HHS Public Access

Author manuscript

J Gay Lesbian Ment Health. Author manuscript; available in PMC 2023 November 23.

Published in final edited form as:

J Gay Lesbian Ment Health. 2022 November 23; 80(8): . doi:10.1080/19359705.2022.2146825.

Professional Expectations of Provider LGBTQ Competence: Where We Are and Where We Need to Go

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Abstract

Introduction: Mental and behavioral health professional organizations use their governing documents to set expectations of provider competence in working with LGBTQ+ clients.

Method: The codes of ethics and training program accreditation guidelines of nine mental and behavioral health disciplines (n=16) were analyzed using template analysis.

Results: Coding resulted in fives themes: mission and values, direct practice, clinician education, culturally competent professional development, and advocacy. Expectations for provider competency vary greatly across disciplines.

Conclusion: Having a mental and behavioral health workforce that is uniformly competent in meeting the unique needs of LGBTQ populations is key for supporting the mental and behavioral health of LGBTQ persons.

Keywords

LGBTQ; cultural competency; mental health services; provider training; mental health care policy

INTRODUCTION

Despite remarkable changes in public sentiment and policy regarding lesbian, gay, bisexual, transgender, and queer (LGBTQ[1]) individuals (Allen & Smith Bynum, 2018; Gallup, 2020), this population continues to be marginalized and stigmatized resulting in stress that can reach debilitating levels (Brooks, 1981; Meyer, 2003). The high levels of stress experienced by LGBTQ populations is evidenced by inequities in mental and behavioral health (MBH)

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[1]LGTBQ is used throughout this article unless the literature being referenced uses different language (e.g. LGBT, sexual and gender minority) or is specific to a subgroup of the population (LGB-only studies).

compared to their heterosexual and cisgender counterparts. These inequities include elevated rates of depression, anxiety, substance abuse, and suicide risk (Bockting et al., 2013; Bostwick et al., 2010; Lipson et al., 2019; McCabe et al., 2009; Plöderl & Tremblay, 2015). Not surprisingly given these inequities, LGBTQ individuals are two to four times more likely to utilize MBH services than their heterosexual and cisgender peers (Dunbar et al, 2017; Platt, Wolf, & Scheitle, 2018).

In spite of the growing attention to LGBTQ-related health inequities in the education and training of MBH practitioners (American Psychological Association, 2013; Substance Abuse and Mental Health Services Administration, 2020), LGBTQ people report experiencing stigma, discrimination, and bias in MBH care settings (Corturillo et al., 2016; Johnson, 2014; Powell & Cochran, 2020). Recognizing the importance of institutionalizing protections for LGBTQ people who engage in MBH care services, many national professional organizations have enumerated affirmative practices for LGBTQ clients in their codes of ethics and accreditation criteria for training programs. These efforts are a timely and important component of increasing competent MBH care and improving the health of LGBTQ persons. In an effort to better understand these institutionalized protections -- and their distinctions across disciplines that train MBH care providers -- we sought to document the discrimination protections for LGBTQ individuals in MBH service disciplines, as well as the ways MBH providers are expected to be trained and/or competent in working with LGBTQ populations.

Meeting the MBH Needs of the LGBTQ Population

Historically, all MBH disciplines (e.g., psychology, marriage and family therapy, social work) have incited, perpetrated, and perpetuated stigma towards LGBTQ communities in one way or another. It was only in 1973 that the Diagnostic and Statistical Manual of Mental Disorders (DSM) depathologized homosexuality. Revisions applied to the DSM in 2013 (American Psychiatric Association, 2013) brought both improvements and setbacks in how transgender and gender diverse individuals are clinically evaluated (Whalen, 2012). Changing *gender identity disorder* to *gender dysphoria* was viewed as an imperfect but positive change. The change disassociated gender diversity from being “disordered” while still acknowledging the identity-related distress experienced by many transgender and other gender diverse persons. However, revising *transvestic fetishism* to *transvestic disorder* has been deemed stigmatizing. In fact, many transgender advocates posit that the inclusion of either diagnoses in the DSM is evidence of transgender persons being viewed through a disease lens that devalues and unnecessarily pathologizes trans people’s very existence. Unfortunately, insurance coverage for affirmative transgender medical care is often dependent on a pathology diagnosis undermining MBH efforts to depathologize transgender identity. Despite calls to expand informed consent models for trans-affirmative care (Cavanaugh et al., 2016; Schulz, 2018; The World Professional Association for Transgender Health, 2011), MBH professionals continue to serve as gatekeepers to affirmative medical care for transgender people (Budge, 2015; Cavanaugh et al., 2016).

Despite increases in the number of people identifying as LGBTQ and a rapidly improving social climate in the United States (Gallup, 2020), LGBTQ clients routinely face challenges

when engaging with MBH care providers. Research across MBH disciplines consistently demonstrates that practitioners lack competence and comfort when working with LGBTQ clients (Corturillo et al., 2016; Eliason, 2000; Logie et al., 2007; McGeorge et al., 2015). For instance, many providers are not knowledgeable about the unique MBH needs of LGBTQ populations or hold negative attitudes about LGBTQ people (Garnets et al., 1991; Hughes, 2011; Shipherd et al., 2010). In one study, nearly half of addiction counselors reported negative or ambivalent attitudes about LGBT clients (Eliason & Hughes, 2004). The same study found that many counselors lacked knowledge about internalized homophobia and family-of-origin issues that LGBT clients may face. In a study of over 700 marriage and family therapists, nearly 20% of providers stated that sexual orientation and gender identity change efforts (i.e. "conversion therapy")[2] are ethical, and that if presented with the opportunity, they could engage in this practice in the future (McGeorge et al., 2015). This despite the practice being outlawed in 20 states plus the District of Colombia to-date (Movement Advancement Project, 2022) due to the clear evidence that the practice undermines mental health, especially among youth (Fish & Russell, 2020).

Provider attitudes and knowledge directly impact the care that clients receive. Powell and Cochran (2020) found that higher levels of provider transphobia predict lower awareness of gender identity issues and unwarranted differences in treatment between clients who explicitly identify as transgender and those who do not. Provider insensitivity to LGBTQ people, such as using incorrect pronouns, or invalidating or questioning a client's queer identity based on the sex or gender of their partners, may be perceived as exclusionary and discriminatory by LGBTQ clients (Eliason, 2000; Eliason & Hughes, 2004; Kreiss & Patterson, 1997; Lombardi & van Servellen, 2000). The extent to which providers are sensitive to and equipped to meet the unique needs of LGBTQ clients is directly related to client satisfaction and retention (Garnets et al., 1991; Israel et al., 2008; Johnson, 2014; Shipherd et al., 2010).

The Importance of Culturally Sensitive Care

Culturally sensitive care – that which respects the cultural concerns of marginalized groups – is increasingly embraced to address inequities in MBH (Department of Health and Human Services, 2001; Nelson, 2002). Culturally sensitive health services have been empirically linked to increased client satisfaction, improved access to mental health care, and higher utilization among all clients (Govere & Govere, 2016; Truong et al., 2014). A growing number of MBH researchers and practitioners have advocated for the adoption of LGBTQ-specific treatment modalities (Cochran, 2001; Hicks, 2000; Pachankis et al., 2015; Substance Abuse and Mental Health Services Administration, 2015). Many MBH professional organizations have outlined expectations for the delivery of culturally sensitive care in their governing documents, issued treatment guidelines for providing affirming services (American Psychological Association, 2012, 2015, 2021; Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling, 2013), and disseminated guidance from population-specific advocacy groups (National Association of Social Workers, 2018).

[2]Conversion therapy (referred to as *sexual orientation and gender identity change efforts* in more contemporary literature) is the harmful practice of attempting to change one's sexual orientation to be heterosexual and/or one's gender identity to be cisgender.

Although the research is in its infancy, studies of LGB-specific treatment strategies suggest such care is more efficacious for LGB clients. General mental health services leave LGB clients less satisfied with care than their heterosexual counterparts (Avery et al., 2001). More specifically, LGB clients in substance abuse treatment have better treatment outcomes, higher levels of satisfaction, and higher retention when they participate in an LGB-specific program (e.g. identity-specific group therapy), as compared to LGB clients in "traditional" (i.e. non LGB-specific) programs (Senreich, 2009, 2010). Further, in their randomized controlled trial, Pachankis et al. (2015) found preliminary support for the use of a cognitive-behavioral treatment adapted to address sexual orientation-related minority stress in young gay and bisexual men. Compared to waitlist clients, those who received the adapted treatment showed reductions in depressive symptoms and heavy alcohol use. Numerous case studies also provide empirical support for mental health treatments that specifically address the unique needs of LGBTQ clients, as evidenced by improvements in symptoms of acute stress disorder, social anxiety disorder, depression, and panic attacks (Kaysen et al., 2005; Ross et al., 2007; Safren & Rogers, 2001; Walsh & Hope, 2010).

System-Level Tools for Developing an LGBTQ-Sensitive Workforce

Despite the demonstrated benefits of LGBTQ-sensitive MBH treatment, many LGBTQ clients have limited options for receiving such care. For many, the issue is one of availability. One analysis of state-approved mental health and substance abuse treatment facilities in the U.S. found that only 12.6% of mental health and 17.6% of substance abuse facilities reported providing LGBT-specific programs (Williams & Fish, 2020). Further, LGBTQ individuals are often aware of their peers' treatment experiences where providers were not equipped to meet these needs. This knowledge shapes their perceptions of specific providers and the health care system at large; word of mouth is a common approach to finding a provider (Martos et al., 2018). It is not surprising, then, that LGBTQ individuals often seek out health care providers that are explicitly affirming, even when their presenting problem is not related to their sexual orientation or gender identity (Martos et al., 2018). However, because of the limited number of clinicians that provide LGBTQ-affirming services, clients who persist in seeking affirming care may expend greater mental and/or financial resources than heterosexual or cisgender clients--if they can locate an affirming provider at all.

The limited availability of LGBTQ-sensitive providers is due, in part, to inadequate training in providing LGBTQ-sensitive treatment. Even when providers appear to hold positive views of LGBTQ people, they do not believe that they have received adequate training for effective clinical work with this population (Graham et al., 2012; Nowaskie, 2020; Rock et al., 2010). In one study of school counselors, the overall sample reported low levels of perceived competency in working with LGBTQ students (Shi & Doud, 2017). Notably, having a non-heterosexual identity and receiving post-masters training in working with LGBTQ students were positively correlated with perceived competency.

This body of research indicates that there are opportunities for improving the training of the MBH workforce in the U.S. System-level efforts have been made to bolster the competence of MBH practitioners and increase the availability of sensitive MBH care, for example, through non-enforceable practice guidelines (American Psychological Association, 2012,

2015, 2021; Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling, 2013). However, MBH care in the U.S. is fractured across various disciplines (e.g. social work, psychology, marriage and family therapy, etc.) and their respective professional organizations. Although all MBH disciplines share the goal of supporting the mental health and wellbeing of those that they serve, each discipline has a different perspective on how mental distress is created and maintained, the degree to which these processes play out intra- and interpersonally, and the impact of contexts beyond the individual person. Further, the origins and histories of each discipline vary widely. Given these differences, MBH disciplines have had different paths and timelines in the creation and revision of their codes of ethics and accreditation guidelines, and vary in the degree to which they have codified expectations that providers be competent in working with LGBTQ clients. Consistency in the expectations of LGBTQ competency across disciplines has important implications for creating a service environment that does not relegate the needs of LGBTQ clients to an optional continuing education topic.

It is necessary to distinguish between treatment guidelines (i.e., recommendations) and ethical and accreditation standards, given the consequences for professionals that do not adhere to ethical guidelines and, similarly, training programs that are not in compliance with accreditation standards. For example, clients can file complaints with the ethics board of their provider's professional organization. In these instances, violations of the code of ethics serve as the foundation for whether consequences are warranted. Sanctions from professional organizations vary by the severity of the infraction and the discipline's ethics complaint process. For most disciplines, the most severe punishment is permanent revocation of membership in the professional organization.

Importantly, codes of ethics are not necessarily legally binding in and of themselves. Although violations of one's code of ethics might inform disciplinary actions taken by a state licensing board, these bodies are only explicitly required to enforce the decisions of any of the reviewed national professional organizations in 18 states. Even in instances that a national code of ethics is binding in a state, there is often a blanket application of a particular document to fields that a professional may not be involved in (e.g. applying APA's code of ethics to all forms of counseling and therapy; AR Code § 17–97-310, 2015). Regardless, breaches of professional codes of ethics weigh heavily into the decisions of state licensing boards, and many states, such as Wisconsin, base their codes of ethics on those of national professional organizations (WI Stat § 455.08, 2018). LGBTQ-related ethics complaints are at risk of being thrown out, or ignored, if a code of ethics excludes LGBTQ protections and expectations.

State legislatures and national professional organizations frequently come into conflict on the best course of practice concerning disciplinary action when a code of ethics has been violated. Tennessee's legislature has actively limited the jurisdiction of the American Counseling Association (ACA) in the state under Section 63–22-110 of its code, a 'conscience clause', by inhibiting the organization's authority to enforce Section A.11.b of the ACA Code of Ethics on state-administered licensees. This section handles discriminatory value- and identity-based referrals, permitting counselors in Tennessee to refuse to see patients on account of their LGBTQ status. Notably, this is the only portion

of the document that is not binding in the state, indicating that these legislatures are highly attuned to professional codes of ethics, especially if they offer protections that overstep existing state discrimination laws. The rapid development of professional standards for protecting the rights of LGBTQ individuals in MBH fields must come in tandem with political advancements in order to be most effective.

Accreditation guidelines serve a similar function for MBH training programs. Programs must adhere to a series of training and coursework guidelines provided by the accrediting entity, which is often an arm of the professional association or an affiliated organization. Failure to meet these requirements can result in a program losing their accreditation, which is valuable for many reasons. Chief among them is the ability to attract top students to the program. Many students seek accredited programs to ensure the quality of their education and training. Additionally, in many disciplines, accreditation standards mirror the competencies and clinical hour requirements of state licensing boards. Thus, accredited programs are desirable to students who intend to seek licensure as quickly as possible following degree conferral. Given that accrediting bodies shape the core curriculum and training components of most professional MBH programs, it is critical to examine the degree to which these guidelines, alongside professional codes of ethics, help to ensure the cultural competence of the wider MBH workforce.

The Current Study

A review of where the major MBH disciplines stand with respect to expected ethics and accreditation guidelines is warranted to highlight gaps. The current study provides a comprehensive examination of the codes of ethics and accreditation guidelines from nine major MBH professions: addiction counseling, marriage and family therapy, mental health counseling, pastoral counseling, professional counseling, psychiatry, psychology, school psychology, and social work. Specifically, we conduct a template analysis to examine strengths and gaps across MBH disciplines in their: (1) discrimination protections for LGBTQ clients and (2) expectations of provider competency in working with LGBTQ clients. Recommendations that build on the strongest identified examples for ways professional organizations can address existing gaps and update their codes of ethics and accreditation guidelines are provided.

MATERIALS AND METHODS

The analytic sample consists of 16 documents comprising the codes of ethics and accreditation guidelines for nine MBH disciplines (Table 1). Given the myriad professions that assist people with MBH, we utilized the following inclusion criteria to arrive at our analytic sample:

1. Overall clientele and presenting problems focus on MBH (as opposed to physical health) AND
2. Code of ethics issued and enforced by a MBH body (as opposed to physical health body) OR

3. Accreditation guidelines issued and enforced by a MBH body (as opposed to general educational accreditation).

We considered the inclusion of governing documents for other professionals that are increasingly being called upon to deliver high quality mental and behavioral health care, including nurses, physician assistants, and primary care doctors. Although professionals with these training backgrounds may be working in MBH and/or providing MBH-related services, they 1) do not have a MBH-specific code of ethics, and 2) their training is not accredited by a MBH-specific body. Additionally, an examination of LGBTQ competence expectations within a medical establishment which has historically been siloed from MBH professionals is beyond the scope of this analysis. Thus, documents from nursing and similar disciplines were excluded from analysis. Notably, although psychiatrists are trained medical doctors, they are bound by a psychiatry-specific code of ethics (as opposed to a code of ethics for medicine in general) and were thusly included in the analysis.

Analytic Approach

We analyzed the codes of ethics and accreditation standards using template analysis, a type of thematic analysis (Brooks et al., 2015; King, 2012). The hallmark of template analysis is the development of an initial coding template after becoming familiar with the data; this template may be modified as additional themes emerge in the coding process (Brooks, et al., 2015). Template analysis was well-suited to this study given its focus on the content and contextual meaning of text, and flexibility to allow for the use of both deductive and inductive codes. To conduct the analysis, NDW and BW (“the coders”) initially read through each document in its entirety to sensitize themselves to the contexts in which LGBTQ individuals were referenced. The coders then developed a deductive coding scheme and associated codebook (Table 2) reflecting the above research questions, informed by NDW’s experience as a licensed MBH professional. This coding scheme and associated codebook included an initial set of eight deductive codes reflecting major domains of clinical standards and practices, including language regarding non-discrimination, service delivery protections for clients, supervision, referrals, LGBTQ students, LGBTQ faculty, and program coursework and curricula. We added three inductive codes to the codebook during the process of data analysis: client-centered advocacy, culturally competent professional development, and mission and values.

Despite codes of ethics and accreditation guidelines serving distinct purposes, we created deductive and codes that could be applied to either type of document; inductive codes developed through the coding process also happened to appear in both types of document. Analyzing all 16 documents together, rather than codes of ethics and accreditation guidelines separately, allows for a comprehensive examination of each major domain of standards and practices. The training of future practitioners (as guided by accreditation guidelines) and the practices of fully-trained clinicians in the field (as guided by codes of ethics) are inextricably linked and equally reflective of a given discipline’s stance regarding LGBTQ persons. As such, we analyzed codes of ethics and accreditation standards as one dataset. This approach allowed us to assess the landscape of LGBTQ protections in the MBH workforce writ large, as opposed to parsing the documents related to each stage of clinical training and practice.

Our team conducted data analysis in NVivo 12.4.0. The coders independently coded each document in its entirety using the deductive coding scheme and collaboratively created a final set of coded documents. As noted, during this process, we added three additional inductive codes to the codebook in response to the data (Table 2). Analysis of MBH disciplines' codes of ethics and accreditation standards produced five themes in protections for LGBTQ individuals and expectations for training and competency in working with LGBTQ populations. Study themes include mission and values, direct practice, clinician education, culturally competent professional development, and advocacy (Figure 1). A program's mission and values are the foundation for all of the other themes; thus, the discipline-specific expectations in the latter four domains related, in varying degrees, to program mission and values. Within each of these five themes, language ranged from suggestions and considerations for LGBTQ individuals (i.e., students, faculty, supervisors, and clients) to explicit expectations for providers and training programs. In the sections that follow, we outline each of the themes with example language from various disciplines' ethics and accreditation documents.

Study Rigor and Researchers' Positionality—We used a number of strategies to enhance study rigor and trustworthiness, including multiple coders, regular peer debriefing, and reflexive journaling (Padgett, 2016). Many qualitative researchers have problematized the notion of inter-rater reliability in qualitative research (Morse, 1997; Sandelowski, 1997). Rather than seeking to quantify a level of congruence between coders, we sought to engage in an independent coding process with two coders, interspersed with regular peer debriefing meetings. Our process emphasized discussion of language observed in the documents, the context in which excerpts of each code occurred, and what differences across documents and disciplines guide protections for LGBTQ people in MBH service delivery. The documents analyzed for this study were publicly available and did not constitute human subjects research. As such, this project was not subject to Institutional Review Board review.

In research, and as is standard in qualitative research, it is critical to identify, reflect upon throughout the process, and share with readers the researchers' positionality in relation to the phenomena under study so that readers have an understanding of the collective worldviews contributing to the study design and data analysis (Holmes, 2020). Our team includes doctoral and undergraduate students and university professors. Our study findings were reviewed by a community advisory board (CAB) of LGBTQ MBH professionals, researchers, and community members prior to submission. NDW gave an oral presentation of the methods and key findings to the CAB and received feedback on how this information can and should inform provider training and competency expectations. Collectively, the authors have been trained in (a) marriage and family therapy, (b) social work, (c) counseling psychology, (d) clinical psychology, (e) family science, and (f) public health. Several of our team members are currently or have previously been licensed MBH clinicians, and we have several decades of collective direct practice experience. Our team includes cisgender women and men of diverse sexual orientations and racial and ethnic identities. All authors are affiliated with the University of Maryland Prevention Research Center.

RESULTS

In our template analysis of LGBTQ protections and competency expectations, every document contained at least one protective statement for either sexual or gender minority individuals -- clients, students, or faculty. Table 3 presents occurrences of each code for each discipline's code of ethics and accreditation guideline document. Addiction counseling, professional counseling, and social work ethics documents had the most comprehensive coverage of LGBTQ-related content, with at least one occurrence of all 10 codes. The social work accreditation guidelines contained the most code occurrences, at 106; there were 128 code occurrences in all other ethics documents combined. All disciplines, and all but two documents, contained language related to non-discrimination. Notably, every discipline enumerated at minimum sexual orientation in their non-discrimination statement. The frequency with which organizations enumerated sexual orientation and gender identity in their non-discrimination statements can be found in Table 4. *Sexual orientation* was included in all nine disciplines, and *gender identity* was included in seven. *Gender expression, sexual expression, and gender identification* appeared less often. Service delivery protections -- protections for LGBTQ clients from harmful practices in the receipt of services -- also appeared in an ethics or accreditation document for all but one discipline.

Theme 1: Mission & Values

Every discipline in our analysis included at least one statement, aside from their non-discrimination statement, that was indicative of the mission and values of the discipline as they relate to human dignity and diversity. This formed a shared thread across all MBH professions. Each discipline in some way recognized the inherent value of every human. For example, Pastoral Counseling's code of ethics noted that their practitioners "affirm and respect the human dignity and individual worth of each person." This sentiment was mirrored in many of the reviewed documents. Some documents reflected broadly the values and the professional domains included within. For example, Marriage and Family Therapists strive for "diversity, equity and excellence in clinical practice, research, education and administration." These mission and values statements underpin the remaining themes in this analysis. The sections that follow demonstrate the variation in how these values are exemplified in codes of ethics and accreditation documents.

Theme 2: Direct Practice

All but one discipline included protections for LGBTQ clients in the receipt of services above and beyond a blanket non-discrimination statement. These protections appeared in three contexts: general service delivery protections for clients in the course of receiving services, clinicians' decisions to refer clients to other providers, and clinical supervision. First, general service delivery protections appeared in the codes of ethics and accreditation standards of seven disciplines. As with the other themes in this analysis, protections in the direct provision of services varied in strength across disciplines. For example, the Mental Health Counseling code of ethics states that "[Practitioners] consider multicultural factors (including but not limited to gender, race, religion, age, ability, culture, class, ethnicity, sexual orientation) in [clinical] test interpretation, in diagnosis, and in the formulation of prognosis and treatment recommendations." In Addictions Counseling, as outlined in their

accreditations documents, the accrediting body expects that practitioners-in-training be able to "adapt counseling strategies to the individual characteristics of the client, including (but not limited to): disability, gender, sexual orientation, developmental level, acculturation, ethnicity, age, and health status." Additionally, in the corresponding Addictions Counseling ethics document, there is a clear statement that "Providers do not endorse conversion therapy." The code of ethics for Psychiatry explicitly deems a client's sexual orientation "sensitive information" that providers should not disclose to anyone unless justifiably necessary.

A second area that many disciplines addressed, namely in their codes of ethics, is when it is appropriate for clinicians to refer their clients to a different provider. For example, Professional Counseling's code of ethics states "[practitioners] refrain from referring prospective and current clients based solely on the counselor's personally held values, attitudes, beliefs, and behaviors." This is seemingly in contrast with the unique language in Psychiatry's code of ethics that allows practitioners to "be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care," with the exception of emergency circumstances.

The final direct service domain that was addressed across ethics and accreditation documents was clinical supervision. The accreditation guidelines for Psychology training programs pointed to the importance of diversity in the demographic backgrounds of supervisors as an important component in producing culturally competent graduates and as a reflection of the climate of the program. Additionally, the code of ethics for Professional Counselors discussed supervisors as gatekeepers, noting that "[supervisors] recommend dismissal from training programs, applied counseling settings, and state or voluntary professional credentialing processes when those supervisees are unable to demonstrate that they can provide competent professional services to a range of diverse clients."

Theme 3: Clinician Education

Language applicable to LGBTQ students and faculty in the educational context mostly appeared in accreditation documents and often referred broadly to diversity, rather than an explicit focus on the recruitment and retention of LGBTQ students and faculty. For example, accredited Psychology programs "must implement specific activities, approaches, and initiatives to increase diversity among its students. It may participate in institutional-level initiatives aimed toward achieving diversity, but these alone are not sufficient." Notably, Marriage and Family Therapy appeared to produce a paradox by allowing religious objection to LGBTQ students and faculty, while simultaneously banning the dismissal of an individual from the program based on LGBTQ status:

> "Programs with a religious affiliation or purpose may have policies that are directly related to their religious affiliation or purpose and that conflict with the aforementioned anti-discrimination policy requirements, provided they are published and accessible policies, and available publicly to applicants, students, faculty members, supervisors and any other relevant educators and/or staff prior to any affiliation with or enrollment in the program. In no circumstance may programs remove a student or faculty member solely on the basis of identifying

> with a group, class, or category in the above aforementioned anti-discrimination policy requirements (e.g., identifying as LGBT) provided he or she is otherwise in compliance with the institution's code of behavioral conduct."

Marriage and Family Therapy not only requires coursework and curriculum components that address working with LGBTQ populations, but also dictates that

> "Work with sexual and gender minorities should involve LGBT Affirmative practices that encourage a positive and supportive view of lesbian, gay, bisexual, transgender or queer identities and an appreciation of the discrimination that LGBT persons experience as a result of living in a heterosexist society."

In addition to "textbook" knowledge, some accrediting bodies, like Addictions Counseling and Psychology, emphasize preparing future clinicians to navigate cultural and individual differences, and gain awareness of "personal blind spots" in clinical and supervisory work.

Theme 4: Culturally Competent Professional Development

Continuing education and professional development are universal expectations in MBH service professions and required to obtain and maintain licensure. However, professions vary in the extent to which they expect students and established clinicians to seek additional training and professional development in particular domains. Findings related to this theme included professional development expectations that broadly reflect cultural competence. For example, Pastoral Counseling requires accreditation portfolios to include "professional development opportunities for staff to gain training in cultural and religious diversity and racial equity." School Psychology's ethics document requires that practitioners "pursue awareness and knowledge of how diversity factors" may impact their clients in context.

Conversely, other disciplines communicate an expectation for members to develop and maintain competency in explicit areas, including working with LGBTQ populations. For example, the Social Work ethics document states:

> "[Practitioners] shall possess and continue to develop specialized knowledge and understanding that is inclusive of, but not limited to, the history, traditions, values, family systems, and artistic expressions such as race and ethnicity; immigration and refugee status; tribal groups; religion and spirituality; sexual orientation; gender identity or expression; social class; and mental or physical abilities of various cultural groups."

Two disciplines included language about clinician self-awareness (e.g., acts of reflection and introspection), with the Mental Health Counseling code of ethics expecting practitioners to examine their own "values, attitudes, beliefs and behaviors, as well as how these apply in a society with clients from diverse ethnic, social, cultural, religious, and economic backgrounds."

Theme 5: Advocacy

Five ethics documents and three accreditation documents included language pertaining to advocacy. This theme reflects expectations that practitioners advocate beyond the MBH services office to address the social issues and inequities facing their clients. Most of these

documents also acknowledged that advocacy occurs across distinct contexts and at different levels of society. For example, Mental Health Counselors "may serve as advocates at the individual, institutional, and/or societal level in an effort to foster sociopolitical change that meets the needs of the client or the community." Other documents used more ardent language, with Addictions Counseling discussing practitioners "being called to advocate" and Social Work stating that they "shall be aware" of social systems and "apply[ing] their understanding of social, economic, and environmental justice to advocate for human rights…" In reference to a different form of activism, Addictions Counseling requires the client's consent before clinicians advocate on their behalf.

DISCUSSION

This analysis of codes of ethics and program accreditation guidelines across MBH disciplines provides an assessment of the protections and expectations for cultural sensitivity to be afforded to LGBTQ clients by MBH providers. Overall, expectations for MBH providers-in-training and those in practice vary greatly by discipline. This lack of consistency limits the availability and quality of sensitive and effective MBH treatment, leaving the MBH needs of many LGBTQ individuals unmet. The consistent inclusion of any consideration for LGBTQ persons across all MBH disciplines speaks to the progress of the MBH field as a whole. Still, MBH professional organizations have ample room for improvement to strengthen both their protections for LGBTQ individuals as well as expectations for provider competence.

It should be noted that the LGBTQ community is not a monolith. Although LGBTQ persons may seek professional mental or behavioral health care for LGBTQ identity-related issues, often presenting problems are related to other identities, socioeconomic status, resources, etc. Affirming, culturally sensitive care attunes to LGBTQ clients' unique needs while also treating the whole person. It is also important to note that the LGBTQ population in the U.S. is sizeable and deserving of effective and affirming care from our country's MBH professionals. LGBTQ people constitute 5.6% of the U.S. population; among young people age 19–24 the proportion is even higher at 15.9% (Gallup, 2021). The mental health workforce must be equipped to meet the needs of this population that will likely continue to grow over time.

Although non-discrimination statements are standard practice and appeared in the codes of ethics for all nine disciplines, the extent to which these statements enumerated protections specifically for LGBTQ communities varied greatly. LGBTQ persons face unique challenges and have unique needs, and adequate protections and practice guidelines for LGBTQ clients requires specific enumeration. Research in other contexts, including education and public policy, has consistently demonstrated the protective function of enumerated non-discrimination policies, even when compared to general protective policies (Hatzenbuehler, 2014). Notably, the separate enumeration of both sexual orientation (LGB) and gender identity (T) is important because of differing protective policies at the federal and state levels (Movement Advancement Project, 2018). Because this change requires simply adding to existing lists of protected groups, the explicit inclusion of LGBTQ people in

non-discrimination clauses does not require the drafting of any new policy and should generally be easily adopted.

Our coding scheme resulted in ten codes: non-discrimination, service delivery protections, supervision, referrals, LGBTQ students, LGBTQ faculty, coursework and curriculum, client-centered advocacy, culturally-competent professional development, and mission and values. Three of the codes of ethics governing MBH practice had at least one instance of all 10 codes: addiction counseling, professional counseling, and social work. No accreditation guideline had all 10 codes. Thus, professional organizations may hold practicing providers to a higher standard than they do the programs that train them. For example, referrals were discussed in seven of the codes of ethics, but did not appear in any accreditation guidelines. Values-based referrals in MBH care have long been a point of contention, with many states enacting so-called “consciousness clauses” or “religious exemption laws” that legalize providers’ refusal to treat clients on the basis of their sexual orientation and/or gender identity (Movement Advancement Project, 2021). Regardless of differences across disciplines in their position on values-based referrals, training programs by definition should be preparing students for independent professional practice, including the ability to provide care that aligns with the code of ethics of their discipline. Professional organizations are encouraged to bring their program accreditation guidelines into alignment with the expectations outlined in their codes of ethics. In doing so, professional organizations must be clear about the circumstances in which it is appropriate for a provider to refer a client out and when this practice constitutes discrimination. Further, providers are called to advocate beyond their professional organizations to affect change in their state legislatures and make known the consequences of laws that effectively legalize discrimination.

Although they were the most recent versions at the time of this analysis, many of the documents examined in this study have effective dates that are years old. Policies, vocabulary, and best practices related to LGBTQ populations are rapidly-evolving. MBH organizations are encouraged to revisit and update their codes of ethics and training program accreditation guidelines on a regular basis. Professional organizations can utilize numerous resources to make these updates. Of note are recent state of science documents like those from National Academies (National Academies of Sciences, Engineering, and Medicine, 2020). It should also be noted that several federal agencies are actively prioritizing the needs of the LGBTQ population given the inequities in MBH that have been documented for decades (Sexual and Gender Minority Research Office, 2021; Substance Abuse and Mental Health Services Administration, 2020; U.S. Department of Health and Human Services, 2020).

It should be noted that most, if not all, of the MBH disciplines analyzed in this study have published supplemental documents (e.g. American Psychological Association, 2012, 2015, 2021; Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling, 2013) outlining practice guidelines and communicating an interest in the protection of LGBTQ clients from harmful practices. For example, many MBH disciplines have issued position statements on the harmful effects of sexual orientation and gender identity change efforts (American Association for Marriage and Family Therapy, 2021; American Counseling Association, 2017; Anton, 2010; National Association of Social Workers, 2015; Scasta

& Bialer, 2013). However, only one professional organization in this analysis directly addressed the harmful nature of this practice in its code of ethics. Codes of ethics dictate professional expectations for the provision of services; accreditation guidelines serve a parallel function: informing how practitioners-in-training are educated. Both ethics and accreditation guidelines include consequences for not meeting standards (e.g. sanctions from an ethics board complaint, failure to achieve accreditation). Thus, while treatment guidelines and policy position statements are important steps in signaling the values of a given discipline or organization, they fall short in holding individual practitioners and training programs accountable for a minimum level of competency in providing affirming care for LGBTQ clients. Professional organizations should directly address the harmful effects of sexual orientation and gender identity change efforts (Fish & Russell, 2020) in their code of ethics and accreditation guidelines and make it clear what the consequences are for engaging in such behavior with clients.

Professional organizations are uniquely poised to influence the competency requirements for the MBH workforce in the U.S. as well as protections for LGBTQ clients. As it stands, these clients often have limited options for MBH care that attends to their unique needs and lived experiences (Corturillo et al., 2016; Eliason, 2000; Logie et al., 2007; McGeorge et al., 2015; Williams & Fish, 2020). Although one barrier to accessing affirming care is related to the personal biases and beliefs of providers, even when providers hold positive views of LGBTQ people, they report that their training has not adequately prepared them to work with the population (Graham et al., 2012; Nowaskie, 2020; Rock et al., 2010). By strengthening and standardizing protections and competency expectations for training program accreditation across disciplines, the MBH workforce in the U.S. can make meaningful progress in addressing the persistent LGBTQ-related inequities in MBH. Practicing MBH professionals, training program faculty and students, and leaders within professional organizations are poised to push for stronger protections and competency expectations.

It should be noted that the inclusion of protections and competency expectations in codes of ethics and accreditation guidelines does not necessarily mean that organizations are firmly or uniformly enforcing them in practice. Further, organizations are only able to administer sanctions when the behavior of a provider or program is reported. Thus, although these documents are a crucial component in improving the competence of care provided to LGBTQ clients, they are not a panacea. Additionally, there is an important distinction between the consequences of violating one's code of ethics or accreditation guidelines and licensure consequences. Providers are licensed to practice by state boards and the extent to which violations of professional organization requirements may affect a provider's license vary by state. Future research should explore the relationship between professional organization policies and state licensing requirements.

Limitations

The sample of MBH disciplines included in this analysis of documents does not include all disciplines that provide MBH services, including psychiatric nurses or primary care physicians who prescribe psychotropic medications for the reasons stated above.

Additionally, it is important to note that not all MBH professionals attend accredited training programs, nor are all MBH professionals bound to the code of ethics set forth by a professional organization. Although changes to these governing documents can push MBH services towards a more uniform level of competence, they do not apply universally to providers outside of these systems. Further, it is possible that new codes of ethics and accreditation guidelines have replaced those obtained in 2019 and reviewed for this study. Finally, it must be acknowledged that research and clinical understanding of sexual and gender diverse communities is a relatively new area of inquiry that is rapidly growing and evolving. The interpretations of the authors regarding this examination of codes of ethics and accreditation guidelines may reflect the time of this analysis and underestimate the need for review and revision of these documents.

CONCLUSION

The results of this study illustrate the inconsistency across MBH disciplines in the protections afforded to LGBTQ persons and expectations of provider competence. Given that codes of ethics and training program accreditation guidelines serve as important enforcement documents, they have a direct impact on the competency of the MBH workforce in the U.S. and, in turn, the availability and quality of MBH care for LGBTQ clients. The domains discussed in this paper each lend themselves to intervention at the systems level. The authors encourage mental health providers as well as those in leadership positions within professional organizations to advocate for updates to codes of ethics and accreditation guidelines to ensure stronger and more universal expectations of provider LGBTQ competency.

Acknowledgements:

This work was supported by the University of Maryland Prevention Research Center cooperative agreement from the Centers for Disease Control and Prevention (grant U48DP006382). N.D.W. also acknowledges support from the Southern Regional Education Board and the Robert Wood Johnson Foundation Health Policy Research Scholars Program. J.N.F. also acknowledges support from the Maryland Population Research Center, by the Eunice Kennedy Shriver National Institute of Child Health and Human Development (grant P2CHD041041). This work does not expressly represent the views of the Centers for Disease Control and Prevention, National Institutes of Health, or the Robert Wood Johnson Foundation.

Data availability statement:

The data that support the findings of this study are openly available. The full titles of each document analyzed are provided in a manuscript table.

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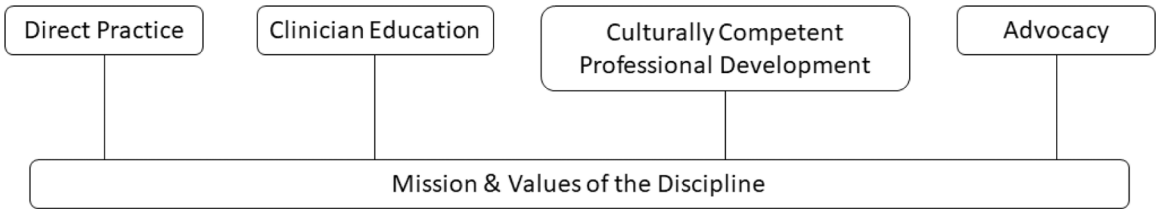

Figure 1.
Study Themes

Table 1.

Analytic Sample of Documents by Mental Health Profession

Profession	Code of Ethics	Accreditation Guidelines
Addiction Counseling	NAADAC and NCCAP Code of Ethics - approved 10.09.2016	National Addiction Studies Accreditation Commission (NASAC) Manual - 3rd Edition
Marriage and Family Therapy	American Association of Marriage and Family Therapists (AAMFT) Code of Ethics - effective January 1, 2015	Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) Accreditation Standards - Version 12.0
Mental Health Counseling	American Mental Health Counselors Association (AMHCA) Code of Ethics - October 2015	Council for Accreditation of Counseling and Related Educational Programs (CACREP) Standards - 2016
Pastoral Counseling	ACPE Code of Professional Ethics for Members of ACPE	ACPE Standards and Portfolio Expectations - 2019
Professional Counseling	American Counseling Association (ACA) Code of Ethics - 2014	Council for Accreditation of Counseling and Related Educational Programs (CACREP) Standards - 2016
Psychiatry *	American Psychiatric Association (APA) Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry - 2013	--
Psychology	American Psychological Association (APA) Ethical Principles of Psychologists and Code of Conduct - effective January 1, 2017	American Psychological Association (APA) Standards of Accreditation for Health Service Psychology and Accreditation Operating Procedures - revised June 2018
School Psychology	National Association of School Psychologists (NASP) Principles for Professional Ethics - 2010	National Association of School Psychologists (NASP) Standards for Graduate Preparation of School Psychologists - 2010
Social Work	National Association of Social Workers (NASW) Standards and Indicators for Cultural Competence in Social Work Practice −2015	Council on Social Work Education (CSWE) Educational Policy and Accreditation Standards - 2015

* Psychiatry does not have specialty-specific accreditation guidelines

Table 2.

Coding Scheme for Template Analysis of Codes of Ethics and Accreditation Guidelines

Deductive Codes and Definitions	
Non-discrimination	Enumeration of at least one LGBTQ identity in non-discrimination statements/anti-discriminatory language
Service delivery protections	Protections for LGBTQ clients from harmful practices in the receipt of services
Supervision	Expectations about clinicians seeking supervision when feeling discomfort about working with a particular presenting problem or client population, efforts at recruiting and/or retaining LGBTQ supervisors
Referrals	Guidelines about the circumstances under which it is appropriate for clinicians to refer a client elsewhere, value- or religion-based referrals
LGBTQ students	Protections for LGBTQ students in training programs, efforts at recruiting and/or retaining LGBTQ students
LGBTQ faculty	Protections for LGBTQ faculty in training programs, efforts at recruiting and/or retaining LGBTQ faculty
Coursework & curriculum	Expectations that a training program's curriculum and/or coursework will support the development of LGBTQ competencies for practitioners-in-training
Inductive Codes and Definitions	
Client-centered advocacy	Expectations that practitioners will advocate outside of the therapy room for the resolution of issues affecting their clients
Culturally-competent professional development	Expectations that practitioners will seek out professional development opportunities that expand their competencies
Mission & values	Overarching mission/values/culture of the discipline or program (e.g. valuing diversity, inclusion, social justice, etc.)

Table 3.

Code Occurrences by Discipline and Document Type

Code	Addiction Counseling		Marriage & Family Therapy		Mental Health Counseling		Pastoral Counseling		Professional Counseling		Psychiatry		Psychology		School Psychology		Social Work	
	E	AG	E	AG	E	AG	E	AG	E	AG	E	AG*	E	AG	E	AG	E	AG
Non-discrimination	●	●	●	●	●		●	●	●		●	--	●	●	●		●	
Service delivery protections	●	●	●	●	●	●			●		●	--	●	●	●	●	●	●
Supervision	●		●	●	●				●			--	●	●	●		●	
Referrals	●		●		●				●		●	--			●		●	
SGM students	●			●		●		●	●			--		●			●	●
SGM faculty	●			●		●			●			--		●			●	●
Coursework & curriculum	●	●		●		●		●	●			--		●		●	●	
Client-centered advocacy	●				●	●			●			--			●	●	●	●
Culturally-competent professional development	●			●	●	●		●	●			--	●		●	●	●	●
Mission & values	●		●	●	●	●	●	●	●			--	●	●	●	●	●	●

E = Ethics AG = Accreditation guidelines

*Accreditation guidelines for psychiatry were not found/not included in this analysis

Table 4.

Frequency of Inclusion of LGBTQ Identities in Non-discrimination Statements

	Frequency
Sexual orientation	9
Gender identity	7
Gender expression	2
Sexual expression	1
Gender identification	1