how they think of themselves, with answer options including: lesbian, gay, or homosexual; straight or heterosexual; bisexual; something else – specify; and don't know. This is considered a best practice for asking respondents how they identify their sexual orientation (The Fenway Institute, 2013).

Sex was used in the regression analysis rather than gender identity because of the make-up of these variables in the data, which is explained in the next chapter. Sex is used in the regression analysis because studies of attitudes toward LGBTQ individuals have found that male is related to more negative attitudes about LGBTQ individuals (Morrison & Morrison, 2011). Gender identity was measured in a two-step method. The first item asked what gender the respondent identifies with now (man, woman, transgender, other), and the next item asks what sex the respondent was assigned at birth (male, female, intersex, other). This is considered best practice in demographic questionnaires when looking to differentiate between cisgender and transgender respondents because it allows a respondent to indicate that they once were identified as one gender but now personally identify as a different gender (The Fenway Institute, 2013).

Level of education is relevant to this study because level of education has been found to be related to attitudes about LGBTQ individuals (Ohlander, Batalova, & Treas, 2005). Education was measured in a single item using answer categories of highest level attained: high school, some college, 2-year degree, 4-year degree, graduate certificate, graduate degree, and post-graduate degree. Political ideology is relevant to this new measure because conservative political ideologies are correlated with more negative attitudes about LGBTQ individuals (Norton & Herek, 2012). Political ideology is defined as how a person identifies their political beliefs among a spectrum of conservative to liberal. It was measured using a single item asking

participants to self-rate on a 7-point scale ranging from 1=strongly liberal to 7=strongly conservative (Norton & Herek, 2012).

The contact hypothesis by Allport (1954) suggests that dialogue among majority and minority groups can reduce prejudices towards minority groups. It is the basis of the hypothesis that contact with – or social distance to – LGBTQ persons is related to attitudes about them (Hans, Kersey, & Kimberly, 2012). More social contact has been found to be positively correlated to attitudes about lesbians and gays (Swank & Raiz, 2010), and to transgender persons (Norton & Herek, 2012). It was measured using 6 items asking about personal distance such as "Have you ever had a friend, relative, or close acquaintance who is lesbian, gay, or bisexual," and professional distance such as "In your job, have you ever interacted with a transgender youth?" and "Have you ever participated in some sort of training or education that was specifically about LGBTQ issues or people?" Answer options were 1=yes, 0=no, or 0=don't know.

Religious beliefs about LGBTQ individuals have been found to be related to attitudes about LGBTQ individuals (Hunsberger, 1996; Whitley, 2009). Respondents were asked about the degree to which they agreed that being LGBTQ was a sin. This was achieved using two questions to ask about sexual orientation and gender identity separately: "How much is the following statement true of what you personally believe? 'Being homosexual is a sin and/or immoral.'" and "How much is the following statement true of what you personally believe? 'Being transgender or transsexual is a sin and/or immoral.'" Response options were in a Likert format ranging from 1=very untrue of what I believe to 5=very true of what I believe.

Organizational factors. As was discussed in Chapter 2 about the conceptual model of cultural competency, it was expected that some organizational and system level factors could act

as covariates to the new measure of LGBTQ cultural competency, meaning that scores on a measure of one construct are related to scores on a measure of another construct. The definition and measurement of the organizational factors will be described next.

Perceived organizational climate. It is unknown whether a worker's perceived climate related to LGBTQ individuals in their organization is related to the worker's level of LGBTQ cultural competency. However, best practice literature suggests that having 'out' LGBTQ staff members and creating an inclusive work environment for LGBTQ workers is an important part of providing a safe and successful environment for LGBTQ youth (Clark et al., 2001; Fisher et al., 2012). Therefore, three questions were fashioned to capture the perceived organizational climate regarding LGBTQ individuals: "In the agency where I work, it's okay to talk about LGBTQ issues"; "If I personally were lesbian, gay, or bisexual, I would feel comfortable being "out" at the agency where I work"; and "If I personally were transgender/transsexual I would feel comfortable being "out" at the agency where I work." Response options for these questions were in Likert format ranging from 1=strongly disagree to 5=strongly agree.

Organizational policy climate. Many professional guidelines suggest that organizations can take a step to become more LGBTQ culturally competent by adopting certain policies, such as prohibiting employment discrimination on the basis of sexual orientation or gender identity, and including sexual orientation and gender identity in the organization's code of conduct with youth (in terms of providing guidelines on how staff should treat LGBTQ youth) (Crisp & McCave, 2007; S. K. Fisher et al., 2012). These policies related to LGBTQ issues in organizations may contribute to an understanding of a direct-care worker's LGBTQ cultural competency (Clark et al., 2001). Therefore, eight questions were constructed to ascertain policy climate, including questions like "Does your organization have any specific policy or guidance

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on working with LGBTQ clients?" and "Does your agency provide employment non-discrimination protection for LGBTQ employees?" They were answered using a Yes=1, No=0 and Don't Know=0 format.

Research Question #6: Is the measure related to other measures concerning training or competency in workers or the work environment? The next research question was directed at understanding whether or not this new measure is related to other measures that can be associated with training workers in the children's mental health field. It was answered using correlations between measures of related competencies and/or of the work environment and the new measure. The Pearson's r coefficient is used to answer whether two variables measured at the interval/ratio level are related, and in what direction are they related (negatively or positively) (Tabachnick & Fidell, 2007). Constructs included were: cultural competency (not LGBTQ-specific), attitudes toward adopting evidence based practices, organizational culture and climate, and job autonomy. These will each be explained next.

Cultural competency. It is unknown to what degree the construct of LGBTQ-specific cultural competency is related to the general construct of cultural competency (*e.g.*, not specific to any one culture or population). The California Brief Multicultural Competence Scale (CBMCS) was used to measure cultural competence (Gamst et al., 2004). Studies that established its psychometric properties specifically included direct-care mental health professionals (Gamst et al., 2004), thus making it an ideal scale for use in the present study. The authors of the CBMCS used several measures of multicultural counseling available at the time to create a composite measure. The underlying model for this new measure is the Cross-Cultural Counseling Competency Model, which was declared by the APA Division 17 to be the model used by psychology educators and practitioners (Sue et al., 1992). The model includes 11

competencies in three broad areas of attitudes/beliefs, knowledge, and skills. The measure consists of four subscales: Nonethnic ability, Awareness of cultural barriers, Multicultural knowledge, and Sensitivity to consumers, and the authors note that these roughly approximate the three-domain model used across many multicultural competency measures (beliefs/attitudes, knowledge, skill). It consists of 21 self-report items, with response options in a Likert-type format ranging from 4=strongly agree to 1=strongly disagree. Some examples of items are: "I am aware that counselors frequently impose their own cultural values on minority clients," "I am aware that being born a White person in this society carries with it certain advantages," and "I have an excellent ability to assess accurately the mental health needs of gay men." In a validation study by the scale's authors, Cronbach's alpha on the subscales ranged from 0.75 to 0.90 (Gamst et al., 2004).

Adoption of evidence based practices. A measure of willingness to adopt evidence-based practices could help to understand if LGBTQ cultural competency correlates with a willingness to evaluate controversial issues systematically and use data to drive service decisions. Knowledge about a worker's attitude toward adopting a new practice could be helpful in the context of LGBTQ cultural competency since LGBTQ issues are still relatively new to the children's mental health field. This was investigated using the Evidence Based Practice Adoption Scale (EBPAS) by Aarons (2004), which is a 15-item scale with 4 sub-scales. Respondents are asked to indicate the extent to which they agree with each item, using a 4-point Likert-type scale. The four domains it consists of are defined as: (1) intuitive appeal of innovation; (2) attitudes toward organizational requirements; (3) openness to innovation; and (4) perceived divergence between current and new practices. Examples of items include: "If you received training in a therapy or intervention that was new to you, how likely would you be to

adopt it if it was required by your agency?" (requirements subscale), "If you received training in a therapy or intervention that was new to you, how likely would you be to adopt it if it 'made sense' to you?" (appeal subscale), "I like to use new types of therapy/interventions to help my clients" (openness subscale), and "Research based treatments/interventions are not clinically useful" (divergence subscale). A validation study by the scale's author found the Cronbach's alpha for the entire scale to be 0.77 (Aarons, 2004).

Autonomy. It is not known whether workers with more job autonomy use more LGBTQ cultural competency, or if the opposite is true. Job autonomy is defined as the perceived amount of control that the worker "has over how they perform tasks, and the degree to which they operate independently" (Aarons, Sommerfeld, Hecht, Silovsky, & Chaffin, 2009, p. 271). Job autonomy was measured in a similar fashion to Aarons and colleagues' study that involved direct-care workers in children's mental health (2009). Three items from the self-determination subscale by Spreitzer (1995) were used (for example: "I have significant autonomy in determining how to do my job"), and one item from the job autonomy subscale of the Job Diagnostic Survey (JDS) ("I use my personal initiative or judgment in carrying out the work") (Hackman & Oldham, 1975; Sams, 2005). Response categories are on a 7-point Likert-type scale.

Culture and climate. The organizational context is important when considering the degree to which direct-care workers adopt LGBTQ culturally competent practices. As Glisson states, "the organizational context of mental health services is believed to affect whether new treatments and service protocols are adopted, how they are implemented, and whether they are sustained and effective" (2002, p. 234). Organizational climate and culture are understood as two distinct constructs. Climate refers to the way that the individual employee perceives the impact of his/her

work environment on his/her well-being (Glisson & James, 2002). Thus it has an individual nature to it and a psychological nature to it. Culture is defined as the expectations, norms, and acceptable ways of doing things in an organization. Culture can be separated further into two dimensions: constructive culture and defensive culture. Constructive culture serves the higher order needs of employees by encouraging innovative thinking and taking risks on new ideas (Glisson & James, 2002). Defensive culture serves lower order needs of employees by encouraging a status quo and discouraging employees from trying new things (Glisson & James, 2002). Organizational culture constructs were measured using items adapted from Glisson and James' work (2002) on organizational constructive culture (example: "The agency where I work pursues a standard of excellence") and passive-defensive culture (example: "At the agency where I work, employees are expected to do as they are told."). Organizational climate construct was measured using items adapted from Cooke and Szumal (1993) such as "I worry that this job is hardening me." There were a total of 9 items, with response options in Likert fashion from 1=strongly disagree to 5=strongly agree.

Chapter 5: Results

Introduction

The purpose of this study was to develop and test a new measure that addressed two main gaps in the measurement literature: a measure that assessed LGBTQ cultural competencies related to practice with youth and a measure that was relevant to the roles and responsibilities of direct-care workers. To accomplish this, it is focused on the research questions outlined in the previous chapter. The processes used to achieve this purpose included creation of a pool of items that were presented to stakeholder groups for review and input. Then data on the survey were collected online from a set of individuals who worked in behavioral health settings. The survey included the newly created measure as well as several other measures used to test the validity of the new measure and to provide insight into how the new measure is related to other constructs associated with training or competency of workers or of the work environment. The previous chapter provided details on the methodology used for each step in the research process, and this chapter presents the results of the survey.

The results of the survey data are presented as follows. First, response rate and final sample size are discussed. Then the results of pre-screening steps are presented, followed by demographics of the final analytical sample. The frequencies of responses to the new scale items are presented along with an explanation of the scoring for the items and an explanation of items excluded from the analysis. Then, results follow the format of the research aims and questions, starting with aim #1 which was to validate the new measure and aim #2 which was to compare the new measure to other indicators of workforce competency. Under each research aim, the associated research questions are presented along with the analyses used to answer each

question. The organization of these analyses is explained prior to the presentation of the associated results.

Response Rate

The response rate is not known for this study because the size of the sampling frame is not known. Chapter 4 described the methods used to recruit participants, and part of the recruiting strategy was to allow agencies to participate without notifying the researcher. Thus it is not known exactly how many of the 105 agencies participated, nor is it known how many staff members in each participating agency were invited to participate.

Sample Size

There were a total of 191 respondents who were eligible for and began the survey. 184 respondents completed all demographic questions. 6 respondents did not begin the first page of the survey after the demographics (n=178). 149 respondents finished at least the portion of the survey that included the new measure's items. 132 respondents completed the entire survey. The total attrition from the beginning of the survey to the end was approximately 31%. The reason for such a high attrition rate is not known, but potential reasons include: the length of the survey (196 fields, 20 separate screens or pages online), the time required to complete the survey (it was estimated to take 20-30 minutes, but for some respondents this could have been longer), the incentive was not alluring enough (a weekly drawing for $50 Amazon.com gift cards), lack of interest in the survey topic, or failure to use the "save and return later" feature offered in the REDCap software.

In order to identify only relevant respondents (those who were likely to have substantial contact with youth), both the job title and agency role were compared against each other. If a response seemed to be misclassified in the agency role variable based on the job title provided, I

reclassified it to the appropriate category. The changes resulted in reclassifying 15 responses, plus 17 more that selected "other" and wrote in their own agency role. For example, a Director categorized himself/herself as a direct-care worker, so that respondent was re-categorized to be a support/administrator role. Also, for those who selected "other" in the agency role question, the author examined what input they specified and used that to determine where they might fit in the category schema. For example, someone who chose "other" for agency role and wrote that they are a Peer Support Specialist was re-categorized to be a direct-care worker because Peer Support Specialists are typically not required to have advanced degrees or licenses. Next, only respondents in the agency roles Direct-Care, Licensed Clinician, or Medical Provider were selected to create the sample for use in analyses. This resulted in narrowing the sample size to n=131, which excludes respondents who are in a clerical, administrative, or administrative support role.

To ensure that there were no significant differences between the direct-care workers and the licensed clinicians and medical professionals, their scores were compared to each other to find any statistically significant differences using a one-way ANOVA. The DV's were the LGBTQY-CC, the GAP-S, the job autonomy scale, the Transphobia scale, the Beliefs about sexual orientation scale, the adopting evidence based practices scale, the CBMCS, and the organizational culture and climate scale. The IV was agency roles, defined as direct care, licensed clinician, or medical professional. The ANOVA resulted in no significant differences among groups. This finding supports the assumption that inclusion of the licensed clinicians and medical professionals did not impact the validity of the study sample for the purpose of testing the new instrument.

Pre-Screening

Items were pre-screened for assumptions that are important for analysis, including pattern of missing data and outliers.

Missing data. The survey was formatted so that respondents must provide an answer to each question, even if their response was "don't know." It was formatted that way (with required responses) to avoid missing values. Thus, most of the survey had no real missing values except when a participant dropped out of the survey. These real missing values were examined in order to identify whether there were any patterns to what types of respondents dropped out of the survey. The assumption of data missing at random is important because if values are not missing at random, it could suggest that a failure to provide an answer on an item is related to an attribute or characteristic about that respondent (Tabachnick & Fidell, 2007).

Missing data were evaluated by dummy coding responses to 1=missing and 0=not missing. Then a bivariate correlation was conducted for all items in the survey. Data can be considered missing at random if there are no significant correlations (Dattalo, 2013). Correlations were patterned in such a way to suggest that the data were not missing at random. Demographic variables that had statistically significant correlations with missing data on at least one item were: medical professionals (highest r=.157, p<.05), High school or equivalent level of education (highest r=.217, p<.01), Social work educational discipline (highest r=.166, p<.05), Residential short-term/crisis program type (highest r=.216, p<.01), Outpatient program type (highest r=.178, p<.05), and more conservative political ideology (highest r=.189, p<.05). The finding of a correlation with conservative political ideology makes sense because those participants may have had political views that were not in support of LGBTQ issues and therefore did not have motivation to continue a survey that supported LGBTQ youth. However,

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some of these demographic variables have no clear explanation for why there was a pattern for the respondent having dropped out of the survey early. One explanation for this could be that interested participants wanted to first look at the survey before taking it; therefore, they began the survey but then did not finish it. Another explanation is respondent fatigue due to the length of the survey which included 196 fields in total (20 pages). This would not just affect responses near the end of the survey because participants could see how many pages were completed out of the total (*i.e.*, page 6 of 20); so, given that they could see their progress, they may have decided that it was taking too long to complete the survey, and they predicted that they did not want to or did not have time to complete the entire survey.

There are two common methods for handling missing data: replacing missing values with the mean (imputation) or list-wise deletion. Typically, imputation is used when data are missing at random (Dattalo, 2013). However, these data are not missing at random, so imputation is not a good option. The most conservative method for dealing with missing data when they are not missing at random is to use list-wise deletion (Dattalo, 2013). Therefore, only cases that had no real missing data on the new measure were included in the psychometric analyses so that the factor analysis could be conducted, giving a sample size of n=114 (which eliminated 17 observations).

Outliers. Outliers are observations that are unusual or extreme and appear to be inconsistent with other observations in a data set (Dattalo, 2013). Outliers can distort factors in a factor analysis and substantially influence coefficients in correlational or regression analyses. Thus it is important that outliers are screened out of the data (Dattalo, 2013). Outliers were identified using the Cook's D distance method wherein Cook's D (a measure that provides an impact of an observation on an estimated regression coefficient) is calculated and a cutoff score

is used to identify outliers (Lorenz, 1987). One method of identifying outliers with Cook's D is to use a cutoff score of Cook's D>1. Only 1 observation had a Cook's D value of greater than 1 (D=21.285). All other outliers were not greater than 1 (the highest value for D among the other outliers was 0.07119). Given that criterion, it can be assumed that only 1 outlier may significantly impact the results of the analysis, and it was eliminated from the analysis, resulting in n=113 observations.

Demographics

Table 7 provides details on all demographics discussed here. The majority of participants' gender identity was female (77.9%) and one individual identified as genderqueer. The average age of respondents was 38, and ages ranged from 23 to 66. There were 16.9% non-heterosexual respondents (*e.g.*, identified as something other than straight or heterosexual). Almost 60% of participants identified as white or Caucasian and 31% identified as black or African-American. Almost 40% had less than a master's degree level of education. Most respondents had majored in human services related fields. The types of disciplines that were most frequently represented were social work (29.2%) and a category that included psychology, counseling, or marriage and family therapy (28.3)%,followed by a social sciences category that included human services, sociology, and political science (15.9%). Most respondents were in a direct-care role within their agency (61%). Program types most represented were in-home treatment (27.4%) followed by long-term residential (20.4%), community-based treatment (11.5%), and inpatient short-term treatment (10.6%). Most respondents worked at agencies that served 500 or fewer clients per year (55.7%). The average number of years that respondents worked at their current agency was 3.85 with a range of 0-26, and the average number of years in the field of children's mental health services was 9.68 years.

Table 7: Demographics

Variable	Frequency	Percentage
Age		
Range 23-66		
Mean (SD) 38 (11.04)		
Gender		
Female	88	77.9
Male	24	21.2
Genderqueer	1	.9
Sex		
Female	89	78.8
Male	24	21.2
Sexual Orientation		
Lesbian, gay, or homosexual	10	8.8
Straight or heterosexual	94	83.2
Bisexual	8	7.1
Queer	1	.9
Race		
Black or African-American	35	31.0
Hispanic or Latino/a	2	1.8
Mixed-race or Bi-racial	5	4.4
White or Caucasian	67	59.3
Prefer not to answer	4	3.5
Level of education		
Some college	5	4.4
2-Year College Degree or Technical Degree	3	2.7
4-Year College Degree	37	32.7
Graduate degree	58	51.3
Post-Grad. Degree (MD, PhD, PsyD, DSW, *etc.*)	10	8.8
Agency Role		
Direct-care, front-line, or paraprofessional	69	61.1
Licensed Clinician	36	31.9
Medical provider	8	7.1
Program Type		
Inpatient, short term (hospitalization, crisis stabilization)	12	10.6
Residential, short term (crisis shelter, respite, emergency foster care, typically less than 30 days)	6	5.3
Residential, long term (foster care, therapeutic foster care, group home, residential treatment facility, typically more than 30 days)	23	20.4
Day treatment	11	9.7

		9	8.0
School-based day treatment		9	8.0
In-home treatment		31	27.4
Community-based treatment (case management, community support)		13	11.5
Outpatient		5	4.4
Other		3	2.7
Agency Tenure (in years)			
Range 0-26			
Mean (SD) 3.85 (4.947)			
Field Tenure (in years)			
Range 0-26			
Mean (SD) 9.68 (7.120)			

Item Distributions. Table 8 shows frequencies for all items in the new scale, grouped by response option wording, including a Likert-style of five degrees of Untrue/True, Disagree/Agree, and Never/Always. In this section, scoring of the new scale will be explained along with a discussion of some items that were excluded from the analyses of research aims #1 and 2.

Table 8: Frequencies of scale items

	Very Untrue	Untrue	Neither True/ Untrue	True	Very true	Don't Know
1. Becoming LGBTQ is a process that unfolds over time.	5	12	32	45	11	8
4. A youth could be dealing with LGBTQ issues secretly without anyone else knowing about it.	4	1	2	24	82	0
6. LGBTQ youth have the same types of life goals and dreams for their future as do heterosexual/non-transgender youth.	3	0	5	22	83	0
7. Being LGBTQ brings with it certain challenges that heterosexual and/or non-transgender people do not have to face.	3	1	3	44	61	1
*8. LGBTQ youth are LGBTQ because of their childhood history of abuse/neglect/poor parenting.	47	31	25	4	1	5

	Strongly Disagree	Disagree	Neither Agree/ Disagree	Agree	Strongly Agree	Don't Know
*9. When youth think they might be gay/lesbian/bisexual, it is just a phase they will grow out of.	29	45	28	2	2	7
*10. When youth think they might be transgender, it is just a phase they will grow out of.	31	50	24	1	0	7
*11. Adolescents (ages 12-17) are not old enough to know whether they are gay/lesbian/bisexual or straight.	39	53	13	3	0	5
*12. Children (ages 5-11) are too young to be thinking about whether they are gay or straight.	26	41	26	12	1	7
*13. Adolescents (ages 12-17) are not old enough to know whether they are transgender or not.	34	54	14	3	0	8
*14. Children (ages 5-11) are too young to be thinking about whether they are transgender or not.	24	48	16	17	1	7
*15. Youth will come out as LGBTQ just to copy other youth who are coming out.	21	41	37	9	1	4
*16. Youth say they are LGBTQ to get attention.	20	43	40	6	0	4
*17. Youth act gay (feel attracted to the same-sex) when they are isolated from the opposite sex, like in an all-girls or all-boys group home.	37	41	19	6	0	10

	Strongly Disagree	Disagree	Neither Agree/ Disagree	Agree	Strongly Agree	Don't Know
2. Even if LGBTQ issues are not addressed in a youth's treatment plan or goal, acknowledging their LGBTQ identity is still an important part of how to provide good treatment.	1	2	9	41	59	1
*3. In my job, I interact with youth because of their mental health problems not because of their sexual orientation/gender identity, so I do not talk about LGBTQ issues with youth I interact with.	11	51	27	19	4	1
*18. I believe that being LGBTQ is a sin.	63	18	10	13	6	3
*19. I think it is best for boys to act like boys and girls to act like girls.	34	32	34	8	5	0
*20. Youth should not be encouraged to be lesbian, gay, bisexual.	18	21	47	14	11	2
*21. Youth should not be encouraged to be transgender.	18	20	47	15	10	3

*22. A youth's family should discourage their child's decision to identify as LGBTQ.	49	34	26	3	1	0
*23. An LGBTQ youth who needed foster care services would be best served in a highly religious foster home so they can get set straight.	72	29	11	1	0	0
25. I would be comfortable if a client came out to me as LGBTQ.	1	1	4	45	62	0
*26. Bisexual youth are just not sure whether they are gay or straight.	23	54	24	8	0	4
*27. In general, LGBTQ people are mentally unstable.	63	43	5	1	0	1
*28. LGBTQ youth are sexually promiscuous.	41	45	21	4	0	2
*29. Questioning youth should just make up their mind, are they gay or straight?	41	47	20	2	1	2
*30. Youth who question their gender should just make up their mind, are they a boy or a girl?	46	41	20	3	2	1
31. I attempt to learn and use terms that reflect LGBTQ youth culture so that I communicate more effectively with youth that I interact with.	0	4	13	56	37	3
32. I screen books, movies, and other media resources for negative stereotypes about LGBTQ persons before sharing them with youth I interact with.	1	18	23	43	24	4
33. I would put an LGBTQ-affirming sticker on the space that I work in if given the opportunity, or I have already.	9	20	28	28	25	3
34. Any youth I interact with should be allowed to engage in gender non-conforming activities (for example, a boy painting his toenails, or a girl dressing in boy clothing).	0	2	22	49	39	1
38. When possible, I do or would connect an LGBTQ youth to LGBTQ resources in the community.	1	1	9	45	57	0
42. I recognize that even when I have good intentions, I can still do or say things that may be hurtful to LGBTQ youth.	3	10	15	57	28	0
43. I am comfortable using the words gay, lesbian, bisexual, and transgender.	1	3	7	48	52	2
44. I am comfortable using the word queer when a youth identifies as queer.	9	27	16	29	30	2
*45. In my job I do not talk to youth about sex or dating, so LGBTQ issues do not apply to my interactions with youth.	30	53	18	8	4	0
*50. I assume a youth is straight/heterosexual	4	31	41	34	2	1

	Never	Rarely	Sometimes	Often	Always	Don't Know
unless they tell me otherwise.						
*51. I assume a youth is not transgender unless they tell me otherwise.	4	26	35	42	5	1
5. If a youth tells me that they are LGBTQ, I avoid sharing that information without their permission.	2	3	6	12	89	1
*18a. If Yes: I tell youth that I interact with that being LGBTQ is a sin.	17	1	1	0	0	0
24. I do not assume that a lesbian, gay, or bisexual youth who is the same sex as me is attracted to me.	11	1	2	5	91	3
35. If a youth wants to use a different gendered name than their given name, I agree to do what they ask (for example, a youth whose given name is James but wishes to be called Christina).	6	3	14	17	63	10
36. I intervene when youth I interact with tell me they have been bullied because of actual or perceived sexual orientation or gender identity.	0	0	16	23	71	3
37. I intervene when I hear co-workers use derogatory language or insinuations about LGBTQ persons in front of youth I interact with.	0	1	12	24	69	7
39. If a transgender youth who was a boy and now identifies as a girl needs to use the bathroom, and asks to use the girls bathroom, I would allow them to use whichever bathroom is most comfortable for them.	8	2	18	18	32	35
40. I think about how my words/actions could be seen as discriminatory against lesbian, gay, and bisexual people.	3	6	11	30	63	0
41. I think about how my words/actions could be seen as discriminatory against transgender people.	4	4	15	31	58	1
46. I see/hear co-workers at my agency saying/doing prejudiced or discriminatory things about lesbian/gay/bisexual people.	50	34	21	5	1	2
46a. If Yes: I intervene when this happens.	0	6	17	26	10	2
47. I see/hear co-workers at my agency saying/doing prejudiced or discriminatory	66	26	14	4	1	2

things about transgender people.						
47a. If yes: I intervene when this happens.	0	4	15	16	9	1
48. I see/hear youth at my agency making fun of lesbian, gay, bisexual people or teasing other youth about being lesbian, gay, or bisexual.	54	19	28	10	1	1
48a. If Yes: I intervene when this happens.	1	1	9	13	34	0
49. I see/hear youth at my agency making fun of transgender people or teasing other youth about being transgender.	64	19	20	5	1	4
49a. If Yes: I intervene when this happens.	0	0	3	6	10	26
*=reverse coded						

Scoring. The response option of "don't know" was available to respondents, and it was chosen at a rate of 0% to 8.8%, with the exception of one item, #39, which had a 35% frequency for the "don't know" response. The text of item 39 is: "If a transgender youth who was a boy and now identifies as a girl needs to use the bathroom, and asks to use the girls bathroom, I would allow them to use whichever bathroom is most comfortable for them." A reason why the "don't know" response was so high for this item might be because respondents may have never encountered this scenario before; therefore, they answered based on their own experience rather than in a hypothetical sense. Another potential reason for the high response of "don't know" could be related to feedback from the worker stakeholder group during the development phase of the present study. The worker stakeholder review group gave feedback on item #39, stating that it may be difficult to answer because oftentimes workers do not have the ability to decide which bathroom a child uses, so it is outside of their power or ability. There were three viable options for how to score these answers of "don't know": (1) they could be replaced with a score of zero; (2) they could be replaced with a neutral score on the 5-point Likert scale (the value 3); or (3) they could be treated as missing and be replaced by imputation of the item mean. If the first option was used, it would imply that a response of "don't know" would be given zero points towards being culturally competent, which would be even fewer points than the "worst" answer

for each particular item, meaning that answering "don't know" is worse than a respondent saying that they "never" use LGBTQ cultural competency. That did not make sense conceptually, so the option of giving the "don't know" scores either a neutral score or a mean score was the better option. Analyses were conducted with both the mean and the neutral score and the results were identical, so the mean score option was chosen so as to better reflect the actual distribution of each item.

Items excluded from analysis. A series of items in the survey involved stop-logic formatting (or branching logic), meaning that only some respondents would be able to answer those questions. In the survey, these items were prompted after items that asked the respondent if they ever witnessed LGBT discriminatory actions by co-workers and youth. If a respondent answered with "rarely", "sometimes", "often", or "always" to the item, then the respondent was prompted with a second item asking how often they intervened when they witnessed those discriminatory actions. These items were formatted with stop-logic because of the idea that it would be important to distinguish between an individual's ability to detect discrimination and the individual's ability to intervene upon detection of a discriminatory event or action. It did not make sense to ask respondents how often they intervene if they never witness discrimination, so the stop-logic format was chosen in order to avoid asking a respondent a question that did not apply. This stop-logic format became problematic during the analysis because it meant that there were missing values for the respondents who did not have the opportunity to answer. The series of items are in Table 9, along with their frequencies. The stop-logic items are labeled with an "a" after the number (*e.g.*, item 46a is the stop-logic item associated with item 46).

Table 9: Series of items with stop-logic.

Item	Never	Rarely	Sometimes	Often	Always	Don't Know	Missing
46. I see/hear co-workers at my agency saying/doing prejudiced or discriminatory things about lesbian/gay/bisexual people.	50	34	21	5	1	2	0
46a. If Yes: I intervene when this happens.	0	6	17	26	10	2	52
47. I see/hear co-workers at my agency saying/doing prejudiced or discriminatory things about transgender people.	66	26	14	4	1	2	0
47a. If yes: I intervene when this happens.	0	4	15	16	9	1	68
48. I see/hear youth at my agency making fun of lesbian, gay, bisexual people or teasing other youth about being lesbian, gay, or bisexual.	54	19	28	10	1	1	0
48a. If Yes: I intervene when this happens.	1	1	9	13	34	0	55
49. I see/hear youth at my agency making fun of transgender people or teasing other youth about being transgender.	64	19	20	5	1	4	0
49a. If Yes: I intervene when this happens.	0	0	3	6	10	26	68

Another problematic issue arose with the interpretation of the four root items (items 46, 47, 48, and 49) because they may have been interpreted by respondents in unintended ways. They were worded in such a way that the respondent could have been answering either about their organization's climate in relation to LGBTQ issues, or the respondent could have been answering based on their own level of awareness. For instance, if a respondent answered "Never" to item 46 "I see/hear co-workers at my agency saying/doing prejudiced or discriminatory things about lesbian/gay/bisexual people," then one of two things could be true: either the respondent is oblivious to the presence of LGB discrimination in the every-day workplace setting, or the organizational climate is truly 100% free of LGB discrimination. Another example is with the "Rarely" answer. If a respondent choose "Rarely" for item 46, does it mean that the respondent rarely notice the discrimination that is really there, or is there truly

only a rare instance of LGB discrimination? Clearly, these items were not worded well and became problematic to interpret.

There was also a stop-logic situation for a series of items that asked about the respondent's religious beliefs in relation to LGBTQ identity. The first item asked the respondent the degree to which they agreed with the statement that being LGBTQ is a sin, and the stop-logic was a follow-up item for those who answered "agree" or "strongly agree." Again, the stop-logic was used because it seemed conceptually important to distinguish between a person who holds certain religious beliefs but does not impose them on their clients, versus the person who does impose their religious beliefs on the client. If the respondent did not hold such a belief, then it made sense to not ask them whether or not they share that belief with the youth in their care, thus the stop-logic format was used. The items and their frequencies are in Table 10.

Table 10: Items with stop-logic regarding religious belief.

Item	Strongly Disagree	Disagree	Neither Agree/ Disagree	Agree	Strongly Agree	Don't Know	Missing
*18. I believe that being LGBTQ is a sin.	63	18	10	13	6	3	0

	Never	Rarely	Sometimes	Often	Always	Don't Know	Missing
*18a. If Yes: I tell youth that I interact with that being LGBTQ is a sin.	17	1	1	0	0	0	94
*=reverse coded							

These stop-logic items became problematic because the missing value ratio was much higher than the rest of the survey and missing values were, by design, correlated with the stem questions. If these items with stop-logic were retained, one option was to replace the missing

value with the item mean. However, this was problematic because of the high number of missing values. Another option was to list-wise delete from the survey those respondents with missing values on those items, but again this became problematic because it would significantly reduce the sample size and it would systematically alter the remaining distribution of scores by excluding respondents with certain scores on certain items. A final option was to eliminate those stop-logic items from the analyses. This was considered the best option because it provided a solution that did not alter the distribution of the remainder of the items and it did not reduce the sample size. Removal of these items could be seen as problematic because the conceptual ideas that these items represented would no longer be present in the analyses of these data. However, that limitation was far less impactful than the limitations imposed by the other options, so it was decided to eliminate those items from the remainder of the analyses. The changes summarized above resulted in a total of 47 items included in the analyses of the new measure.

Research Aim #1 Results

Research aim #1 was, "to what extent can a measure capture the variability of cultural competence in direct-care behavioral health workers as it related to LGBTQ issues in youth?" The goal of this first aim was to validate the new measure, and to reduce the number of items. Therefore, the analyses used to meet this aim were: Cronbach's alpha, factor analysis, correlation with previously tested instruments, and correlation with a measure of social desirability. The results will be presented in the order of the research questions associated with this research aim.

Research Question #1: Internal Consistency. The coefficient alpha test was used to assess for internal consistency. Cronbach's alpha coefficient (Cronbach, 1951) is a statistic used to test for the internal consistency of a measure by indicating the amount of covariance items in a measure share (Gardner, 1995). Cronbach's alpha was 0.94 for all 47 items, which is very good.

Research Question #2: Factor Analysis. Research question #2 was, "what is the underlying factor structure of the measure?" and a follow-up question of "does the factor structure support a multi-dimensional model that aligns with my conceptual model of cultural competency?" Results for this section will include an explanation of the factorability of the new measure, the number of factors in the analysis, factor loadings in the factor analysis solutions, factor name for the results of the factor analysis, and composite scores for the new measure.

Factorability. The KMO coefficient is used to determine the homogeneity of the variables in the measure, meaning whether or not they are all items that reflect the same construct (Kaiser & Rice, 1974). The KMO was 0.789 which is middling according to Kaiser and Rice, suggesting that the factorability is moderate.

Number of factors. A scree plot is interpreted by visually inspecting the plots of eigenvalues and determining at what point the line graph flattens out (Dattalo, 2013). When the line flattens out, this means that the eigenvalue changes from one factor to the next are small, and the subsequent factors' eigenvalues approach a slope of zero. According to the scree plot in Figure 3 it appeared that a 4 factor solution would be best. However, to investigate this further, PAF's were conducted retaining factors of 1, 2, 3, 4, and 5 to investigate the underlying structure of this new measure.
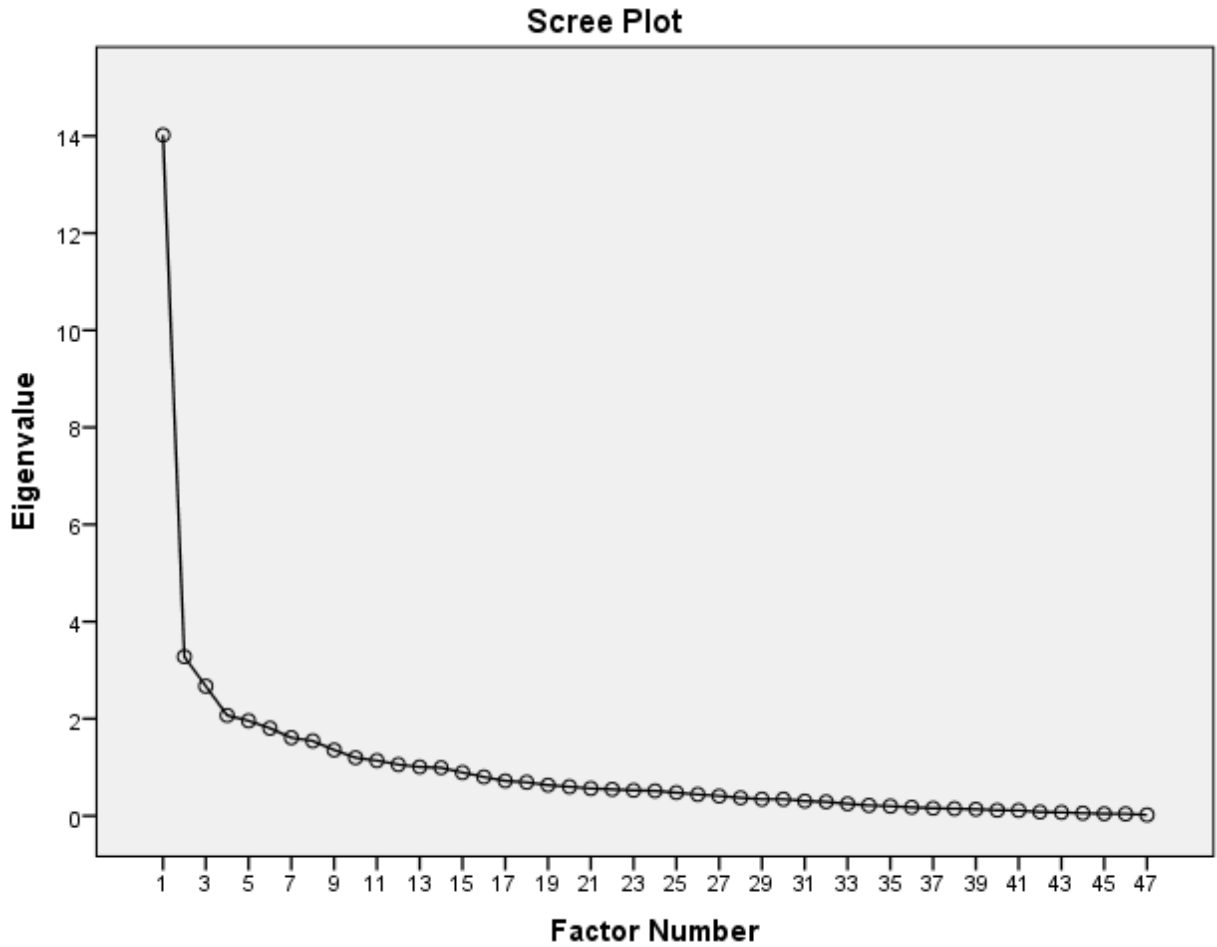
Figure 3: Scree plot for factor analysis

The factor solutions were examined to determine which provided the most interpretable and parsimonious solution. This was achieved using a number of steps, starting with the eigenvalues and variance explained for each factor solution. The variance explained was then compared across all factor solutions to consider whether each solution added considerably more information than the other solutions. Table 11 provides the eigenvalues and percent of variance explained for each rotated factor solution.

Table 11: Total variance explained for each rotated factor solution.

Number of Factors Specified	Factor Number	Rotated Sums of Squared Loadings		
		Total	% of Variance	Cumulative %
1[a]	1	13.407	28.525	28.525
2	1	10.000	21.276	21.276
	2	6.051	12.875	34.150
3	1	10.928	23.251	23.251
	2	4.369	9.296	32.547
	3	2.981	6.342	38.890
4	1	8.385	17.840	17.840
	2	5.294	11.264	29.104
	3	3.223	6.857	35.961
	4	3.140	6.680	42.641
5	1	8.221	17.492	17.492
	2	5.105	10.862	28.354
	3	3.079	6.551	34.905
	4	3.023	6.433	41.338
	5	2.267	4.824	46.162

[a] The unrotated solution is presented because the solution could not be rotated due to having only 1 factor specified in the analysis.

Although the explained variance increased with each additional factor in the overall solution, there were only 2 or 3 items loading onto factors 3, 4, and 5. Thus the scree plot was revisited and it was determined that the scree plot could also be interpreted using a 1 factor solution with several smaller factors, but these smaller ones would likely be unstable due to having only 2-3 few items loading on them. Although the 2-factor solution had more than 3 items loading on the second factor, the scree plot supported the assumption that the first factor was an adequate representation of the variance in these data because of how sharply the scree line drops from factor 1 to factor 2, and then how the scree line flattens out considerably starting after factor 2. For these reasons the factor loadings in the 1-factor model provided the most interpretable solution for these data. In none of the multi-factor solutions did the factors clearly

group items in a way that distinguished the a priori categories of knowledge, skills, awareness, and attitudes. Rather, these were mixed together across factors in the various solutions.

Factor loadings. Using the criterion of retaining items with factor loadings of 0.5 or higher, 20 items were eliminated from the final instrument. Items that failed to meet the 0.5 criterion are in Table 12 along with their factor loadings and communality value in the 1 factor solution. Items that had a factor loading of 0.5 or higher and thus were retained for the final scale are in Table 13. This resulted in a final instrument with 27 items.

Table 12: Items that were eliminated from the final scale (factor loadings of less than 0.5).

Item	CC Domain	Item text	Factor Loading
21	Attitude	Youth should not be encouraged to be transgender.	.489
31	Skill	I attempt to learn and use terms that reflect LGBTQ youth culture so that I communicate more effectively with youth that I interact with.	.489
45	Awareness	In my job I do not talk to youth about sex or dating, so LGBTQ issues do not apply to my interactions with youth.	.488
39	Skill	If a transgender youth who was a boy and now identifies as a girl needs to use the bathroom, and asks to use the girls bathroom, I would allow them to use whichever bathroom is most comfortable for them.	.449
35	Skill	If a youth wants to use a different gendered name than their given name, I agree to do what they ask (for example, a youth whose given name is James but wishes to be called Christina).	.427
03	Knowledge	In my job, I interact with youth because of their mental health problems not because of their sexual orientation/gender identity, so I do not talk about LGBTQ issues with youth I interact with.	.417
07	Knowledge	Being LGBTQ brings with it certain challenges that heterosexual and/or non-transgender people do not have to face.	.388
51	Awareness	I assume a youth is not transgender unless they tell me otherwise.	.388
50	Awareness	I assume a youth is straight/heterosexual unless they tell me otherwise.	.370
32	Skill	I screen books, movies, and other media resources for negative stereotypes about LGBTQ persons before sharing them with youth I interact with.	.324

04	Knowledge	A youth could be dealing with LGBTQ issues secretly without anyone else knowing about it.	.288
41	Awareness	I think about how my words/actions could be seen as discriminatory against transgender people.	.259
40	Awareness	I think about how my words/actions could be seen as discriminatory against lesbian, gay, and bisexual people.	.256
37	Skill	I intervene when I hear co-workers use derogatory language or insinuations about LGBTQ persons in front of youth I interact with.	.254
05	Knowledge	If a youth tells me that they are LGBTQ, I avoid sharing that information without their permission.	.216
06	Knowledge	LGBTQ youth have the same types of life goals and dreams for their future as do heterosexual/non-transgender youth.	.214
42	Awareness	I recognize that even when I have good intentions, I can still do or say things that may be hurtful to LGBTQ youth.	.210
24	Attitude	I do not assume that a lesbian, gay, or bisexual youth who is the same sex as me is attracted to me.	.144
36	Skill	I intervene when youth I interact with tell me they have been bullied because of actual or perceived sexual orientation or gender identity.	.132
01	Knowledge	Becoming LGBTQ is a process that unfolds over time.	-.025

Table 13: Items kept in final scale (factor loadings of greater than 0.5).

Item	CC Domain	Item text	Factor Loading
30	Attitude	Youth who question their gender should just make up their mind, are they a boy or a girl?	.773
29	Attitude	Questioning youth should just make up their mind, are they gay or straight?	.743
11	Knowledge	Adolescents (ages 12-17) are not old enough to know whether they are gay/lesbian/bisexual or straight.	.729
19	Attitude	I think it is best for boys to act like boys and girls to act like girls.	.727
22	Attitude	A youths family should discourage their childs decision to identify as LGBTQ.	.698
34	Skill	Any youth I interact with should be allowed to engage in gender non-conforming activities (for example, a boy painting his toenails, or a girl dressing in boy clothing).	.697
26	Attitude	Bisexual youth are just not sure whether they are gay or straight.	.692
18	Attitude	I believe that being LGBTQ is a sin.	.692
23	Attitude	An LGBTQ youth who needed foster care services would be	.669

		best served in a highly religious foster home so they can get set straight.	
13	Knowledge	Adolescents (ages 12-17) are not old enough to know whether they are transgender or not.	.658
10	Knowledge	When youth think they might be transgender, it is just a phase they will grow out of.	.657
14	Knowledge	Children (ages 5-11) are too young to be thinking about whether they are transgender or not.	.656
08	Knowledge	LGBTQ youth are LGBTQ because of their childhood history of abuse/neglect/poor parenting.	.655
27	Attitude	In general, LGBTQ people are mentally unstable.	.647
15	Knowledge	Youth will come out as LGBTQ just to copy other youth who are coming out.	.646
38	Skill	When possible, I do or would connect an LGBTQ youth to LGBTQ resources in the community.	.644
44	Awareness	I am comfortable using the word queer when a youth identifies as queer.	.641
12	Knowledge	Children (ages 5-11) are too young to be thinking about whether they are gay or straight.	.636
17	Knowledge	Youth act gay (feel attracted to the same-sex) when they are isolated from the opposite sex, like in an all-girls or all-boys group home.	.614
33	Skill	I would put an LGBTQ-affirming sticker on the space that I work in if given the opportunity, or I have already.	.602
28	Attitude	LGBTQ youth are sexually promiscuous.	.567
09	Knowledge	When youth think they might be gay/lesbian/bisexual, it is just a phase they will grow out of.	.563
25	Attitude	I would be comfortable if a client came out to me as LGBTQ.	.551
43	Awareness	I am comfortable using the words gay, lesbian, bisexual, and transgender.	.539
16	Knowledge	Youth say they are LGBTQ to get attention.	.528
02	Knowledge	Even if LGBTQ issues are not addressed in a youths treatment plan or goal, acknowledging their LGBTQ identity is still an important part of how to provide good treatment.	.503
20	Attitude	Youth should not be encouraged to be lesbian, gay, bisexual.	.503

Factor name. Among the 27 items in the new scale, 11 were designed to assess knowledge; 3 assessed skills; 11 assessed attitudes, and 2 assessed awareness. Since there is only one factor and it cuts across all four domains in the conceptual model, this factor is simply called

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"attitudes, knowledge, skills, and awareness of cultural competency related to LGBTQ youth."
This new measure is named the LGBTQ Youth Cultural Competency scale (abbreviated as
LGBTQY-CC).

Composite scores. Composite scores were created based on the mean of the 27 items that
were retained based on their factor loadings. The alpha coefficient for the 27-item LGBTQY-CC
is =.946, which is very good. Even though the alpha for the 27-item version is similar to the 47-
item version, the 27-item version helps to reach the goal of a shorter measure for the sake of
reducing respondent fatigue in future uses of the measure. The frequency distribution of the
scores on the scale is displayed in a histogram, Figure 4. The LGBTQY-CC captured variability
as evidenced by the range of potential scores (1-5) versus actual scores (2.44-5). The mean for
this sample was 4.00 and the standard deviation was 0.55. The distribution shows some
skewness, with few respondents scoring in the lower range of the scale and over-representation
of the higher scores.
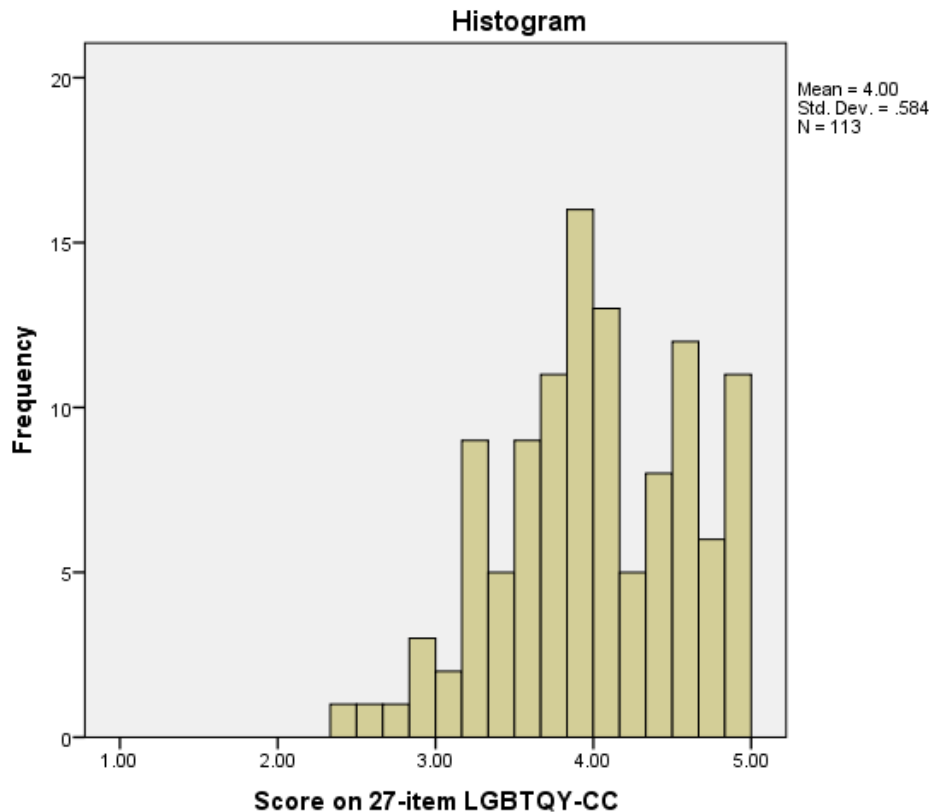
Figure 4: Distribution of composite scores after the factor analysis

Research Question #3: Social Desirability. Research question #3 was, "are items significantly influenced by social desirability?" To assess this, a correlation was calculated between the LGBTQY-CC and the social desirability scale. For the social desirability scale, the range of scores was 1-4 and the mean was 2.76 (SD=.843). The Pearson's r correlation between the two scales suggests that there is no significant correlation between LGBTQY-CC and social desirability (r=.071, p=.454, n=113).

Research Question #4: Concurrent Validity. Research question #4 was, "does the newly constructed scale correlate as expected with existing measures of gay affirmative practice and attitudes towards LGBTQ persons?" This question was answered using correlations with three scales: the Gay Affirmative Practice Scale Short Version, the Transphobia Scale, and the

Beliefs about Sexual Minorities scale. This section will present results of correlations conducted between the new measure and each of these scales.

Gay Affirmative Practice – Short Version. The GAP-20 was designed to measure beliefs and behaviors of gay affirmative practice. "Don't know" values were replaced by the mean for each item. Then the score for the scale was computed using the mean of all 20 items. The range for answers was 2.45-5 out of a possible 1-5 (higher score indicating more gay affirmative practice) and the mean was 4.27 (SD=.583). The Pearson's r was r=.619 (p<.001, n=113), suggesting good construct validity with this measure of beliefs and behaviors about gay affirmative practice.

Transphobia Scale. The transphobia scale was designed to measure the level of transphobia present in a respondent. "Don't know" values were replaced by the mean for each item. Then scores were calculated by computing the mean of all 9 items. The range was 1-6.89 out of a possible score of 7, with a higher score indicating more presence of transphobia and the mean was 2.71 (SD=.987). The Pearson's r correlation was r=-.693 (p<.001, n=99) which was in the expected direction, which suggests that the construct validity with the measure of transphobia is good.

Beliefs about LGB. The Beliefs about Sexual Minorities (BSM) scale was designed to assess beliefs about lesbians, gay men, bisexual men, and bisexual women. The scores for this single item scale ranged from 1 – 6, with a higher score indicating more positive beliefs about LGB individuals. The range of scores for these data was 3-6 (higher scores meaning more positive beliefs) and the mean was 5.32 (SD = .777). The Pearson's r correlation between the LGBTQ-CC and this scale was r=.664 (p<.001, n=99) which suggests that the new scale has good construct validity with this measure of beliefs about sexual minorities.

Conclusion. Results from this first research aim suggest that the new measure has good internal consistency and good construct validity. The 47-item measure was reduced to 27 items by interpretation of a factor analysis. These findings support the research aim that a measure could capture variability of LGBTQ cultural competency.

Research Aim #2 Results

Research aim #2 was, "How is this measure related to concepts related to behavioral health workforce competence and development?" It was answered by examining characteristics of workers, characteristics of organizations, a measure of organizational culture and climate, a measure of general cultural competency, a measure of willingness to adopt evidence based practices, and a measure of job autonomy. Results in this section are organized by research question and the analyses used to answer each respective research question.

Research Question 5: Regression. Research question #5 was, "does the measure vary systematically with characteristics of workers and organizations?" A multiple regression analysis was used to investigate what factors contribute to explaining the variance of the new measure, the LGBTQY-CC. The independent variables chosen for this analysis were: age, sex, race, sexual orientation, level of education, political ideology, personal social distance to LGBTQ individuals, personal sin belief about LGBTQ identities, organizational climate factors related to LGBTQ individuals, and organizational policies related to LGBTQ individuals. Gender identity was not included because there was only one response in a category other than male or female: the one observation was a write-in response, "genderqueer." The distribution of the gender identity variable was identical to the sex variable (the genderqueer individual chose within the male/female binary for their sex), so the sex variable was used.

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This section will present methods in the regression analysis and findings of the analysis. It will start by explaining the independent variables and how they were formatted, and then the pre-screening steps involved in the process. Then, a table of the results of the regression analyses will be presented along with a summary of the results of each regression model.

Explanation of IV's. Race was converted to a dichotomous variable for the purpose of this analysis because there were not enough observations in all categories. Thus, for the race variable, 1=white/Caucasian (n=67) and 0=non-white (including Black/African-American, Hispanic/Latino, and Mixed-race/Bi-racial) (n=42). For the sex variable, there were no responses outside of male or female, thus it was coded as 1=male and 0=female. For the sexual orientation variable, it was treated in a similar fashion to the race variable: 1=queer (lesbian, gay, bisexual, or queer) (n=19) and 0=heterosexual/straight (n=94). For the level of education, because respondents were not asked to answer how many years of education they completed, the variable could not be used as a continuous variable. Therefore, it was recoded to a dichotomous variable to compare graduate-level or higher level of education to 4-year-college or less level of education, and coded as 1=graduate or higher (n=68) and 0=4 year or less (n=45). Political ideology was coded such that 1 = strongly liberal and 7 = strongly conservative.

Personal factor values (listed in Table 14) were initially coded as yes/no with the exception of two items. One of the variables was a stop-logic item which caused it to have several missing values; thus it was excluded from the analysis. It was a follow-up to the first personal variable asking whether or not the respondent had attended any LGBTQ-specific cultural competency training, so the construct being measured was captured by the first question about whether the respondent had ever had training. The distributions for all personal factor variables are in Table 14. These items were combined to create a composite score on that group

of variables. Personal social variables were defined as items that were related to social distance to LGBTQ individuals and personal experience with LGBTQ-specific training. All items had response options of "don't know" but those responses were recoded to equal zero because if a person did not know an answer to these questions, the resulting effects would be the same as answering no (for instance, if you don't know whether or not you've worked with an LGB youth, that would likely have the same influence as saying that you've never worked with an LGB youth).

Table 14: Frequencies of personal factor items related to social distance.

Item	1 Yes	0 No	0 Don't Know	Missing
1. Have you ever participated in some sort of training or education that was specifically about LGBTQ issues or people?	77	20	1	15
2. (stop-logic) If No to #1, have you ever participated in some sort of training or education that was about diversity and/or cultural competency and included some information about LGBTQ issues?	15	4	1	93
3. In your job, have you ever interacted with an LGBQ youth?	93	3	2	15
4. In your job, have you ever interacted with a transgender youth?	52	32	14	15
5. In your personal life, have you ever had a relative or close friend who is lesbian, gay, or bisexual?	90	6	2	15
6. In your personal life, have you ever had a relative or close friend who is transgender or transsexual?	36	55	7	15

The distribution for the composite variable for these personal social items is displayed in Figure 5.
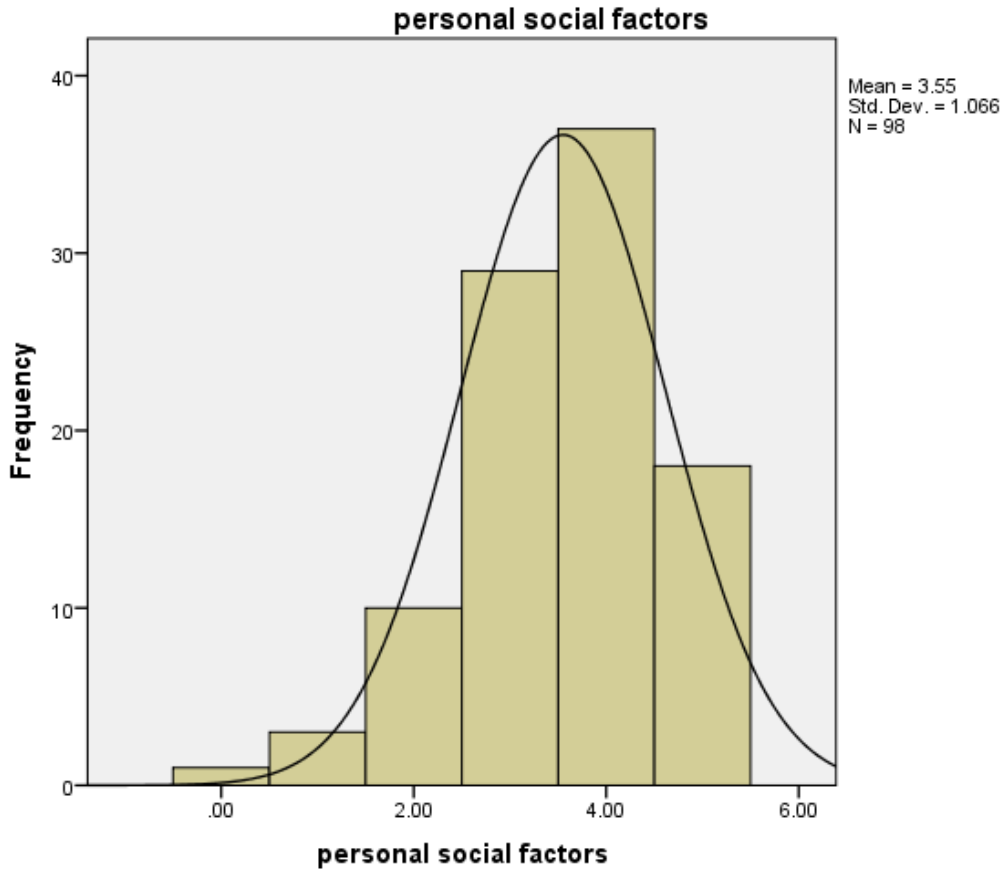
Figure 5: Distribution of composite variable of personal social distance factors

Personal sin belief variables were the two items that were not coded as yes/no. They were coded as a Likert-type scoring method using 1 = very untrue of what I believe to 7 = very true of what I believe. Frequencies of these two variables are in Table 15. There were two separate items asking about sin beliefs about sexual orientation and about gender identity. These items were combined to create a composite score of personal sin beliefs. Distributions for the individual items and for the composite item are in Figure 6. Responses of "don't know" were recoded to the neutral value of 4.

Table 15: Frequencies of personal sin belief items.

	1 Very untrue	2 Untrue	3 Somewhat untrue	4 Neutral	5 Somewhat true	6 True	7 Very true	4 Don't Know	Missing
1. How much is the following statement true of what you personally believe? Being homosexual is a sin.	54	11	3	7	3	7	9	4	15
2. How much is the following true of what you personally believe? Being transgender or transsexual is a sin.	51	13	4	9	2	6	8	5	15
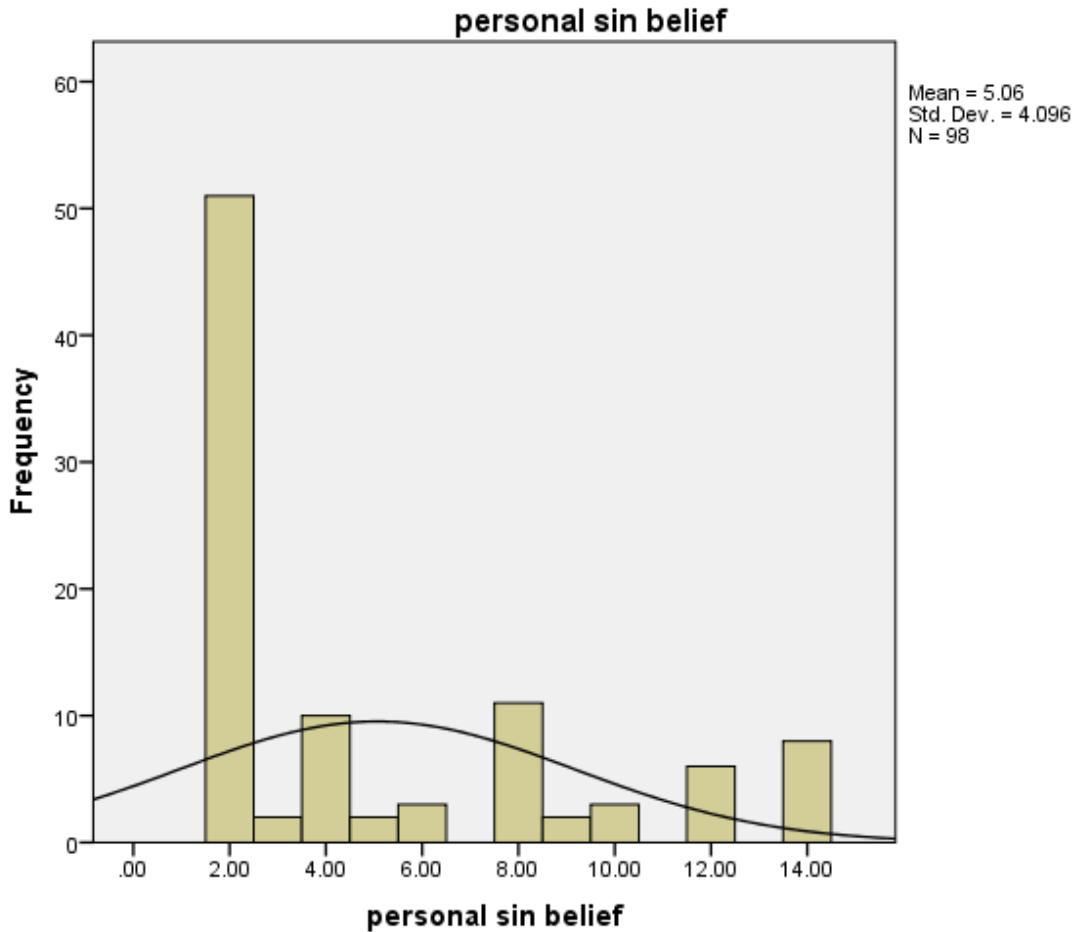
Figure 6: Distribution of composite variable of personal sin belief.

The organizational climate related to LGBTQ individuals was measured using a series of 11 items. Three of the items addressed perceived climate for LGBTQ individuals. These items were measured in a Likert type scoring method with 1=strongly disagree to 5=strongly agree. All responses of "don't know" were replaced with the neutral response of 3 (neither agree nor disagree). Item scores were summed to create the composite score. The frequencies for each item are in Table 16 and the distribution of the composite item is in Figure 7.

Table 16: Organizational climate perception variables.

Item	1 Strongly disagree	2 Disagree	3 Neither	4 Agree	5 Strongly agree	3 Don't Know	Missing
1. In the agency where I work, it's okay to talk about LGBTQ issues.	0	0	7	47	40	2	17
2. If I personally were lesbian, gay, or bisexual, I would feel comfortable being out at the agency where I work.	1	9	16	37	28	5	17
3. If I personally were transgender/transsexual I would feel comfortable being out at the agency where I work.	2	15	22	28	21	8	17
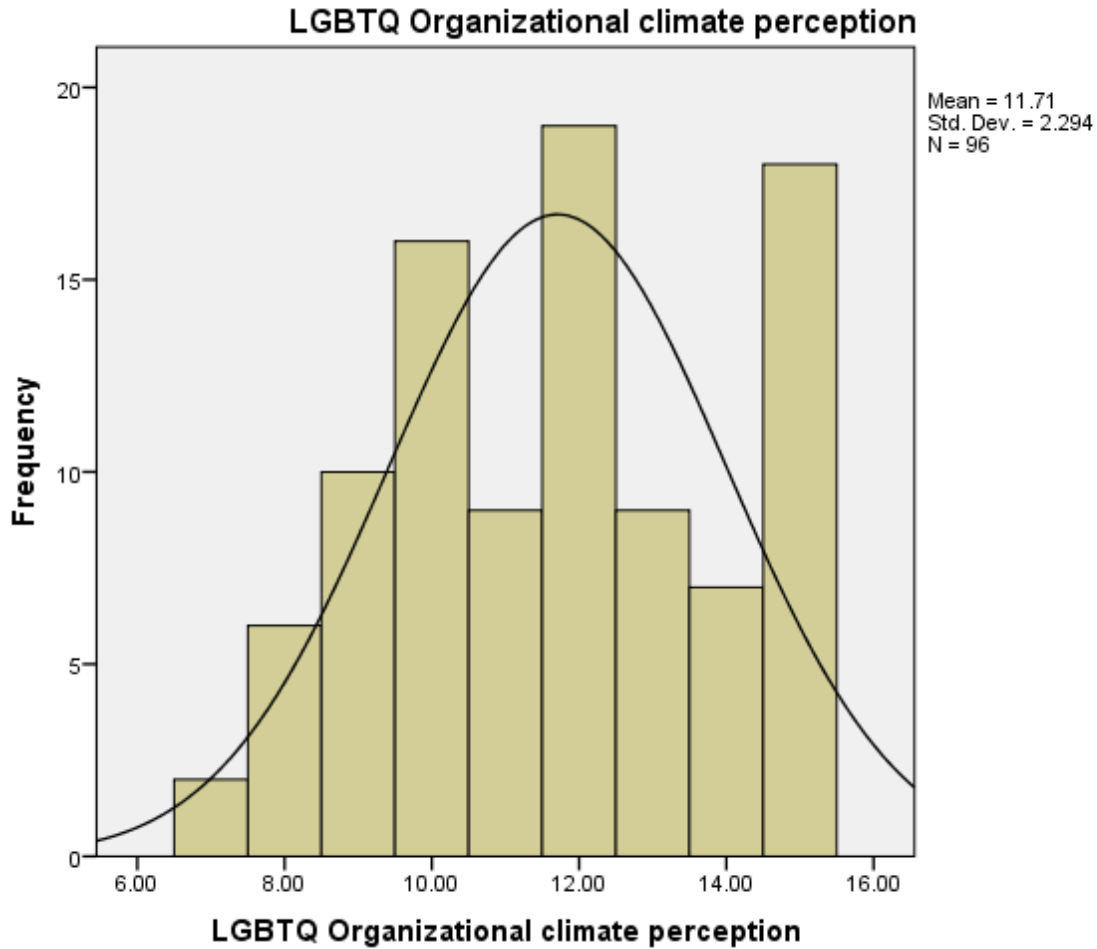
Figure 7: Distribution of composite scores for organizational climate variable.

The other 8 items addressed whether the organization had policies and/or statements that were directly related to LGBTQ individuals, or whether there were LGBT identified employees at the organization, with answers in a yes/no/don't know format. Frequencies of these variables are in Table 17. Responses of "don't know" were recoded to equal zero for the same reason as the personal variables that had yes/no/don't know response options. These items were summed to create a composite score that reflected the organization's policies related to LGBTQ individuals, and the distribution is displayed in Figure 8.

Table 17: Organizational climate and policies variables.

Item	1 Yes	0 No	0 Don't Know	Missing
There are lesbian, gay, and/or bisexual coworkers at the agency where I work.	63	3	30	17
There are transgender/transsexual coworkers at the agency where I work.	6	12	78	17
The agency where I work has a policy that protects employees from discrimination based on their sexual orientation.	73	2	21	17
The agency where I work has a policy that protects employees from discrimination based on their gender identity.	65	2	29	17
The agency where I work has a specific policy or guidance on interacting with lesbian, gay, and bisexual youth.	30	16	50	17
The agency where I work has a specific policy or guidance on interacting with transgender youth.	22	21	53	17
On forms where it's relevant, the agency where I work has questions that allow clients to identify their sexual orientation (for example: on an intake form).	44	21	31	17
On forms where it's relevant, the agency where I work has questions that allow clients to identify their gender identity/expression (for example: on an intake form).	40		34	17
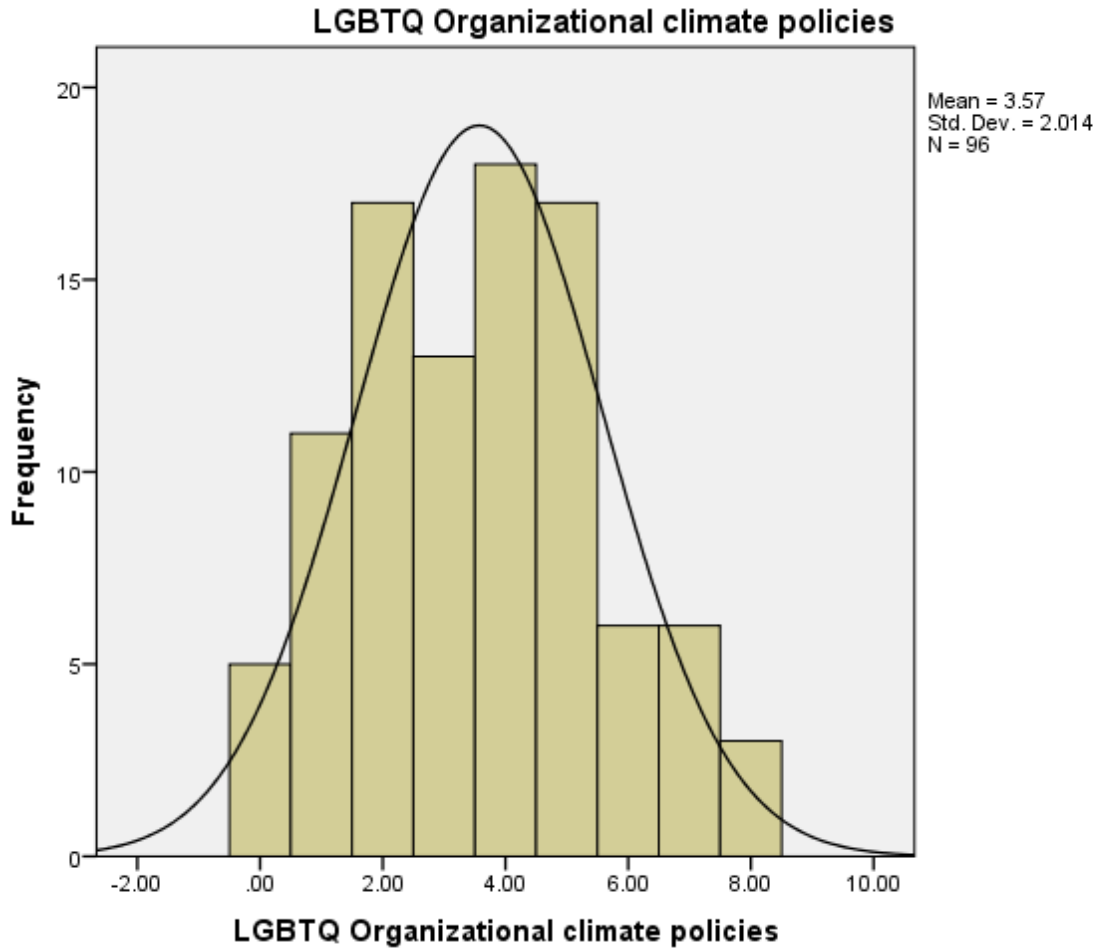
Figure 8: Distribution of composite scores for organizational policies variables.

Pre-screening. Assumptions relevant to a regression analysis include data missing at

random, absence of outliers, absence of multicollinearity, linearity, and homoscedasticity. Some

of these assumptions were already addressed earlier in the results section, including missing data

and outliers. The data were screened for the remainder of the assumptions listed.

Multicollinearity is defined as when variables are highly correlated (typically over a

Pearson's r value of 0.8) or are perfectly correlated (called singularity) (Dattalo, 2013). It is

relevant to a multiple regression analysis because if variables are highly or perfectly correlated,

there will be no unique regression solution and the predicted value will be the same as the

observed value, so the regression will have presented no new information or had no predictive

power (Dattalo, 2013). This was tested using a correlation matrix of all IV's. See Table 18 for this matrix. No items were correlated at or above a Pearson's r value of 0.8, so the assumption of an absence of multicollinearity was met.

Table 18: Correlation Matrix of IV's included in the regression.

	race	sex	Sexual orientation	Level of education	Political ideology	Personal social factors	Personal sin beliefs	LGBTQ Org. Perception	LGBTQ Org. Policies
age	.107	.115	-.174	-.186*	.035	.089	.038	.054	.088
Race (1=white)		-.122	.066	.132	-.292**	.005	-.326**	.025	-.194
sex (1=male)			-.051	-.238*	.049	.112	.147	.241*	.324**
Sexual orientation (1=LGBQ)				.076	-.293**	.233*	-.278**	.066	-.148
Level of education (1=master's or more)					-.217**	-.008	-.180	.022	-.286**
Political (degree of conservatism)						-.253*	.587***	-.067	.150
Personal social factors (degree of social contact)							-.220*	.255*	.266**
Personal religious factors (degree of belief that LGBTQ is sin)								-.009	.138
Org. climate perception (degree of LGBTQ positive climate)									.310**
*p<.05, **p<.01, ***p<.001									

Linearity is defined as the assumption that there is a straight-line relationship between variables (Dattalo, 2013). It is relevant to a multiple regression analysis because regression is a linear test and if variables do not at least approach a linear relationship, then the regression model will underestimate the relationships between variables (Dattalo, 2013). It was tested using

the same correlation matrix used for the multicollinearity assumption, and typically linearity is assessed by looking for values of Pearson's r greater than 0.6 (Dattalo, 2013). There were no Pearson's r values greater than 0.6, which suggests that there is a low level of linearity in these data. If there is a low level of linearity, then one solution for dealing with it is to transform the data. However, most variables were at least somewhat correlated at a significant level, so no transformations were made to the data to meet the assumption of linearity.

Homoscedasticity is characterized by the assumption that the variance of scores in the DV are similar across all IV's (Tabachnick & Fidell, 2007). It is relevant to a multiple regression analysis because the value of residual errors from the regression model should be the same for all IV's (Dattalo, 2013). It was tested using plots of predicted and residual values of z in the regression model. See Figure 9 for these results. The plots suggest that there is the presence of heteroscedasticity because of the shape of the distributions (they lacked a clear oval shape). The decision for whether or not to transform data to better meet the assumptions of any multivariate analysis has to weigh the impact of the transformation on the interpretability of the analysis (Tabachnick & Fidell, 2007, p. 86). It was decided that the interpretability of the scores on the new scale would be more difficult if the data were transformed; therefore, no transformation was conducted. Also, if the violation of the homoscedasticity assumption is only moderate, then it will only have a minor impact on the regression estimates, which is the case for these data (Dattalo, 2013).

Scatterplot

Dependent Variable: LGBTQY-CC
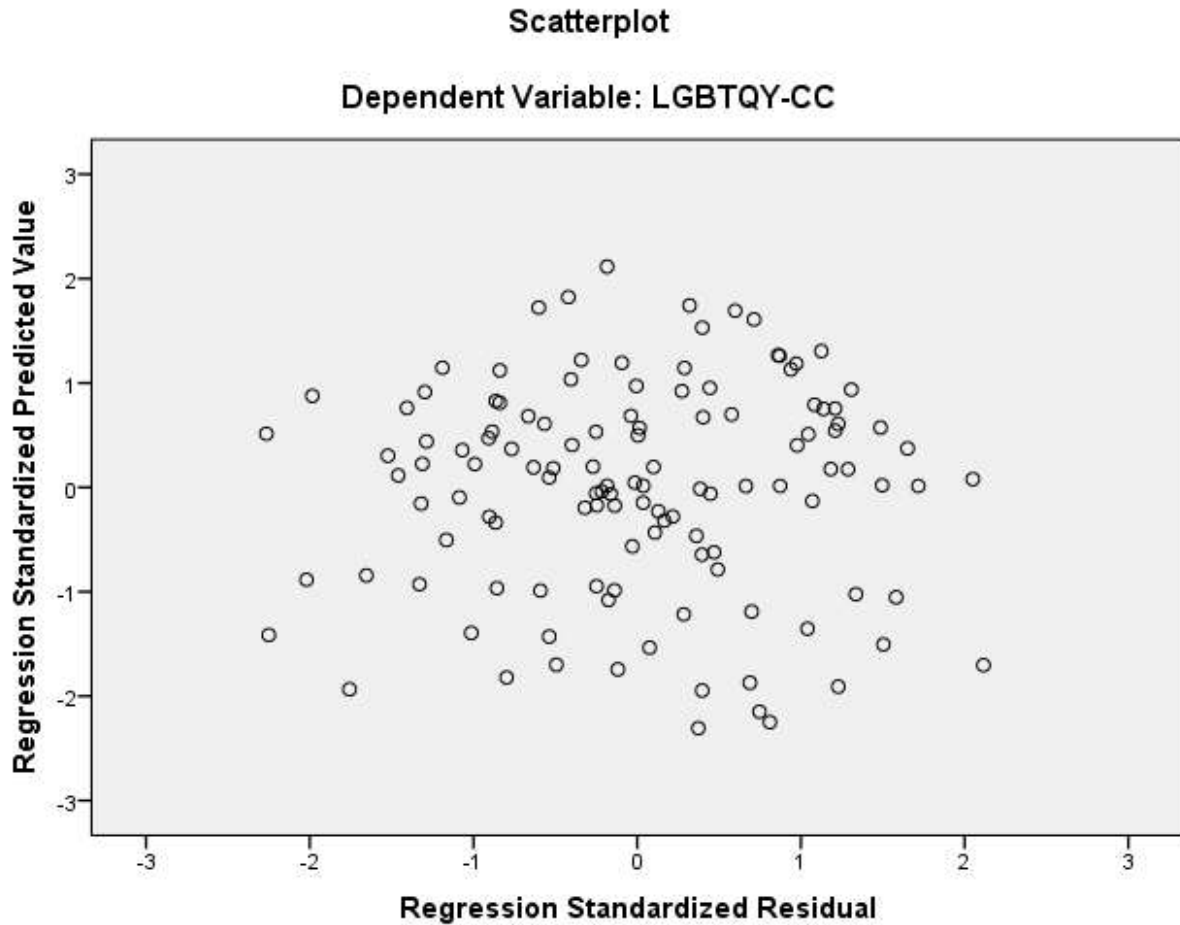
Figure 9: Plots of predicted and residual values of z for the regression model.

Results. Bivariate analyses of the DV (LGBTQY-CC) and the IV's show that total score on the LGBTQY-CC was related to all IV's except sex and the organizational variables of LGBTQ climate and LGBTQ policies (Table 19).

Table 19: Correlation Matrix of IV's to DV.

	age	race	sex	Sexual orientation	Level of education	Political ideology	Personal social factors	Personal sin beliefs	LGBTQ Org. Perception	LGBTQ Org. Policies
LGBTQY-CC	-.219**	.336**	-.150	.403***	.304**	-.618***	.301**	-.680***	.109	-.129

*p<.05, **p<.01, ***p<.001

In order to examine whether these bivariate relationships continued to be significant in the presence of other factors, a series of regression models were conducted. The goal of these models was to examine the presence and strength of each IV while controlling for the other variables in the model. First, a "baseline demographics" model was conducted to evaluate what basic characteristics of a respondent contributed to the explanation of variance in the DV. These demographic characteristics were: age, race, sex, sexual orientation, and level of education. Then, subsequent models were analyzed sequentially by adding in a new set of variables, starting with political ideology, then personal factors (including social distance and sin beliefs), and ending with organizational climate factors (including perception of the organizational climate for LGBTQ individuals, and the presence of LGBTQ relevant policies). These four models are summarized in Table 20.

Table 20: Regression results.

	Model 1 R^2_{adj} 0.289 (F5,102=9.715) ***	Model 2 R^2_{adj} 0.477 (F6,101=17.242) ***	Model 3 R^2_{adj} 0.612 (F8,85=19.332) ***	Model 4 R^2_{adj} 0.591 (F10,81=14.17) ***
	b (std. err.) β	*b* (std. err.) β	*b* (std. err.) β	*b* (std. err.) β
Age	-.008 (.004) -.148	-.008 (.004) -.153*	-.011 (.003) -.211**	-.011 (.003) -.218**
Race (1=white)	.357 (.099) . 301***	.213 (.088) .179*	.162 (.084) .137	.150 (.086) .128
Sex (1=male)	-.063 (.118) -.045	-.076 (.101) -.055	-.057 (.095) -.042	-.076 (.101) -.057
Orientation (1=LGBQ)	.526 (.129) .339***	.330 (.115) .212**	.187 (.114) .117	.184 (.119) .114
Level of ed (1=masters or +)	.220 (.102) .186*	.147 (.088) .124	.119 (.079) .104	.125 (.085) .110
Political (degree of conservatism)		-.199 (.032) -.471***	-.103 (.034) -.252**	-.104 (.035) -.255**
Personal social factors (degree of social contact)			.079 (.037) .149*	.065 (.040) .123
Personal belief factors (degree of belief that LGBTQ is sin)			-.055 (.012) -.388***	-.058 (.012) -.405***
Org. climate (degree of LGBTQ positive climate)				.014 (.018) .059
Org. policy (number of LGBTQ positive policies)				.010 (.023) .034
*p<.05, **p<.01, ***p<.001				

Regression Results. When looking at regression coefficients, the p-value is the signifier

for whether or not the coefficient is statistically significant, which means that the associated

variable holds statistically significant explanatory power for the variance in the LGBTQY-CC

scores. The coefficients themselves are indicators of how much the DV changes when the IV

changes. The unstandardized coefficient *b* is a value that shows how much change in an IV occurs when the DV changes by one unit. The standardized beta (β) coefficient is a standardization of the *b* values so that they can be compared to each other, since the unstandardized coefficients reflect the original metric of the variable and, hence, may reflect different metrics.

Table 20 displays all results from the regression analyses. In model 1, the adjusted R^2 was 0.289. Variables that were significantly related to higher LGBTQY-CC scores were race (white), sexual orientation (LGBQ), and level of education (master's degree or higher). In model 2 when the political ideology variable was added, the adjusted R^2 increased substantially ($R^2 =$ 0.477). Variables that were significant were age (younger), race (white), sexual orientation (LGBQ), and political ideology (less conservative). Model 3 added the personal factors, including social distance and religious beliefs about LGBTQ being a sin. The adjusted R^2 was 0.612. The only demographic variable that remained significant was age (younger). Personal factors that were significant were political ideology (less conservative), personal social distance (more social contact), and personal sin beliefs (less belief in LGBTQ is sin). In the final model, the organizational factors were added, which included perception of LGBTQ-positive climate and number of LGBTQ-positive policies. The adjusted R^2 was reduced to 0.591 and neither of the included organizational factors was significantly related to LGBTQY-CC scores.

In the best fitting model, the IV's that were statistically significant were age (younger), political ideology (less conservative), personal social contact (more contact), and personal sin belief (less belief in LGBTQ is sin). This suggests that lower age, more liberal political ideology, and more social contact with LGBTQ individuals predict higher scores on the LGBTQY-CC.

More agreement that LGBTQ is a sin predicts lower scores on the LGBTQY-CC. These findings and their implications will be discussed in the next chapter.

Research Question 6: Relationships with Training/Competency. Research question #6 was examined using Pearson's r correlation coefficients to answer whether constructs associated with training and workforce competency are related to the LGBTQY-CC. Results of the correlations will be presented in Table 21, followed by a summary of the results.

Table 21: Correlations between LGBTQY-CC and constructs related to workforce competency & training.

	Correlation with LGBTQY-CC	
Scale	n	Pearson's r
Organizational Culture & Climate	106	.125
Subscale: Positive climate	106	.144
Subscale: Constructive culture	106	.138
Subscale: Passive culture	106	-.035
California Brief Multicultural Competency Scale	96	.308**
Subscale: Awareness	96	.418***
Subscale: Sensitivity	97	.250*
Subscale: Non-ethnic skill	96	.146
Subscale: Knowledge	96	.258*
Willingness to Adopt Evidenced Based Practices	96	.380***
Subscale: Openness	96	.211*
Subscale: Divergence	96	.201*
Subscale: Appeal	96	.391***
Subscale: Requirements	96	.146
Job autonomy	106	.284**

*p<.05, **p<.01, ***p<.001

Summary of Correlation Results. The Organizational Climate and Culture scale and subscales were not significantly correlated with the LGBTQY-CC. This suggests that, for this sample, organizational climate and culture are unrelated to scores on the LGBTQY-CC. The California Brief Multicultural Competence Scale was significantly correlated with the LGBTQY-CC as were all subscales with the exception of the non-ethnic subscale. This finding is interesting because the non-ethnic subscale asks questions specific to gay men and lesbians. The

lack of correlation suggests that the LGBTQY-CC taps into a construct that is not represented by the non-ethnic subscale. The Willingness to Adopt Evidence Based Practices scale was significantly correlated with the LGBTQY-CC as were the subscales with the exception of the requirements subscale. This finding is interesting because sometimes the use of LGBTQ culturally competent practices is a requirement that is "handed down" by leaders of an organization or management entities that dictate what and how services should be delivered to consumers. The Job Autonomy scale was significantly correlated with the LGBTQY-CC, which suggests that job autonomy and scores on the LGBTQY-CC are related. The more autonomous a respondent is in their job, the more highly they score on the LGBTQY-CC.

Conclusion

This chapter presented the results of the survey used to test the new measure. Analyses used to validate the new measure included Cronbach's alpha, factor analysis, and correlations; regression analyses were used to predict what independent variables predicted values of the new measure; and correlations were conducted that helped to identify what constructs about training or competence were related to scores on the new measure. The new measure had a sufficiently high Cronbach's alpha value. The factor analysis reduced the number of items in the new measure to 27 items, and the new measure was named the LGBTQ Youth Cultural Competency scale (abbreviated as LGBTQY-CC). The LGBTQY-CC correlated as expected to measures of gay affirmative practice, beliefs about sexual minorities, and transphobia. The new measure was not significantly influenced by social desirability. The regression analysis provided information on what characteristics of workers and of organizations predicted scores on the LGBTQY-CC, and the significant variables in the regression model were age, political ideology, personal social contact, and personal sin belief. The correlations with other constructs about training and

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competence revealed that the LGBTQY-CC was related to measures of general cultural competency (with the exception of non-ethnic skill), willingness to adopt evidence based practices (with the exception of the requirements subscale), and job autonomy, but not related with a measure of organizational culture and climate. The next chapter will present a discussion about the implications of these findings, limitations of the study, and directions for future research.

Chapter 6: Discussion

Introduction

The purpose of this study was to explore how a newly developed measure could capture variability in the level of LGBTQ-related cultural competency in direct-care behavioral health workers who work with youth. The research aims and questions are restated here:

Aim 1: To what extent can a measure capture the variability of cultural competence in direct-care behavioral health workers as it is related to LGBTQ issues in youth?

1. What is the internal consistency of the measure?

2. What is the underlying factor structure of the measure?

    a. Does the factor structure support a multi-dimensional model that aligns with the conceptual model of cultural competency?

3. Are items significantly influenced by social desirability?

4. Does the new measure correlate as expected with existing measures of gay affirmative practice and attitudes towards LGBTQ persons?

Aim 2: How is this measure related to concepts associated with behavioral health workforce competence and development?

5. Does the measure vary systematically with characteristics of workers and organizations?

    a. Personal factors: sexual orientation, gender, age, race, level of education, political ideology, social distance to an LGBTQ person, and personally held sin belief about LGBTQ individuals.

    b. Organizational factors: perceived organizational climate related to LGBTQ individuals; policies in place related to LGBTQ individuals.

6. Is the measure related to other measures concerning training or competency in workers or the work environment?"

   a. General cultural competency

   b. Worker willingness to adopt evidence-based practice

   c. Organizational culture and climate

   d. Job autonomy

This final chapter begins by summarizing the study's main features. It then describes and discusses the key findings. Next the findings are discussed in relationship to the theory and conceptual model. Next, it offers implications of those findings for research, policy, and practice. The chapter also addresses limitations of the study. Then it discusses future directions for research. It ends with a summary and conclusion of the study.

Summary

This study developed and tested a measure of LGBTQ cultural competency for direct-care behavioral health workers. The measure, the LGBTQY-CC, was developed using the input of stakeholder groups as well as literature and best practices on working with LGBTQ youth in behavioral health care. It was then administered to a sample of behavioral health workers who provide mental health services to children and adolescents.

Item Development. A pool of items was developed from existing measures and literature on best practices and then stakeholders were involved in the item review process. There were three groups of stakeholders: young adults who identify as LGBTQ and had behavioral health treatment experience, workers with direct-care experience, and research professionals. The initial item pool was presented to each group. Feedback was obtained regarding clarity of the items, whether the items tapped constructs that were relevant to the respective stakeholders' experience

and/or knowledge, and what concepts were missing from the item pool. The major adjustment

that the stakeholders' input inspired was to add several items addressing how workers view the

"questioning" process in youth and common misconceptions that workers have about LGBTQ

identity (*i.e.*, youth identify LGBTQ just to copy others, being LGBTQ is just a fad, *etc.*)

Data Collection. The survey was administered to behavioral health workers primarily in

the mid-Atlantic region of the United States, although recruitment spread to a limited extent

beyond that region. After 7 weeks, the sample size goal of 100-150 was met and data collection

was ended. The final analyzed sample included 113 respondents.

Data Analysis – Measure Validation. A series of factor analyses was conducted to

examine possible multi-factorial structures underlying the data. While the scree plot and

explained variance suggested that a multi-factored solution could fit the data, examination of the

rotated factors showed that these secondary factors had very few items and were not

conceptually clear or stable. None of these solutions with multiple factors provided a factor

structure that mimicked the categories in the conceptual model (*e.g.*, knowledge, skills, attitudes,

and awareness). Instead, it appeared that there was a primary factor that explained the largest

proportion of variance, and this single factor cut across all four domains of the conceptual model.

Overall, the factor analysis results were interpreted to mean that cultural competency consists of

a primary factor made up of knowledge, skill, attitudes, and awareness in a way that those

domains should not be considered separate. Factor loadings were examined to determine items

that should be retained when reducing the number of items in a new measure. Using a cutoff

criterion of 0.5, 27 items were retained that made up the new scale, named the LGBTQ Youth

Cultural Competency scale (abbreviated as LGBTQY-CC). Scores on the new measure were

calculated using the average of scores on all 27 items. The LGBTQY-CC captured variability as

evidenced by the range of potential scores (1-5) versus actual scores (2.44-5). The mean for this sample was 4.00 and the standard deviation was 0.55. These findings suggest that the LGBTQY-CC was capable of capturing some variability of the construct LGBTQ cultural competency.

Cronbach's Alpha on the LGBTQY-CC was 0.946, suggesting excellent internal validity. Further analysis suggested that the items in the LGBTQY-CC were not correlated to a measure of social desirability (r=.071, p=.454, n=113), suggesting that it is not influenced by social desirability. Examination of construct validity showed that the new measure correlated as expected with existing measures of gay affirmative practice and attitudes towards LGBTQ persons. The LGBTQY-CC was correlated with a measure of gay affirmative practice (r=.619, p<.001, n=113), and was correlated in the expected direction for a measure of transphobia (r=-.693 p<.001, n=99) and with a measure of beliefs about sexual minorities (r=.664, p<.001, n=99).

The second primary research aim was focused on investigating how the new measure is related to concepts associated with behavioral health workforce competence and development. Regression analyses were conducted to examine what factors were significantly related to the LGBTQY-CC. It was found that the demographic variable of age (younger) and the personal factors of political ideology (more liberal), personal social distance to LGBTQ individuals (more social contact), and personal sin belief (LGBTQ is not a sin) were significant predictors for higher scores on the new measure. No organizational factors were significant in the model. The most parsimonious model explained over 60% of the variance of the LGBTQY-CC (adjusted R^2 = 0.612).

Correlations were conducted to determine what constructs related to behavioral health workforce training and development might be related to scores on the LGBTQY-CC. A measure of organizational culture (passive, defense) and climate (positive) was not significantly

correlated with the LGBTQY-CC. A measure of non-specific cultural competency was significantly correlated with the LGBTQY-CC. However, the non-ethnic subscale of the cultural competency measure was not correlated with the LGBTQY-CC. A measure of workers' willingness to adopt evidence based practices was correlated with the LGBTQY-CC with the exception of the requirements subscale. A measure of job autonomy was significantly correlated with the LGBTQY-CC.

Key Findings and Discussion

One conclusion that can be drawn from these findings is that the new measure has good internal validity and consistency. This is supported by the results of analyses involving Cronbach's alpha, correlation with social desirability, and correlations with measures of gay affirmative practice and attitudes towards LGBTQ individuals.

A second conclusion that can be drawn from these findings is that the new measure consisted of one primary factor rather than several smaller factors, as was anticipated based on the conceptual model of four domains (knowledge, attitude, skill, awareness). One reason behind this could be that LGBTQ cultural competency is best conceptualized as a combination of knowledge, attitude, skill, and awareness rather than separating those concepts from each other. An issue that arises in this finding is the need to identify the underlying latent construct that is being measured. If the factor solution does not mirror that of the conceptual model, perhaps the measure is tapping into a different construct all together. An examination of what items loaded highest on the measure indicates that the construct could be related to open-mindedness, tolerance for ambiguity, or having a client-led practice approach. This issue of latent construct identification should be explored in future research in with the LGBTQY-CC. More discussion of how this finding relates to the theory on cultural competency will be provided later.

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A third conclusion to be drawn from the findings is that the new measure varies systematically with certain characteristics of workers. The characteristics that were statistically significant were age, political ideology, personal social distance, and personal sin beliefs. Several demographic factors were initially significantly related to the LGBTQY-CC scores. However, when other personal and organizational factors were included in the model, only age remained significant. This suggests that factors related to experiences and beliefs are more strongly related to this measure of cultural competence than are ascribed demographic characteristics. These personal choices and experiences of social contact, religious beliefs, and political ideology appear to be more important to understanding what influences LGBTQ youth cultural competency than are factors such as knowledge of organizational policies or perceived climate about LGBTQ individuals. There were a large proportion of participants who responded "don't know" to the questions about whether there were LGBTQ-related policies in their organization, which might be more a function of the individual's "privileged" position of not needing to know this information than it is a function of the effect of those policies. If a direct-care worker is in a privileged position – either as a non-LGBTQ identified person, or as an adult whose life is not directly influenced by such policies – then the fact that they are unaware of whether or not their organization has LGBTQ-related policies could have less to do with their amount of knowledge about those policies and more to do with their amount of awareness of both the privileges and disadvantages associated with LGBTQ identities.

Results also suggested that the new measure is related to other constructs about training and worker competencies. Specifically, the new measure is related to general cultural competency but not non-ethnic cultural competency, which suggests that the LGBTQY-CC taps into a dimension that general cultural competency does not capture, especially when it comes to

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LGBTQ populations. The new measure is also related to workers' willingness to adopt evidence based practices (except for the requirements subscale), which suggests that workers' level of adoption of LGBTQ culturally competent practices is not dependent on whether they are a requirement. One explanation for this finding is that the motivating influence for workers to adopt LGBTQ culturally competent practice could be less about being required to do so and more about personal motivations, such as those identified previously (social contact, sin belief, political ideology).

Relationship of Results to Theory and Conceptual Model

The new instrument, the LGBTQY-CC, was compared to measures of transphobia and beliefs about sexual orientation. The results of those analyses supported the assumption that constructs informed by heterosexism and genderism are related to LGBTQ-related cultural competency, as theory would suggest (as explained in Chapter 2). Respondents whose scores indicated a higher level of transphobia and less affirming beliefs about sexual minorities had lower scores on the LGBTQY-CC, indicating lower levels of LGBTQ youth cultural competency.

In terms of the conceptual model, the factor analysis did not support the theory that there were four distinct cultural competency domains that equally contributed to the new measure. The factor analysis results indicated that all four domains were retained in one factor, meaning that the domains are best interpreted without separating them from each other. Rather than grouping the items by domain, perhaps they should have been grouped by direct-care worker activity (*i.e.*, supervision; treatment plan implementation; redirection; discussion of sensitive subjects like sex, romance, and attraction; contact with family members; general management of the treatment

milieu, *etc.*). This may better reflect where items are applicable because diverse situations require application of certain types of knowledge, attitude, skill, and/or awareness.

Implications

      Research. One implication for research from this study is that direct-care workers may not be best recruited through the methods used in this study. I learned that direct-care workers are hard to reach via e-mail. According to anecdotal evidence provided by agency contacts that provided ideas on how to reach their direct-care workers, some of these direct-care workers had two or three jobs because they are the lowest paid earners in the company. Also, they may not have access to a company e-mail address. This is particularly true of part-time workers, which is a common employment status for direct-care workers. Or, they may not have a computer or be in a position to check e-mail regularly (even though the survey was available on any mobile device with internet or data connectivity). Also the nature of their jobs is such that they are not sitting in front of a computer and are not able to devote a 30 minute period of time to complete a survey. So, the first lesson learned in this process was that direct-care workers are hard to reach for research. Perhaps that is one reason why there have not been many studies involving direct-care workers. The lesson learned is that in order to recruit this specific type of worker, a researcher would need to work more closely with each agency to recruit those workers and perhaps use other methods for gathering data other than through online means.

      An analysis of the response option "don't know" has implications for measurement research because of the differing ways that the answer can be interpreted. If a respondent answered "don't know" to an item, does that mean the respondent has more awareness about their level of competence? Or does it mean that the respondent truly just does not know? This

issue should be explored further in research using this scale and proxy measures of self-awareness.

There are four major gaps in the measurement literature that the LGBTQY-CC fills: direct-care behavioral health practice, practices that pertain to youth specifically, a measure that follows the model of cultural competency established in the children's mental health field by Cross and colleagues (Cross et al., 1989), and practices that pertain to sexual orientation as a separate construct from gender identity. The last gap is important because of the need to separate out gender identity issues from sexual orientation issues. Prior measures have labeled themselves as addressing both, but in reality only addressed sexual orientation. On one hand, some researchers may want to use two separate measures for these two issues. However, the identity process in youth is fluid, and an issue that on one day might be relevant to a youth's sexual orientation may the next day be relevant to their gender identity, because both identities are still in the process of formulating during childhood and adolescence. For that reason, sexual orientation and gender identity issues were both included in the measure, but unlike other measures, it did not conflate sexual orientation to mean that it also addressed gender identity; they were still treated as two separate constructs. Lastly, the LGBTQY-CC is not a self-assessment tool but rather is a scale designed to measure the amount of LGBTQ-related knowledge, attitude, skill, and awareness. Unlike some self-assessment methods for assessing cultural competency (as described in Chapter 2), this new measure was not influenced by social desirability. The LGBTQY-CC could be used as a self-assessment tool to increase a worker's awareness about their own level of LGBTQ cultural competency, but this is not the main intent or use of the measure.

Policy. Since 2010, SAMHSA has increased their focus on addressing health and mental health disparities faced by the LGBTQ population (Substance Abuse and Mental Health Services Administration, 2014). The block grant for SAMHSA's federally funded services for fiscal year 2014 encouraged state applicants to acknowledge health disparities faced by LGBTQ persons, and to explain how applicants would gather data on outcomes for LGBTQ persons who receive substance abuse treatment. This indicates that LGBTQ persons are becoming more of a policy priority, which means that soon providers will be required to demonstrate how they are improving access to and quality of care for LGBTQ individuals. Therefore, tools such as the LGBTQY-CC could be used to gather data on efforts made by states to improve their behavioral health workforce's capacity to serve LGBTQ youth.

Practice. There are reasons why improving practice with LGBTQ youth is important, and the LGBTQY-CC can be a part of improving practice by providing a valid form of measuring the level of LGBTQ cultural competency in direct-care workers. Scholars state that service providers should address the therapeutic milieu for safety concerning gender identity and expression, because its associated with increased odds for substance abuse (Reisner et al., 2014). So, the LGBTQY-CC can be a part of assessing the degree to which service providers are capable of addressing safety concerns for transgender and questioning youth. In a study of sexual minority youth and the effects of anti-gay victimization, it was found that a hostile environment (defined as involving sexual minority-specific victimization) was associated with mental health disparities such as suicidality and depressive symptoms (Burton, Marshal, Chisolm, Sucato, & Friedman, 2013). This work by Burton and colleagues supports the idea that efforts to reduce sexual minority specific stressors can improve the mental health of lesbian, gay, bisexual, queer, and questioning youth. Therefore, it backs the assumption that training direct-care workers to be

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more LGBTQ culturally competent would benefit sexual and gender minority youth, and the LGBTQY-CC can be a part of such training efforts. Mayer, Garofalo, and Makadon (2014) assert that LGBTQ youths access services in non-specialized centers, so it cannot be assumed that LGBTQ youth only go to LGBTQ-specific agencies for their mental health treatment. Therefore, creating a culture of safety and competence is important regardless of the population served by an individual agency, and direct-care workers are often very involved in creating and maintaining a therapeutic atmosphere.

The issue of dealing with ambiguities in identity became a recurring theme in the worker stakeholder review group findings. Stakeholders reported having observed workers who demonstrated a lack of acceptance for questioning youth. This lack of support for questioning youth is important because questioning youth have an even greater risk of negative outcomes than LGBT youth, such as suicide, depression, and substance abuse (Sherriff et al., 2011; Zhao et al., 2010). It is interesting that the workers reported a lack of tolerance for the questioning that youth naturally do during their childhood and adolescent years of development, particularly because a questioning stage is the one wherein workers will most likely encounter youth. This finding could have been reflective of the assumption that LGBTQ identities develop in a linear fashion, which could lead a worker to assume that if a youth will eventually identify as gay, lesbian, bisexual, or transgender, then the worker is simply helping them achieve a milestone in development by encouraging them to "just choose" who or what they identify as. If workers instead used a less-linear approach to understanding identity development, would that help them focus less on bringing a youth's identity to a final destination? Would a more fluid understanding of identity lead a worker to have more tolerance for ambiguity in the labels that youth use to identify themselves? This finding can shed light into how to improve care with LGBTQ youth

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who are in treatment settings – workers appear to need additional training and help for how to tolerate ambiguity in youth's sexual orientation and/or gender identity.

Limitations

Limitations of this study include problems with the data, problems with the sample, and limitations of the conceptual model.

Data Problems. The limitations in the data included the violation of assumptions for multivariate analyses and missing data. These are explained next.

Distributions. An assumption of multivariate analyses is that data are normally distributed. This assumption can be violated in certain analyses, but is generally applicable. Some variables used in the regression model had very skewed distributions. No transformation of these variables was conducted so that the results would be interpretable back to the metrics of the original measures. Thus the results were subject to violations of the assumption of normality. Also, the data moderately violated the assumptions of linearity, homoscedasticity, and multicollinearity. However, these violations were not severe, and likely did not impact the analyses to a large extent.

Missing Data. Data missing at random is an assumption of bivariate and multivariate analyses. Data in this study were not missing at random, and although the missing data correlated with certain demographic variables, there were no correlations above r=0.25. It is still more desirable to have data missing at random. Missing data were dealt with by list-wise deleting observations that had true missing values. Less conservative methods for dealing with missing data could have been used, which would have resulted in a larger analytic sample size.

Sample Limitations. The limitations related to the sample included the recruitment of direct-care workers, self-selection bias, and the sample size. These are explained next.

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Direct-care worker recruitment. Although the sampling goal was to only recruit direct-care workers, I was unable to recruit only those workers without also recruiting other workers such as licensed clinicians, medical professionals, and support or leadership personnel. The reasoning behind recruiting only direct-care workers was that by definition they would have limited educational attainment and would be responsible for basic oversight and supervision of youth who are in treatment settings. However, throughout the course of the study, it became clear that some licensed clinicians and medical providers include direct-care activities in their responsibilities. Also, due to the team-based approach of today's behavioral health services, it may not be relevant to separate out direct-care workers from other members of the team, because they all interact with youth for the same overall purposes. Yet, the main justification for focusing primarily on direct-care workers for the present study is that they have not been the subjects of a study that focused on LGBTQ cultural competency.

Self-selection bias. People who oppose LGBTQ rights or are against supporting youth who identify as LGBTQ may have decided not to take the survey. A study found that when people encountered a simple demographic question that included transgender in the gender categories and asked them to identify their sexual orientation, it made them uncomfortable, and some even decided not to participate in the survey after they encountered those questions (Stanhope et al., 2005). Therefore, it could be possible that this survey did not capture the full range of ideologies, competencies, attitudes, beliefs, skills, and awareness because of the questions about sexual orientation and gender identity in the demographics section. Thus, it may not be representative in the manner of capturing a wide variety of the multiple beliefs and ideologies that people hold. Indeed, the demographics of the sample indicated that liberal political ideologies were more highly represented, and there were a very high number of

participants who reported ever having social contact with an LGBTQ individual; therefore, this sample may be more liberal and affirming than a representative sample would be.

Sample size. Although a factor analysis can be conducted using as few as 50 respondents, some scholars suggest that the ideal sample size is dependent on the number of items, where the ratio of respondents to items should be anywhere from 5:1 to 10:1 (Dattalo, 2013). The scale being tested in this study had 56 items, so if the ratio criterion was used, the sample size would have needed to be 280 to 560 respondents. Another limitation was generalizability. The sample was a convenience sample, so it cannot be assumed to be representative of the behavioral health workforce; therefore, the results are not generalizable.

Conceptual Framework. The conceptual framework chosen to guide this study was a tripartite cultural competency model with the addition of an awareness domain. If a different conceptual framework was chosen, such as that of cultural sensitivity or cultural humility, then the measure would have been developed much differently and potentially could have tapped into dimensions not represented with the current framework. Therefore, it must be acknowledged that the present study's cultural competency framework has strengths and weaknesses, and using it as the guiding framework for this new measure meant that those strengths and weaknesses are an inherent part of the measure (these strengths and weaknesses were described in Chapter 2).

Despite these limitations, the study was able to develop and test a new measure that moved the field beyond the previous measures that focused only on therapy or counseling settings. It provided a stakeholder-informed measure that is specific to issues about LGBTQ youth. The new measure was found to be internally consistent and had good construct validity. It is a good step towards improving the field of children's mental health.

Directions for Future Research

The next step in this line of inquiry is to collect data from a representative sample of direct-care behavioral health workers in order to determine where the field stands in its ability to provide culturally competent care to LGBTQ youth. This will build on the present study because the present study did not capture a representative sample, so the results are not generalizable.

It will be important to further explore how to reach direct-care workers for research. The challenges faced in this dissertation study illuminated some of the difficulties faced when trying to gain access to this particular set of workers. Strategies should be created to reach these workers because they are a vital part of the children's behavioral health workforce, and without data on their practice competencies, workforce development efforts may stall.

A report produced for the Administration of Children and Families identified some research areas that need to be conducted related to low-income and at-risk LGBTQ individuals, including youth (Burwick, Gates, Baumgartner, & Friend, 2014). Themes relevant to the present study included the need to identify and document efforts to improve LGBT service delivery, and the need to evaluate the effectiveness of interventions designed to meet the needs of LGBT populations. In particular, child welfare professionals encouraged the development of LGBTQ cultural competency in agency staff and foster parents. Although the child welfare system is not the same as the children's behavioral health system, it is not uncommon for youth to be involved in both, so the implications can be transferrable to a behavioral health context. Furthermore, implications for workers of the child welfare system can be useful for children's mental health workers because they are both working with at-risk youth, so culturally competent practices may translate well between the two fields. Indeed, some of the studies reviewed for this dissertation came from the child welfare literature. The present study provides a first important step towards

fulfilling some of the research needs identified in the Administration of Children and Families report because it offers a valid way to document and evaluate efforts on improving human service delivery to LGBTQ youth by measuring the level of LGBTQ cultural competency. The Administration of Children and Families report clearly sets a pathway for future research in the area of improving practitioners' ability to work effectively with LGBTQ youth, and the present study is meant to be a first step towards that end.

The LGBTQY-CC was created with the long-term goal of training interventions for direct-care workers. The measure could be used to assess training participants' knowledge, attitudes, skills, and awareness prior to a training intervention session so that the trainer may gear the curriculum more towards the actual training needs of those in participation. Along those lines, conclusions from research aim #2 can lead to a better understanding of what is needed to guide the development and implementation of training interventions for direct-care workers (*i.e.*, workers who are more willing to adopt evidence based practices have more LGBTQY-related cultural competency; so, workers who are less willing to adopt evidence based practices could benefit from LGBTQ-related cultural competency training interventions). Results from the regression analysis of worker and organizational characteristics offer insight into what factors may play a role in a worker's use of LGBTQY-CC competencies and therefore what training methods might be used to best reach such workers. For instance, training programs should keep in mind that religious beliefs of workers may play a role in how they use LGBTQ cultural competency practices. This may be a concern for religious-based institutions and workers whose religious beliefs motivate their desire to work with at-risk or under-privileged youth, if the religious beliefs of such entities include that being LGBTQ is a sin. Training interventions need to be designed so that institutions and individual workers can successfully engage in LGBTQ

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cultural competency regardless of their personal sin belief. One factor that can be modified is that of social distance to an LGBTQ person. The findings of the present study found that social contact with LGBTQ individuals is predictive of higher scores on the LGBTQY-CC. A training intervention method that could be of use for addressing social distance is to offer a panel of LGBTQ individuals who give a short presentation of their experiences relative to the training seminar topic. Then, the participants and panel engage in a question and answer period during which participants can ask questions and become more acquainted with an LGBTQ individual's life experience. Although this is not social contact in the sense of having a close friend or relative who is LGBTQ, it does provide an avenue through which participants can learn more about LGBTQ individuals from a more personalized experience rather than through hypothetical case studies, lectures, or videos, and has been found to be effective in workshops and trainings (Christensen & Sorensen, 1994; Rye & Meaney, 2009). Additional factors such as organizational factors need further investigation in order to better understand how they influence a worker's use of LGBTQ cultural competency. The measures of organizational factors in this study were brief, so future studies could expand on the organizational, community, and system level factors that contribute to an understanding of LGBTQ cultural competency. In particular, the organizational culture (formal and informal) towards LGBTQ individuals may have an important influence on how much workers use LGBTQ youth culturally competent practices.

Furthermore, the LGBTQY-CC can be used to evaluate the effectiveness of varying types and styles of training programs. The assumption behind many current training programs is that training curriculums should focus on changing knowledge, attitudes, and awareness, and that a change in those domains would lead to a change in behavior (in the form of skills). This may or may not be true, as studies have not yet linked those concepts in order of attitude and knowledge

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change equals behavior change. However, some scholars suggest using theories to help guide what predicts actual behavior using the theory of planned behavior (McCabe, Rubinson, Dragowski, & Elizalde-Utnick, 2013), in which case the LGBTQY-CC could be used as a correlate of LGBTQ related practice behaviors.

The number of LGBTQ youth who receive behavioral health treatment is unknown. This is an important piece of information that could help to evaluate the effectiveness of workers' use of LGBTQ cultural competency on the treatment outcomes of LGBTQ youth. Thus, future studies should aim to identify LGBTQ youth who are in in behavioral health care.

Conclusion

The present study successfully developed and tested a new measure that assessed the level of LGBTQ cultural competency in direct-care workers who provide behavioral health services to youth. The LGBTQY-CC fills several gaps in the literature on LGBTQ cultural competency in direct-care workers as it relates to youth. As this study demonstrates, there are inherent limitations to addressing direct-care worker competencies. However, the impact that direct-care workers can have on the treatment experience of youth is vital to creating successful outcomes for youth in care, so their work must be addressed.

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Appendix A: Young adult review group recruitment flyer.

HELP WANTED
Youth Focus Group

- Do you identify as lesbian, gay, bisexual, transgender, queer, questioning, intersex, or asexual?
- Have you ever had counseling, therapy, seen a psychiatrist, been in the psychiatric unit of a hospital, been in a group home or therapeutic foster home, or any other sort of mental or behavioral health treatment?

Date of focus group:
Tuesday,
September 30th
4:30 PM

How long will it take?

About 60 – 90 minutes

Where will it be held?

At ROSMY

Study approved by VCU's
Institutional Review Board,
HM 15385

If you answered yes to both questions above, and are at least 18 years old, please consider participating in our focus group. We'll be asking for your input on a survey we are creating to evaluate the knowledge and behavior of mental health workers as it relates to LGBTQQIA youth.

If you decide to participate, you'll get a $25 gift card! And there will be free food at the focus group.

To find out more and/or to sign up, contact:

Megan Gandy (804) 396–3828 or
gandyme@vcu.edu

Appendix B: Young adult group informed consent document.

Focus Group with ROSMY-affiliated Young Adults

RESEARCH SUBJECT INFORMATION AND CONSENT FORM

TITLE: Pilot testing a measure assessing service provider practice behavior.

VCU IRB NO.: HM 15385

If any information contained in this consent form is not clear, please ask the study staff to explain any information that you do not fully understand. You may keep this copy of this consent form to think about or discuss with family or friends before making your decision.

PURPOSE OF THE STUDY
The purpose of this study is to find out about behavioral health workers' knowledge, attitude, and skill related to lesbian, gay, bisexual, transgender, queer, questioning, intersex, or asexual (LGBTQQIA) issues in youth. You are being invited to participate in a focus group where your input is needed on the questions to be included in the scale. You are being asked to participate because you identify as LGBTQQIA, and have had experiences in behavioral or mental health treatment.

DESCRIPTION OF THE STUDY AND YOUR INVOLVEMENT

If you decide to be in this research study, you will be invited to attend a focus group, after you have had all your questions answered and understand what's involved.

In this study you will be asked to attend one focus group meeting. The meeting will last approximately 60 – 90 minutes. In the meeting, you will be in a group with 5-9 other young adults. In the meeting, you will be asked to review a questionnaire (list of questions) about what it's like for direct-care mental health workers to be knowledgeable of and affirming towards lesbian, gay, bisexual, transgender, and queer/questioning issues in youth. You will be then asked to rank each question based on how well it fits what characteristics you'd like to have in a mental health worker, and how important it is to you as a LGBTQQIA identified youth. Next, everyone in the meeting will be asked to discuss why they ranked the questions the way that they did, and what changes (if any) they would suggest making to the questions. Last, you will be asked to fill out a brief demographic questionnaire.

RISKS AND DISCOMFORTS
There are no anticipated risks for your involvement in this study. The chance of some discomfort may occur because talking about these subjects can cause people to become uncomfortable. You do not have to talk about any subjects you do not want to talk about, and you may leave the meeting at any time. If you become upset, use the resource list given out by study staff at the start of the focus group, which has names of counselors and resources to contact so you can get help in dealing with these issues.

BENEFITS TO YOU AND OTHERS
You may not get any direct benefit from this study, but, the information we learn from people in this study will help us design better training programs for workers to learn how to work effectively with LGBTQQIA youth. Please be aware that the investigative team and the University may receive money for the conduct of this study.

COSTS
There are no costs for participating in this study other than the time you will spend in the meeting and filling out questionnaires.

PAYMENT FOR PARTICIPATION
You will receive a $25.00 gift card at the end of the meeting.

ALTERNATIVES
The only alternative for this study is to not participate.

CONFIDENTIALITY
Potentially identifiable information about you will consist of focus group meeting notes and observations by study staff during the meeting, and a brief anonymous demographic questionnaire. Data is being collected only for research purposes. Your data will be identified by ID numbers, not names, and stored separately in a locked research area. All personal identifying information will be kept in password protected files and these files will be deleted one year after the end of the study. Access to all data will be limited to study personnel. A data and safety monitoring plan is established.

We will not tell anyone the answers you give us; however, information from the study and the consent form signed by you may be looked at or copied for research or legal purposes by Virginia Commonwealth University. Personal information about you might be shared with or copied by authorized officials of the Department of Health and Human Services (if applicable).

What we find from this study may be presented at meetings or published in papers, but your name will never be used in these presentations or papers.

The focus group session will be audio taped, but no names will be recorded. At the beginning of the session, all members will be asked to use initials only so that no names are recorded. The recorded audio and the notes will be stored in a locked cabinet. After the information from the recorded audio is typed up, it will be destroyed.

VOLUNTARY PARTICIPATION AND WITHDRAWAL
You do not have to participate in this study. If you choose to participate, you may stop at any time without any penalty. You may also choose not to answer particular questions that are asked in the study. ROSMY has given Megan permission to use their facility. However, your decision on whether or not to participate will never be reported to anyone at ROSMY, and your decision will in no way affect your access to ROSMY programs and services.

Your participation in this study may be stopped at any time by the study staff without your consent. The reasons might include:
- the study staff thinks it necessary for your health or safety;
- you have not followed study instructions;
- administrative reasons require your withdrawal.

QUESTIONS
If you have any questions, complaints, or concerns about your participation in this research, contact:

> **Megan E. Gandy, Ph.D. Candidate, Student Investigator**
> **E-mail: gandyme@vcu.edu**
> **Phone: (804) 396-3828**
>   *and/or*
> **Elizabeth M. Z. "Betsy" Farmer, Ph.D., Dissertation Chair**
> **E-mail: efarmer4@vcu.edu**
> **Phone: (804) 828-0410**
> **Mailing Address: P.O. Box 842027, Richmond, VA 23284**

The researcher/study staff named above are the best persons to call for questions about your participation in this study.

If you have any general questions about your rights as a participant in this or any other research, you may contact:

> Office of Research
> Virginia Commonwealth University
> 800 East Leigh Street, Suite 3000
> P.O. Box 980568
> Richmond, VA 23298
> Telephone: (804) 827-2157

Contact this number for general questions, concerns or complaints about research. You may also call this number if you cannot reach the research team or if you wish to talk with someone else. General information about participation in research studies can also be found at http://www.research.vcu.edu/irb/volunteers.htm.

CONSENT
I have been given the chance to read this consent form. I understand the information about this study. Questions that I wanted to ask about the study have been answered. By attending the focus group, that says that I am willing to participate in this study. I may keep this copy of the consent form.

Counseling and Support for LGBTQ Youth & Young Adults in Richmond

<u>Community Services:</u>

- GCCR (Gay Community Center of Richmond)

  1407 Sherwood Ave Richmond, VA 23220-1004, (804)-622-4646,

  www.gayrichmond.com/GCCR

Vision: "We are the physical and virtual center for the enrichment of the lives of sexual and gender minority people in Central Virginia through individual and organizational achievement and growth."

Mission: "We develop and help sustain organizations, programs and services that contribute to a vibrant Central Virginia community that shares our values of diversity, inclusion, individual dignity, equality and civic engagement."

The Center can make referrals to organizations and providers in Central Virginia.

- ROSMY (Richmond Organization for Sexual Minority Youth)

  (804)-644-4800 or the Youth Support Hotline at (888) 644-4390, www.rosmy.org

Ensures "equal opportunities for success for Virginia's LGBTQ youth through access to support, education, and advocacy. Offers weekly youth support meetings, sensitivity training for professionals, educational resources, youth leadership initiatives, and a safe place where all youth are encouraged to value the diverse individuals who make our community a dynamic, exceptional place."

- Fan Free Clinic

  1010 N Thompson St Richmond VA 23230, (804) 358-8538

"Fan Free Clinic (FFC) provides medical treatment, health education and outreach, support services and advocacy for those in the Richmond area with limited access to care. We place special emphasis on welcoming the least served."

- Richmond Behavioral Health Authority

107 South Fifth Street, Richmond, VA 23219, (804) 819-4000 or crisis services at (804) 819-4100, www.rbha.org

Mission: "RBHA enhances the quality of life for the people of Richmond by promoting and providing quality behavioral health and developmental services that are available, accessible, and cost-effective." Offers 24-hour emergency services, assessment and referral, counseling and support, and more.

● Dr. Lisa Griffin, Clinical Psychologist (Private Practice).
14 South Auburn Avenue, Richmond, VA 23221. (704) 458-0433. www.drlisagriffin.com
Private practitioner specializing in individual therapy to address issues related to identity. Individual therapy rates and fees apply.

For VCU students:
● University Counseling: Offers individual counseling, solely for VCU students. (http://www.students.vcu.edu/counseling/)
  ○ Monroe Park Campus: University Student Commons, Room 238; 907 Floyd Avenue, Richmond VA. (804) 828-6200, M-F 8-5pm
  ○ MCV Campus: Grant House, B011; 1008 East Clay Street, Richmond VA. (80) 828-3964, M- 11-8PM, Tu-F- 8-5PM
  ○ After Hours Emergency: VCU Police dispatcher 804-828-1234, ask to speak to therapist
● Rainbow Group: Offers a safe environment for LGBTQ identified VCU students to gather and discuss issues related to sexual orientation and gender identity.

https://docs.google.com/a/mymail.vcu.edu/file/d/0B7z3ZniSHWXVZlBtLWR3YTJzSkk/ed

Contact Jan Altman, Ph.D., Safe Zone Coordinator, (804) 828-6200 or jhaltman@vcu.edu

State Resources:

- Virginia Anti-Violence Project - LGBTQ Partner Abuse and Sexual Assault Helpline Monday-Friday, 8am-8pm - 1.866.356.6998

The LGBTQ Partner Abuse and Sexual Assault Helpline provides a free and confidential

telephone service for lesbian, gay, bisexual, trans, and queer or questioning callers looking for

information or help regarding intimate partner abuse, sexual assault, and stalking. For Virginia

callers.

- Virginia Transgender Resource List - a list of resources statewide

  http://www.vdh.virginia.gov/epidemiology/diseaseprevention/hotline/transrrlist.pdf

National Resources:

- Trevor Lifeline – free hotline for LGBTQ-identified young people up to age 24 who are experiencing crisis or feeling suicidal – available 24 hours a day, 7 days a week 1-866-488-7386

Appendix D: Worker review group recruitment materials.

Research Study Information Sheet

Title of Study: *Pilot Testing an Instrument to Measure Practice Behaviors*

Principal Investigator (PI):	Elizabeth (Betsy) M. Z. Farmer, Ph.D.
	School of Social Work
	(804)
Student Investigator:	Megan E. Gandy, LCSW
	School of Social Work
	(804) 396-3828

Overview: The aim of this research is to find out about how behavioral health workers view lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ) issues in youth. This study will create and test a questionnaire to measure knowledge, attitudes, and skills related to working with LGBTQ youth in mental health care. You are being asked to participate in this study because you work in a direct-care role providing mental or behavioral health services to youth. As a participant, you will be reviewing and providing suggestions on questions and items that will be included in a survey that will later be distributed in a regional survey of providers. We want to know if you think the questions in the survey make sense and if they match up to what a direct-care worker would be doing during the course of their workday.

Your potential involvement: You will be invited to attend a focus group meeting with about 5-9 other workers from VHBG. The group will last approximately 60 – 90 minutes, and located on the campus of VHBG. In the group, you will be asked to review questions and items from a questionnaire about what it's like for direct-care mental health workers to be competent in lesbian, gay, bisexual, transgender, and queer/questioning issues in youth. You will be then asked to rank each question based on whether or not it makes sense, and how well it fits your role as a direct-care worker. Next, everyone in the meeting will be asked to discuss why they ranked the questions the way that they did, and what changes they would suggest making to the questions. Last, you will be asked to fill out a brief, anonymous demographic questionnaire. Each person who participates in the focus group will receive a $25 gift card as compensation for their time.

Expected benefits & outcomes: The feedback you give us will be used to make the final questionnaire. We will then distribute the questionnaire to regional service providers to help us learn more about behavioral health workers' views of LGBTQ issues in youth.

For more information: contact Megan Gandy at (804) 396-3828 or gandyme@vcu.edu, or Betsy Farmer at (804) 828-0410 or efarmer4@vcu.edu.

August 26, 2014

Dear Staff of _____,

This letter is to invite you to consider participating in a focus group. It is for a dissertation research study titled "Pilot testing a measure assessing service provider practice behavior" (approved by VCU's institutional review board, # HM15385). The study's purpose is to create a scale (i.e., survey) to measure LGBTQ cultural competency in direct-care (or front-line) mental health workers. LGBTQ stands for Lesbian, Gay, Bisexual, Transgender, and Queer/Questioning. You are being invited to participate in a focus group where your input is needed on the questions to be included in the scale. You are being asked to participate because you work as a service provider for children and adolescents in mental/behavioral health settings. You don't need to have had any experience with LGBTQ youth.

This study is being conducted by Megan Gandy, a Ph.D. student at the School of Social Work at VCU. She is interested in training direct-care mental health staff on how to be competent in LGBTQ issues in youth. Enclosed in this letter is a document called an Informed Consent form. Please read over it, because it will tell you more about the study and your involvement.

As a "thank you" for your participation, you will receive a $25 gift card if you participate in the focus group. The group is limited to 10 people, and there must be some staff represented from different departments of VHBG, so everyone who contacts me may not be able to participate if we get more interest from one department over another.

If you'd like to participate, please contact Megan Gandy so that she can send you details about the date and time of the focus group. The focus group will be held at VHBG. By contacting Megan, you are agreeing to let her contact you for reminders about the focus group date and time. And by attending the focus group, you agree that you are informed of the study's details, and have agreed to participate.

To register for the focus group, contact Megan Gandy at: (804) 396-3828 or by e-mail at gandyme@vcu.edu. You may also contact Megan if you have questions but are not ready to register yet.

Sincerely,

Megan E. Gandy

School of Social Work
Ph.D. Program

ALC Building, 3rd floor
1000 Floyd Avenue
P.O. Box 842027
Richmond, Virginia 23284

804 828-1030 • Fax: 804 828-0716

http://socialwork.vcu.edu

Megan E. Gandy
Ph.D. Candidate
gandyme@vcu.edu

Appendix E: Worker review group informed consent document.

<u>Focus Group with direct-care workers</u>

<u>RESEARCH SUBJECT INFORMATION AND CONSENT FORM</u>

TITLE: Pilot testing a measure assessing service provider practice behavior.

VCU IRB NO.: HM 15385

If any information contained in this consent form is not clear, please ask the study staff to explain any information that you do not fully understand. You may keep this copy of this consent form to think about or discuss with family or friends before making your decision.

PURPOSE OF THE STUDY
The purpose of this research study is to find out about behavioral health workers' levels of competency in lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ) issues in youth. The purpose of the current phase of the study is to gather feedback from stakeholder groups about the survey questions to be included in the final phase of the study. You are being asked to participate in this study because you work in a direct-care role providing mental or behavioral health services to youth.

DESCRIPTION OF THE STUDY AND YOUR INVOLVEMENT

If you decide to be in this research study, you will be invited to attend a focus group, after you have had all your questions answered and understand what will happen to you.

In this study you will be asked to attend one focus group meeting. The meeting will last approximately 60 – 90 minutes. In the meeting, you will be in a group with 5-9 other workers. In the meeting, you will be asked to review a list of questions about what it's like for direct-care mental health workers to be competent in lesbian, gay, bisexual, transgender, and queer/questioning issues in youth. You will be then asked to rank each question based on whether or not it makes sense, and how well it fits your role as a direct-care worker. Next, everyone in the meeting will be asked to discuss why they ranked the questions the way that they did, and what changes (if any) they would suggest making to the questions. Last, you will be asked to fill out a brief demographic questionnaire.

RISKS AND DISCOMFORTS
There are no anticipated risks for your involvement in this study. The chance of some discomfort may occur because talking about these subjects can cause people to become uncomfortable. You do not have to talk about any subjects you do not want to talk about, and you may leave the meeting at any time. If you become upset, use the resource list given out by study staff at the start of the focus group, which has names of counselors and resources to contact so you can get help in dealing with these issues.

BENEFITS TO YOU AND OTHERS

You may not get any direct benefit from this study, but, the information we learn from people in this study will help us design better training programs for workers to learn how to work effectively with LGBTQ youth. Please be aware that the investigative team and the University may receive money for the conduct of this study.

COSTS
There are no costs for participating in this study other than the time you will spend in the meeting and filling out questionnaires.

PAYMENT FOR PARTICIPATION
You will receive a $25.00 gift card at the end of the meeting.

ALTERNATIVES
The only alternative for this study is to not participate.

CONFIDENTIALITY
Potentially identifiable information about you will consist of focus group meeting notes and observations by study staff during the meeting, and a brief anonymous demographic questionnaire. Data is being collected only for research purposes. Your data will be identified by ID numbers, not names, and stored separately in a locked research area. All personal identifying information will be kept in password protected files and these files will be deleted one year after the end of the study. Access to all data will be limited to study personnel. A data and safety monitoring plan is established.

We will not tell anyone the answers you give us; however, information from the study and the consent form signed by you may be looked at or copied for research or legal purposes by Virginia Commonwealth University. Personal information about you might be shared with or copied by authorized officials of the Department of Health and Human Services (if applicable).

What we find from this study may be presented at meetings or published in papers, but your name will never be used in these presentations or papers.

The focus group session will be audio taped, but no names will be recorded. At the beginning of the session, all members will be asked to use initials only so that no names are recorded. The recorded audio and the notes will be stored in a locked cabinet. After the information from the recorded audio is typed up, it will be destroyed.

VOLUNTARY PARTICIPATION AND WITHDRAWAL
You do not have to participate in this study. If you choose to participate, you may stop at any time without any penalty. You may also choose not to answer particular questions that are asked in the study. VHBG has given Megan permission to use their facility. However, your decision on whether or not to participate will never be reported to anyone at VHBG, and your decision will in no way affect your employment at VHBG.

Your participation in this study may be stopped at any time by the study staff without your consent. The reasons might include:

- the study staff thinks it necessary for your health or safety;
- you have not followed study instructions;
- the sponsor has stopped the study; or
- administrative reasons require your withdrawal.

QUESTIONS

If you have any questions, complaints, or concerns about your participation in this research, contact:

> **Megan E. Gandy, Ph.D. Candidate, Student Investigator**
> **E-mail: gandyme@vcu.edu**
> **Phone: (804) 396-3828**
> *and/or*
> **Elizabeth M. Z. "Betsy" Farmer, Ph.D., Dissertation Chair**
> **E-mail: efarmer4@vcu.edu**
> **Phone: (804) 828-0410**
> **Mailing Address: P.O. Box 842027, Richmond, VA 23284**

The researcher/study staff named above are the best persons to call for questions about your participation in this study.

If you have any general questions about your rights as a participant in this or any other research, you may contact:

> Office of Research
> Virginia Commonwealth University
> 800 East Leigh Street, Suite 3000
> P.O. Box 980568
> Richmond, VA 23298
> Telephone: (804) 827-2157

Contact this number for general questions, concerns or complaints about research. You may also call this number if you cannot reach the research team or if you wish to talk with someone else. General information about participation in research studies can also be found at http://www.research.vcu.edu/irb/volunteers.htm.

CONSENT

I have been given the chance to read this consent form. I understand the information about this study. Questions that I wanted to ask about the study have been answered. By attending the focus group, that says that I am willing to participate in this study. I may keep this copy of the consent form.

Appendix F: Documentation of the item revision process.

Domain	Original Item	Source	Keep, Drop, Revise, Add	Justification	Final item or decision
Knowledge	1. I understand that identifying as LGBTQ is a developmental process that involves many stages, and that youth can experience these stages in uniquely individual ways.	(Goode & Fischer, 2009)	Revise	Stakeholder input. Clarification of wording so as to not confuse with the idea that "it's just a phase"	1. Becoming LGBTQ is a process that unfolds over time.
Knowledge	2. LGBTQ youth may keep secret their sexual orientation/gender identity from people in their own racial, ethnic, or cultural group.	Adapted from (Goode & Fischer, 2009)	Drop	Stakeholder input, Clarification of wording	Drop, because stakeholders were mixed on whether it is relevant, whether it makes sense.
Knowledge	3. I understand that family members and others may believe that LGBTQ identity among youth is a mental illness, emotional disturbance/disability, or moral/character flaw.	Adapted from (Goode & Fischer, 2009)	Drop	Stakeholder input, rating of importance	Drop, this isn't important to providing quality care.
Knowledge	4. I accept that religion, spirituality, and other beliefs may influence how families respond to a child or youth who identifies as LGBTQ.	Adapted from (Goode & Fischer, 2009)	Drop	Stakeholder input, suggestion to drop due to leading phrases.	Drop, stakeholder were mixed on whether to include this and how.
Knowledge	5. I understand that even if LGBTQ issues are not addressed in a youth's treatment plan or goal, being LGBTQ-affirming is still an important part of how to provide good treatment.	Alternative to the "aggressive neutrality" described in (S. King, 2008)	Revise	Stakeholders said they didn't like the word "affirming." Clarification of wording.	2. Even if LGBTQ issues aren't addressed in a youth's treatment plan or goal, acknowledging their LGBTQ identity is still an important part of how to provide good treatment.
Knowledge		Stakeholder input	Add	Stakeholder input. This is a way to get at how it is important to address LGBTQ issues by "breaking the silence"	3. In my job, I interact with youth because of their mental health problems not because of their sexual orientation/gender identity, so I

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					without actually having the item worded as "I think it's important to 'break the silence' about LGBTQ issues".)	don't talk about LGBTQ issues with youth I interact with.
Knowle dge	6. I understand that a youth could be dealing with LGBTQ issues secretly without anyone else knowing about it.	Adapted from (Goode & Fischer, 2009)	Revise	Stakeholder input. Suggestion to drop leading phrases.	4. A youth could be dealing with LGBTQ issues secretly without anyone else knowing about it.
Knowle dge	7. If a youth "comes out" to me as LGBTQ, I avoid sharing that information without their permission.	Adapted from (Goode & Fischer, 2009)	Revise	Clarification	5. If a youth tells me that they are LGBTQ, I avoid sharing that information without their permission.
Knowle dge	8. The parents of LGBTQ youth should be made aware of their child's identity as LGBTQ, if they are not already aware.	Pilot measure	Drop	Stakeholder input.	Drop, this isn't important to providing quality care
Knowle dge	9. I understand that LGBTQ youth can grow up to have children if they want to.	Pilot measure	Drop	Stakeholder input.	Drop, other items address this concept better.
Knowle dge	10. I understand that LGBTQ youth have the same typical goals and dreams for their future as do heterosexual/non-transgender youth.	This comes from the (Goldbach & Holleran Steiker, 2011) study where the youth said they were no different than heterosexu al youth	Revise	Stakeholder input. Suggestion to drop leading phrases.	6. LGBTQ youth have the same types of life goals and dreams for their future as do heterosexual/non-transgender youth.
Knowle dge	52. I am aware that being LGBTQ brings with it certain challenges that heterosexual and/or non-transgender people do not have to face.	This comes from the (Goldbach & Holleran Steiker, 2011) study, the	Add	Stakeholder input.	7. Being LGBTQ brings with it certain challenges that heterosexual and/or non-transgender people do not

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	youth also acknowledged that they do face unique barriers)			have to face.
Knowledge		Stakeholder input	Add	Stakeholder input	8. LGBTQ youth are LGBTQ because of their childhood history of abuse/neglect/poor parenting.
Knowledge		Stakeholder input	Add	Stakeholder input, include items about belief that it's a "phase".	9. When youth think they might be gay/lesbian/bisexual, it is just a phase they will grow out of.
Knowledge		Stakeholder input	Add	Stakeholder input, add items about popular misconceptions	10. When youth think they might be transgender, it is just a phase they will grow out of.
Knowledge		Stakeholder input	Add	Stakeholder input, add items about popular misconceptions	11. Adolescents (ages 12-17) aren't old enough to know whether they are gay/lesbian/bisexual or straight.
Knowledge		Stakeholder input	Add	Stakeholder input, add items about popular misconceptions	12. Children (ages 5-11) are too young to be thinking about whether they are gay or straight.
Knowledge		Stakeholder input	Add	Stakeholder input, add items about popular misconceptions	13. Adolescents (ages 12-17) aren't old enough to know whether they are transgender or not.
Knowledge		Stakeholder input	Add	Stakeholder input, add items about popular misconceptions	14. Children (ages 5-11) are too young to be thinking about whether they are

					transgender or not.
Knowledge		Stakeholder input	Add	Stakeholder input, add items about popular misconceptions.	15. Youth will come out as LGBTQ just to copy other youth who are coming out.
Knowledge		Stakeholder input	Add	Stakeholder input, add items about popular misconceptions.	16. Youth say they are LGBTQ to get attention.
Knowledge		Stakeholder input	Add	Stakeholder input, add items about popular misconceptions.	17. Youth act gay (feel attracted to the same-sex) when they are isolated from the opposite sex, like in an all-girls or all-boys group home.
Attitude /Belief					
Attitude	11. I think it is okay for a youth to come out as LGBTQ.	Pilot measure	Drop	Stakeholder input.	Drop, other items capture this better.
Attitude	12. I believe that LGBTQ youth are sinful.	Pilot measure	Revise and Add	Stakeholder input. Clarify that a worker can have their own personal beliefs but never tell the youth.	18. I believe that being LGBTQ is a sin. 18a. If Yes: I tell youth that I interact with that being LGBTQ is a sin.
Attitude	13. I think it's best for boys to act like boys and girls to act like girls.	Pilot measure	Keep		19. I think it's best for boys to act like boys and girls to act like girls.
Attitude	14. I do not believe that youth should be encouraged to identify as lesbian, gay, bisexual, or queer.	Pilot measure	Revise	Stakeholder input, wording clarification and no leading phrases.	20. Youth should not be encouraged to be lesbian, gay, bisexual.

Attitude	15. I do not believe that youth should be encouraged to identify as transgender or queer.	Pilot measure	Revise	Stakeholder input, wording clarification and no leading phrases.	21. Youth should not be encouraged to be transgender.
Attitude	16. Youth should be allowed to explore their same-sex attraction feelings.	Pilot measure	Drop	Stakeholder input, experiment will resonate better than explore	Drop, this concept is covered by the items about "youth should not be encourage to be lgbt" and "being lgbt is a healthy expression of SO/GI"
Attitude	17. Youth should be allowed to explore their gender identity.	Pilot measure	Drop	Stakeholder input, experiment will resonate better than explore	Drop, this is covered by the items about "youth should not be encourage to be lgbt" and "being lgbt is a healthy expression of SO/GI"
Attitude	18. Youth should be allowed to spend time around people who identify as LGBTQ.	Pilot measure	Drop	Stakeholder input.	Drop, this isn't important to providing quality care
Attitude	19. A youth's family should not encourage their child's decision to identify as LGBTQ.	Pilot measure	Revise	Stakeholder input, suggestion to drop leading phrases.	22. A youth's family should discourage their child's decision to identify as LGBTQ.
Attitude	20. I think a LGBTQ identified youth who needed foster care services would be best served in a highly religious foster home.	Pilot measure	Revise	Stakeholder input, suggestion to drop leading phrases, and to clarify meaning (at the end)	23. An LGBTQ youth who needed foster care services would be best served in a highly religious foster home so they can get set straight.
Attitude	21. I do not assume that a lesbian, gay, bisexual, or queer client or co-worker is attracted to me.	Personal Comfort Scale	Revise	Clarify wording	24. I do not assume that a lesbian, gay, or bisexual youth who is the same sex as me is

					attracted to me.
Attitude	22. I would be comfortable if a client came out to me as LGBTQ.	Personal Comfort Scale	Keep		25. I would be comfortable if a client came out to me as LGBTQ.
Attitude	23. Being lesbian, gay, bisexual, or queer is a healthy expression of sexuality.	Personal Comfort Scale	Drop	Stakeholder input, change "is" to "can be"	Drop, this idea is captured with other items (youth shouldn't be encouraged to be LGBTQ)
Attitude	24. Being transgender or queer is a healthy expression of gender identity.	Personal Comfort Scale	Drop	Stakeholder input, change "is" to "can be"	Drop, this idea is captured with other items (youth shouldn't be encouraged to be LGBTQ)
Attitude	25. Bisexual identified youth are not sure whether they are gay or straight.	Pilot measure	Revise	Clarify wording	26. Bisexual youth are just not sure whether they are gay or straight.
Attitude	26. I believe that LGBTQ persons are mentally unstable, even though it is no longer a diagnosable mental disorder.	Pilot measure	Revise	Stakeholder input, clarify wording	27. In general, LGBTQ people are mentally unstable.
Attitude	27. LGBTQ youth are sexually promiscuous.	Pilot measure	Keep		28. LGBTQ youth are sexually promiscuous.
Attitude			Add	Stakeholder input, add items about popular misconceptions.	29. Questioning youth should just make up their mind, are they gay or straight?
Attitude			Add	Stakeholder input, add items about popular misconceptions.	30. Youth who question their gender should just make up their mind, are they a boy or a girl?
Skill					
	28. I attempt to learn and use terms that reflect LGBTQ 'youth culture' so that I communicate more effectively with youth during treatment.	(Goode & Fischer, 2009)	Revise	Stakeholder input, "interact with" is better wording.	31. I attempt to learn and use terms that reflect LGBTQ 'youth culture' so that I communicate more effectively with youth that I interact with.
	29. I screen books, movies, and	(Goode &	Revise	Stakeholder	32. I screen

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other media resources for negative stereotypes about LGBTQ persons before sharing them with youth and their parents/families served by my program/agency.	Fischer, 2009)		input, clarify wording	books, movies, and other media resources for negative stereotypes about LGBTQ persons before sharing them with youth I interact with.
30. I intervene when I observe others (i.e., staff, parents, family members, children, youth) within my program/agency behave or speak about sexual orientation/gender identity in ways that are insensitive, biased, or prejudiced.	(Goode & Fischer, 2009)	Drop	Stakeholder input.	Drop, other items capture this better.
31. I intervene when a youth is being teased by being called LGBTQ-derogatory slurs (e.g., "fag", "dyke", "tranny").	Pilot measure	Drop	Stakeholder input.	Drop, other items capture this better.
32. I have resources or literature relevant to LGBTQ issues readily available to give to a youth, or know where to get some.	(Goode & Fischer, 2009)	Drop	Stakeholder input.	Drop, this can be covered by "I connect youth to resources"
33. I would put an LGBTQ-affirming sticker on my office or workspace if given the opportunity, or I do already.	Personal Comfort Scale	Revise	Stakeholder input, clarify wording to apply better to direct care workers	33. I would put an LGBTQ-affirming sticker on the space that I work in if given the opportunity, or I have already.
34. I think any child or adolescent I work with should be allowed to engage in gender non-conforming play activities (for example, a boy painting his toenails).	Pilot measure	Revise	Clarify wording, stakeholder input to add clothing example	34. Any youth I interact with should be allowed to engage in gender non-conforming activities (for example, a boy painting his toenails, or a girl dressing in boy clothing).
35. If a youth wants to use a different gendered name than their given name, I agree to do what they ask (for example, a youth whose given name is James but wishes to be called Christina).	Personal Comfort Scale	Keep		35. If a youth wants to use a different gendered name than their given name, I agree to do what they ask

				(for example, a youth whose given name is James but wishes to be called Christina).
36. I use the preferred gender pronouns of a transgender or queer youth I work with (or might in the future work with), even when their preferred pronoun is different than what is in their record, chart, or notes (for example, if a youth's chart says that they are female, but the youth uses male pronouns such as he/him/his).	Personal Comfort Scale, Goode & Fischer 2009	Drop	Clarify wording	Drop, other items capture this idea adequately (using different gendered name).
37. I know how I would respond if a youth came out to me as lesbian, gay, bisexual, or queer.	Pilot measure	Drop	Stakeholder input.	Drop, this is too vague.
38. I know how I would respond if a youth came out to me as transgender or queer.	Pilot measure	Drop	Stakeholder input.	Drop, this is too vague.
39. I intervene when youth tell me they have been bullied because of actual or perceived sexual orientation or gender identity.	(Goode & Fischer, 2009)	Revise	Stakeholder input. Clarify wording	36. I intervene when youth I interact with tell me they have been bullied because of actual or perceived sexual orientation or gender identity.
40. I intervene when I hear co-workers use derogatory language or insinuations about LGBTQ persons.	(Goode & Fischer, 2009)	Revise	Stakeholder input, Important when it happens in front of youth	37. I intervene when I hear co-workers use derogatory language or insinuations about LGBTQ persons in front of youth I interact with.
41. When I am on shift, I make sure to create and/or maintain an affirming environment about LGBTQ issues.	Adapted from (Goode & Fischer, 2009)	Revise	Stakeholder input, the word affirming sounds too celebratory	Drop, this is too vague.
42. When possible, I link (or would link) services between an LGBTQ identified youth and LGBTQ resources in the community.	Adapted from (Goode & Fischer, 2009)	Revise	Stakeholder input, "connect" will resonate better with direct care	38. When possible, I do or would connect an LGBTQ youth to LGBTQ resources

				workers	in the community.
	43. I do not automatically assume that I know a youth's sexual orientation.	Pilot measure	Drop	Clarify wording.	Drop, create a new item with different wording, not as leading.
	44. I do not automatically assume that I know a youth's gender identity.	Pilot measure	Drop	Clarify wording.	Drop, create a new item with different wording, not as leading.
	45. When providing services (or if I were to provide services) to a transgender or queer identified youth, I ensure that they have access to a gender-neutral bathroom, or the bathroom of their preferred gender.	Pilot measure	Revise	Stakeholder input: direct-care workers do not always have the power to ensure such bathroom options. Revised so as to capture the possibility	39. If a transgender youth who was a boy and now identifies as a girl needs to use the bathroom, and asks to use the girl's bathroom, I would allow them to use whichever bathroom is most comfortable for them.
Awareness					
	46. I think about how my actions could be seen as homophobic.	Pilot measure	Revise	Stakeholder input, workers may not know what homophobic is	40. I think about how my words/actions could be seen as discriminatory against lesbian, gay, and bisexual people.
	47. I think about how my actions could be seen as transphobic.	Pilot measure	Revise	Stakeholder input, workers may not know what transphobic is	41. I think about how my words/actions could be seen as discriminatory against transgender people.
	48. I recognize that even when I have good intentions, I can still do or say things that may be hurtful to LGBTQ youth.	Pilot measure	Keep		42. I recognize that even when I have good intentions, I can still do or say things that may be hurtful to LGBTQ youth.
	49. I avoid imposing values that may conflict or be inconsistent with	(Goode & Fischer,	Drop	Stakeholder input.	Drop, input that this is too vague.

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those of LGBTQ youth cultures or groups.	2009)			
50. I am comfortable using the words 'gay', 'lesbian', 'bisexual', and 'transgender'.	Personal Comfort Scale	Keep		43. I am comfortable using the words 'gay', 'lesbian', 'bisexual', and 'transgender'.
51. I am comfortable using the word 'queer' when a youth identifies as queer.	Personal Comfort Scale	Keep		44. I am comfortable using the word 'queer' when a youth identifies as queer.
52. *item moved to Knowledge section.*				
53. I can identify my reactions that are based on stereotypical beliefs about LGBTQ people.	Pilot measure	Drop	Clarification	Drop, because this is too vague, and it's covered by the previous items about "I am aware of when my actions are discriminatory"
		Add	Stakeholder input, add this dimension of "I don't talk about it"	45. In my job I don't talk to youth about sex or dating, so LGBTQ issues don't apply to my interactions with youth.
54. I witness co-workers saying homophobic things at my agency.	Adapted from (Goode & Fischer, 2009)	Revise	Stakeholder input, make distinction between observing it and intervening when it happens	46. I see/hear co-workers at my agency saying/doing prejudiced or discriminatory things about lesbian/gay/bisexual people. 46a. If Yes: I intervene when this happens.
55. I witness co-workers saying transphobic things at my agency.	Adapted from (Goode & Fischer, 2009)	Revise	Stakeholder input, make distinction between observing it and intervening when it	47. I see/hear co-workers at my agency saying/doing prejudiced or discriminatory things about transgender

				happens.	people.
					47a. If yes: I intervene when this happens. (every time it happens, sometimes when it happens, etc.)
56. I witness co-workers allowing youth to display homophobic or transphobic behaviors.	Adapted from (Goode & Fischer, 2009)	Revise	Stakeholder input, make distinction between observing it and intervening when it happens	48. I see/hear youth at my agency making fun of lesbian, gay, bisexual people or teasing other youth about being lesbian, gay, or bisexual. 48a. If Yes: I intervene when this happens.
		Add	To distinguish between sexual orientation and gender identity.	49. I see/hear youth at my agency making fun of transgender people or teasing other youth about being transgender. 49a. If Yes: I intervene when this happens.
		Add	Replaced the item about "I don't assume SO/GI" so it's not so leading.	50. A youth is straight/heterosexual unless they tell me otherwise.
		Add	Replace the item about "I don't assume SO/GI" so it's not so leading.	51. A youth is not transgender unless they tell me otherwise.

Appendix G: Introductory e-mail to Executive Directors

Dear _____,

I am writing to you to introduce an upcoming study that I will be conducting across several mid-Atlantic states (including North Carolina) and would like to invite employees of Institute for Family Centered Services to participate. The study is designed to help advance knowledge about cultural competence of "front line" treatment professionals (e.g., group home staff, treatment parents, substitute caregivers, behavioral technicians, etc.) for youth with mental health problems. I am currently completing my doctorate in Social Work at Virginia Commonwealth University in Richmond, VA, and worked in residential, inpatient, and community based care in North Carolina for over 5 years before I returned to graduate school. My practice background helped me recognize how complex and critical front line workers are in the treatment and care of youth. It also made me realize that the field needs better ways to understand and explore their approaches, behaviors, and attitudes when working with youth.

The survey's purpose is to expand knowledge about how these front line staff members view lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ) issues in youth. I'm interested in surveying only direct-care/front-line workers, not workers who serve an ancillary role in the treatment process like administrators/directors or office staff, and not workers who have advanced degrees and/or licenses such as an LCSW, LPC, MD, RN, etc.

The online survey should take about 20 minutes to complete, and can be completed at any computer with internet access. I will be offering a drawing for gift cards as incentive for participating in the survey. There is no follow-up involved; this is a one-time survey only. Your role in this process would be to pass the invitation on to your staff, along with some explanatory/introductory information about the study's purpose and details about their participation (which I will provide for you to forward). The data will be collected confidentially, and responses will remain anonymous. Participants will be asked to identify their geographic location of employment for descriptive purposes only; I will not use names of agencies in my reporting of results. I will share results in academic social work and mental health journals and in social work conferences such as the Council on Social Work Education or the Society for Social Work Research. I will also share copies of the aggregated results with any agency directors who are interested (please let me know if you would like to receive them).

I will be opening the survey in early November, so I will re-contact you then with a link and instructions for how to participate. At that time, I would need you to pass the invitation on to your employees. Or if you wish to provide me with a list of e-mail contacts, I will send the invitation myself. In my past experience with a survey like this, agencies have sent the invitation in an employee newsletter or via an e-mail from a director or administrator. Each agency has their own preferred lines of communication with their staff, so I would leave it up to you for how best to send the invitation to your employees.

Thank you for your time in reading and considering this request. I hope that you will be willing for staff members at your agency to be involved in this quick but important work. I plan to use the data I collect in this project to work towards developing improved training and approaches for effectively serving the diverse range of youth who receive treatment. If you have any questions about the project or your agency's participation, I would be very happy to talk with you. Please feel free to contact me via email at gandyme@vcu.edu or phone at(704) 451-4634. I will follow up this letter by contacting you again in the next 2 weeks.

Sincerely,
Megan Gandy

--
Megan E. Gandy, MSW, LCSW
Ph.D. Candidate
School of Social Work
Virginia Commonwealth University

gandyme@vcu.edu
(704) 451-4634
http://vcu.academia.edu/megangandy

Appendix H: E-mail invitation sent to agencies, forwarded to staff

Hello _____,
I wanted to let you know that the survey for my research project is ready, if _____ is interested in participating. If so, below is the e-mail invitation that I have prepared for you to forward to your staff. I sincerely appreciate your interest in my research project. If you have any questions, don't hesitate to contact me.

Thank you very much,

-Megan Gandy

Feel free to delete the text above this line, then forward to your staff.

Please forward to your staff: Invitation to complete survey, enter to win $50

Dear staff of _____,

Thank you for taking the time to read this note. I am excited to invite you to complete a short one-time survey. Its purpose is to help advance knowledge about the cultural competence of "front-line" treatment professionals (e.g., group home staff, treatment parents, substitute caregivers, behavioral technicians, case managers, etc.) who work with youth who have mental health problems. The survey will expand knowledge about how staff members view lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ) issues in youth. I am inviting participants who work at agencies throughout the mid-Atlantic region. It is not necessary for you to know anything about LGBTQ issues in order to participate.

I am a doctoral student in Social Work at Virginia Commonwealth University in Richmond, VA, and this survey is for my dissertation. I worked in residential, inpatient, and community based mental health care for over 5 years before I returned to graduate school. My practice background helped me recognize how complex and critical front-line workers are in the treatment and care of youth. It also made me realize that the field needs better ways to understand and explore their approaches, behaviors, and attitudes when working with youth.

The survey should take you about 20-30 minutes to complete, and you may access it at any computer or mobile device with internet access. If you can't complete the entire survey in one sitting, you can save your answers and return to it later. If you do decide to participate, you can enter into a **weekly drawing for a $50 Amazon.com gift card**. Drawings will be held every Friday (starting November 21st) until the close of the survey, December 19th, or until we reach 250 participants (whichever comes first).

Participation in the survey is voluntary. Your answers to the survey questions will be anonymous, and in no way tied back to you or the agency you work for. Results will be reported only in aggregate so that individuals cannot be identified. At the end of the survey, there is an opportunity to enter a raffle for a $50 Amazon.com gift card.

Click here to start the survey on a computer: https://redcap.vcu.edu/rc/surveys/?s=RCIUMcfiDD

or on a mobile device: https://redcap.vcu.edu/rc/surveys/?s=RCIUMcfiDD/mobile

If you have questions about the survey, you may contact me, Megan Gandy, at gandyme@vcu.edu or (804) 396-3828, or my adviser, Dr. Betsy Farmer, at efarmer4@vcu.edu or (804) 828-0410.

Also, you can read more about the survey or keep up to date with the results at the blog website, available at: http://LGBTQcompetencystudy.blogspot.com.

Thank you very much for your time and consideration. Your input is very important to me, and I look forward to learning more about this important area of the field.

Sincerely,

Megan E. Gandy, LCSW

Appendix I: Recruitment flyers for survey.

Help Put the Pieces Together!

You are invited to complete a short one-time survey. The survey is part of a VCU student's doctoral dissertation, which aims to expand knowledge about how staff members view lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ) issues in youth. I am inviting participants who work at behavioral health agencies throughout the mid-Atlantic region. It is not necessary for you to know anything about LGBTQ issues in order to participate.

Chance to WIN $50!!

The survey should take you about 20-30 minutes to complete, and you may access it at any computer or mobile device with internet access. If you do decide to participate, you can enter into a weekly drawing for a $50 Amazon.com gift card. Drawings will be held every Friday.

To learn more, or start the survey, go to: http://goo.gl/TrL3xd

If you can't complete the entire survey in one sitting, you can save your answers and return to it later.

Questions? Contact Megan Gandy at gandyme@vcu.edu or (804) 396-3828, or her adviser Dr. Betsy Farmer, at efarmer4@vcu.edu or (804) 828-0410.
Keep up to date with the results at the blog website, http://LGBTQcompetencystudy.blogspot.com

| Complete the survey for a chance to win a $50 gift card! http://goo.gl/TrL3xd | Complete the survey for a chance to win a $50 gift card! http://goo.gl/TrL3xd | Complete the survey for a chance to win a $50 gift card! http://goo.gl/TrL3xd | Complete the survey for a chance to win a $50 gift card! http://goo.gl/TrL3xd | Complete the survey for a chance to win a $50 gift card! http://goo.gl/TrL3xd | Complete the survey for a chance to win a $50 gift card! http://goo.gl/TrL3xd | Complete the survey for a chance to win a $50 gift card! http://goo.gl/TrL3xd | Complete the survey for a chance to win a $50 gift card! http://goo.gl/TrL3xd |

Invitation to complete survey, enter to win $50

Dear staff of _____,

Thank you for taking the time to read this note. I am excited to invite you to complete a short one-time survey. Its purpose is to help advance knowledge about the cultural competence of "front-line" treatment professionals (e.g., group home staff, treatment parents, substitute caregivers, behavioral technicians, case managers, etc.) who work with youth who have mental health problems. The survey will expand knowledge about how staff members view lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ) issues in youth. I am inviting participants who work at agencies throughout the mid-Atlantic region. It is not necessary for you to know anything about LGBTQ issues in order to participate.

I am a doctoral student in Social Work at Virginia Commonwealth University in Richmond, VA, and this survey is for my dissertation. I worked in residential, inpatient, and community based mental health care for over 5 years before I returned to graduate school. My practice background helped me recognize how complex and critical front-line workers are in the treatment and care of youth. It also made me realize that the field needs better ways to understand and explore their approaches, behaviors, and attitudes when working with youth.

The survey should take you about 20-30 minutes to complete, and you may access it at any computer or mobile device with internet access. *If you can't complete the entire survey in one sitting, you can save your answers and return to it later*. If you do decide to participate, you can enter into a **weekly drawing for a $50 Amazon.com gift card**. Drawings will be held every Friday.

Participation in the survey is voluntary. Your answers to the survey questions will be anonymous, and in no way tied back to you or the agency you work for. Results will be reported only in aggregate so that individuals cannot be identified. At the end of the survey, there is an opportunity to enter a raffle for a $50 Amazon.com gift card.

To begin the survey, type this website address exactly as it is below into the browser of any computer that has internet access:
http://goo.gl/TrL3xd

Or use a QR code scanner on your mobile phone to complete the survey on any mobile device that has internet access:

If you have questions about the survey, you may contact me, Megan Gandy, at gandyme@vcu.edu or (804) 396-3828, or my adviser, Dr. Betsy Farmer, at efarmer4@vcu.edu or (804) 828-0410.

Also, you can read more about the survey or keep up to date with the results at the blog website, available at: **http://LGBTQcompetencystudy.blogspot.com**.

Thank you very much for your time and consideration. Your input is very important to me, and I look forward to learning more about this important area of the field.

Sincerely,

Megan E. Gandy, LCSW

Complete survey, enter to win $50!
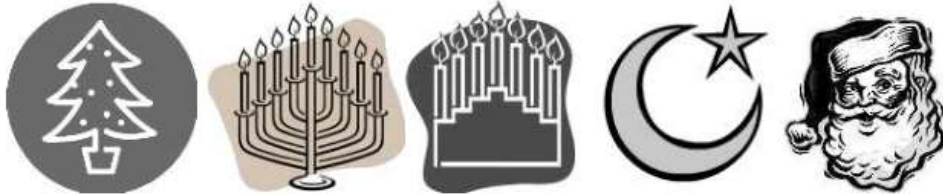
Last chance before the holidays!

You are invited to complete a short, one-time survey. The survey is part of a doctoral student's dissertation, which aims to expand knowledge about how staff members view lesbian, gay, bisexual, transgender, and queer/ questioning (LGBTQ) issues in youth. I am inviting participants who work at behavioral health agencies throughout the mid-Atlantic region. It is not necessary for you to know anything about LGBTQ issues in order to participate.

The survey should take you about 20-30 minutes to complete, and you may access it at any computer or mobile device with internet access. If you can't complete the entire survey at one time, you can save your answers and return to it later. If you do decide to participate, you can enter into a weekly drawing for a $50 Amazon.com gift card. Drawings will be held every Friday, **ending on December 19th**. Your answers will always remain anonymous.

To learn more, or to start the survey, go to:
http://gool.gl/TrL3xd

Or use your mobile device:

Questions? Contact Megan Gandy at gandyme@vcu.edu or (804) 396-3828, or her adviser Dr. Betsy Farmer, at efarmer4@vcu.edu or (804) 828-0410.

Keep up to date with the results at the blog website,
http://LGBTQcompetencystudy.blogspot.com

Appendix J: Beginning of survey from REDCap website.

Assessing LGBTQ Cultural Competency

WELCOME and THANK YOU for responding to my invitation to participate in this survey!

Below, you can read some information about the survey, and after you finish reviewing it you can decide whether or not you wish to participate.

Thank you for your time, and more importantly - your input into my research!

If you wish to find out the results of this study, bookmark the dissertation blog and check back in spring of 2015. The website is: http://LGBTQcompetencystudy.blogspot.com.

You may access the survey on your mobile device by clicking this link:

https://redcap.vcu.edu/rc/surveys/?s=RCIUMcfiDD/Mobile

RESEARCH SUBJECT INFORMATION AND CONSENT FORM
Please read this study information, and take some time to think about whether or not you wish to participate. If any information here is not clear, please ask the research staff by using their contact information at the bottom of this page.

PURPOSE OF THE STUDY
The purpose of this study is to help advance knowledge about the cultural competence of front-line treatment professionals (e.g., group home staff, treatment parents, substitute caregivers, behavioral technicians, case managers, etc.) who work with youth who have mental health problems. The survey will expand knowledge about how staff members view lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ) issues in youth. I am inviting participants who work at agencies throughout the mid-Atlantic region. It is not necessary for you to know anything about LGBTQ issues in order to participate.

DESCRIPTION OF THE STUDY AND YOUR INVOLVEMENT
You are being asked to participate in this study because you work in a direct-care role for a mental/behavioral health agency that provides services to children and youth.

The survey should take you about 20-30 minutes to complete, and you may access it at any computer or mobile device with internet access. If you cannot complete the entire survey in one sitting, you can save your answers and return again later. If you do decide to participate, you can enter into a weekly drawing for a $50 Amazon.com gift card. Drawings will be held every Friday (starting November 21st) until the close of the survey, December 19th, or until we reach 250 participants (whichever comes first).

Participation in the survey is voluntary. Your answers to the survey questions will be anonymous, and in no way tied back to you or the agency you work for. Results will be reported only in aggregate so that individuals cannot be identified.

QUESTIONS
If you have any questions, complaints, or concerns about your participation in this research, contact:

Megan E. Gandy, LCSW
P.O. Box 842027
Richmond, VA 23284
(804) 396-3828
gandyme@vcu.edu

and/or

Dr. Elizabeth M. Z. "Betsy" Farmer
P.O. Box 842027
Richmond, VA 23284

www.project-redcap.org   **REDCap**

(804) 828-0410
efarmer4@vcu.edu

This study has been approved by Virginia Commonwealth University?s Institutional Review Board as Exempt. Protocol No.: HM15385, Title: Pilot testing a measurement tool assessing service provider practice behavior.

CONSENT
By clicking ?agree?, I indicate that I am willing to participate in this study, and any questions I had about the study have been answered.

I have read the above information and agree to participate.

☐ Yes
☐ No

Instructions: Please answer the following questions to determine if you are eligible to take the survey.

Do you currently work in a behavioral health or mental health agency that serves children or adolescents? (If you do not work at a children's mental health agency, you are not eligible. If you work at an agency that works with all age groups, but you only work with adults, you are not eligible.)

☐ Yes
☐ No

What issues or problems do youth have that you interact with at your job? (If you work at an agency where you work with youth who ONLY have a developmental disability and do not also have a mental health or substance abuse problem, you are not eligible.)

☐ Mental/Behavioral Health and/or Substance Abuse
☐ Developmental Disability and Mental/Behavioral Health or Substance Abuse
☐ Developmental Disability only

15   What category best describes your job role in your agency/company?

☐ Direct-care, Front-line, or Paraprofessional: responsible for directly interacting with youth and/or their families, but does NOT require a license or a graduate degree. If you personally have a graduate degree but your job does not require you to have one, you are still eligible. (Examples include but are not limited to: group home staff, treatment parents/foster parents, substitute caregiver, behavioral technician, case manager, day treatment behavioral counselor, mobile crisis associate, inpatient unit behavioral counselor, substance abuse counselor, recreational counselor, associate professional (AP), qualified professional (QP), qualified mental health professional (QMHP), etc.)
☐ Licensed clinician: provides therapy, counseling, or other clinical treatment, and a license and/or graduate degree are required (e.g., LCSW, LPC, MFT, Licensed Psychologist, etc.). This does NOT include "QP" or "QMHP".
☐ Medical provider (e.g., MD, Nurse, NP, PA, etc.) (Note: if this is describes your job role, you are ineligible to take the survey and you will be re-directed to end the survey)
☐ Support or administrative staff: no direct clinical contact with consumers/clients, or not responsible for directly interacting with youth related to their treatment plan
☐ Something else - Please specify

Please specify what best describes your job role in your agency/company:

_____

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Definitions

DEFINITIONS
If you are unclear on what LGBTQ means, please review any of the following definitions. If you do not need to review the definitions, skip down to the CLARIFICATIONS section and review, then click Next Page.

Lesbian: a female person attracted romantically, sexually, and/or emotionally to other female persons.

Gay: a male person attracted romantically, sexually, and/or emotionally to other male persons.

Bisexual: a person attracted romantically, sexually, and/or emotionally to both sexes.

Transgender: a person who identifies in their mind as a gender/sex other than the one to which they were assigned at birth (i.e., was born a male but sees them self as a woman, or was born female but sees them self as a man). Also known as transsexual.

Queer: This term is sometimes used as a sexual orientation label instead of bisexual, or as a way of stating a non-heterosexual orientation without having to state who they are attracted to. It is considered a reclaimed word that was formerly used solely as a slur but that has been redefined by members of the LGBT community, who use it as a term of pride.

Questioning: a person who thinks they might be lesbian/gay/bisexual/transgender.

Sexual orientation: how one defines who they are attracted to romantically, emotionally, and/or sexually.

Gender identity: A persons sense of being male, female, or other gendered.

LGBTQ: a common abbreviation for lesbian, gay, bisexual, transgender, and queer/questioning people.

(adapted from PDF by Eli R. Green and Eric N. Peterson at the LGBT Resource Center at UC Riverside, 2003-2004)

CLARIFICATIONS
Youth: a child or adolescent between the ages of 5 to 17.

Youth I interact with: this refers to any child or adolescent who you work with in your job at your agency.

Agency: the company that you work for as a direct-care/front-line worker.

Vita

Megan Elizabeth Gandy was born on July 18, 1982, in Kanawha County, West Virginia, and is a citizen of the United States of America. She graduated high school from First Assembly Christian School, Concord, North Carolina, in 2000. She graduated *summa cum laude* with her Bachelor of Arts in Psychology from Lenoir-Rhyne College, Hickory, North Carolina, in 2004. She worked as a Community Support Qualified Mental Health Professional for two years before enrolling in graduate school in 2007. She received her Master of Social Work degree from the University of North Carolina at Charlotte in 2009, and was inducted into the Phi Kappa Phi academic honor society. She practiced in North Carolina as a Licensed Clinical Social Worker in both community and inpatient psychiatric settings before returning to school to earn her Ph.D. She held adjunct instructor appointments in the MSW program of VCU's School of Social Work, and in the JMSW program at North Carolina Agricultural and Technical State University and the University of North Carolina at Greensboro. She first-authored peer-reviewed manuscripts published in the *Journal of LGBT Youth* and in the journal *Residential Treatment for Children and Youth*, and co-authored a manuscript published in the *Administration and Policy in Mental Health and Mental Health Services Research*.