

# Providing Culturally Competent Care for LGBTQ Youth in School-Based Health Centers: A Needs Assessment to Guide Quality of Care Improvements

Samantha Garbers, PhD<sup>1</sup>, Craig J. Heck, MPH<sup>1</sup>,  
Melanie A. Gold, DO, DABMA, DMQ<sup>1,2,3</sup>,  
John S. Santelli, MD, MPH<sup>1,2</sup>, and Melina Bersamin, PhD<sup>4</sup>

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## Abstract

School-based health centers (SBHCs) can take specific steps to provide culturally competent care for lesbian, gay, bisexual, transgender, and queer (LGBTQ) youth, potentially impacting well-being. A needs assessment survey was conducted among a convenience sample of SBHC administrators and medical directors to assess climates and actions supportive of LGBTQ quality medical care. Half (53%) of the SBHCs surveyed ( $N = 66$ ) reviewed print materials for negative LGBTQ stereotypes, and 27.3% conducted exhaustive materials review. Regional differences were detected: 46.2% of Southern SBHCs conducted any materials review compared to 91.3% in the West and all in the East and Midwest ( $\chi^2$ ,  $p < .001$ ). In the last academic year, 45.5% conducted no medical provider trainings, and 54.5% conducted no general staff trainings on providing care for LGBTQ youth. On intake forms, 85.4% included preferred names, but only 23.5% included preferred pronoun. There are significant gaps in the extent to which SBHCs provide culturally competent care. These findings can guide future training and advocacy.

## Keywords

school-based health, cultural competency, LGBT health, training, quality care, adolescents, school nurse

Lesbian, gay, bisexual, transgender, and queer (LGBTQ) youth—a diverse group that includes youth who identify as lesbian, gay, or bisexual (LGB; regardless of behavior) and/or identify as transgender or a gender identity that does not conform to prevalent binary gender constructions (transgender, gender-fluid [TGF], or queer)—have been found to have higher rates of depression and anxiety, suicidality, and high-risk behaviors compared to heterosexual or cisgender peers (Marshall et al., 2011; Reisner et al., 2015). In the realm of sexual and reproductive health, disparities among some LGBTQ youth subgroups include higher rates of sexually transmitted infections and HIV among young men who have sex with men compared to other groups and higher sexual risk including rates of unintended pregnancy among lesbian and bisexual young women compared to those who identify as heterosexual (Graham et al., 2011). These health disparities may stem from the stigma, discrimination, and victimization faced by LGBTQ youth at home, in their communities, and at school (Kosciw, Greytak, Bartkiewicz, Boesen, & Palmer, 2012; Russell, Ryan, Toomey, Diaz, & Sanchez, 2011; Toomey, Ryan, Diaz, Card, & Russell, 2010).

Specific support systems have been shown to mitigate these disparities. Support from family or nonfamily

(McConnell, Birkett, & Mustanski, 2016) and specific school climate elements (Goodenow, Szalacha, & Westheimer, 2006)—for example, including the presence of a Gay-Straight Alliance, inclusive curricula, antibullying policies, trained staff, and nondiscriminatory policies around dress codes and school events (Goodenow et al., 2006; Kosciw et al., 2012; McGuire, Anderson, Toomey, & Russell, 2010)—have been associated with improved well-being among LGBTQ youth.

<sup>1</sup> Heilbrunn Department of Population and Family Health, Columbia University Mailman School of Public Health, New York, NY, USA

<sup>2</sup> Department of Pediatrics, College of Physicians and Surgeons, Columbia University, New York, NY, USA

<sup>3</sup> New York–Presbyterian Hospital, New York, NY, USA

<sup>4</sup> Prevention Research Center, Pacific Institute for Research and Evaluation, Oakland, CA, USA

## Corresponding Author:

Samantha Garbers, PhD, Heilbrunn Department of Population and Family Health, Columbia University Mailman School of Public Health, 60 Haven Avenue, Room 2D, New York, NY 10032, USA.  
Email: [svg2108@cumc.columbia.edu](mailto:svg2108@cumc.columbia.edu)

School-based health centers (SBHCs), on-site clinics providing primary care and other health services to students, have been shown to reduce health disparities and to have positive effects on youth health and academic outcomes (Knopf et al., 2016). They have been cited as a promising strategy for reaching underserved populations (Desai & Romano, 2017). Research has further found that SBHCs have a differentially positive effect for some underserved adolescent subgroups—including adolescents of color and those of low socioeconomic status (Bersamin, Garbers, Gaarde, & Santelli, 2016). SBHCs are thought to improve outcomes primarily through increasing access to health services and enhancing school connectedness (Strolin-Goltzman, Sisselman, Melekis, & Auerbach, 2014). Yet there are no studies identified in the literature examining whether SBHCs could serve as a similar buffering entity for LGBTQ youth or examining the specific mechanisms and capabilities through which SBHCs could do so. This is a missed opportunity to address the needs of an at-risk population.

As a first step in exploring how and whether SBHCs mitigate health disparities for LGBTQ youth, a needs assessment survey was undertaken to assess the ways in which SBHCs provide a culturally competent clinical environment for LGBTQ youth. The needs assessment focused specifically on structural, systemic, and interpersonal components—such as a welcoming environment with appropriate materials; collection of sexual orientation, gender identity and/or preferred pronoun; and training for provider and frontline staff on the health needs of and communicating with LGBTQ patients (Wilkerson, Rybicki, Barber, & Smolenski, 2011). Additionally, the extent to which these culturally competent practices co-occur, and whether differences in these practices emerge by school size or geographic region, were examined.

## Method

### Study Design

A cross-sectional web-based needs assessment was conducted among SBHC administrators and medical directors in June–October 2016. Potential participants were recruited through tabling at a national conference and e-mail newsletters of the national school-based health organization.

### Participants

Participants were eligible if they were an administrator or medical director of a SBHC serving students in Grades 9–12. Respondents received a US\$10 gift card incentive. Of 91 screened respondents, 6 were ineligible, 11 did not consent; of 74 consented, 66 (89%) completed the entire survey. The purposive sampling approach resulted in low response (2.9%) from the 2,315 SBHCs in the United States in 2013–2014 (<http://censusreport.sbh4all.org>), with response varying by region: 1.3% in the South, 3.3% in the Northeast, 4.3% in the West, and 4.8% in the Midwest.

### Survey Instrument

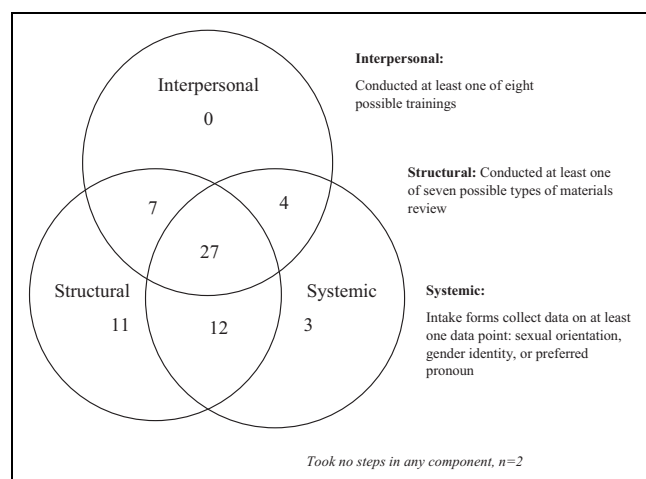
The 43-item survey explored SBHC and school climates supportive of LGBTQ quality medical care—including screening for inclusive messages, training staff and providers, climate, and setting. The instrument was adapted from existing self-assessment instruments used to assess cultural competence of environments and care for LGBTQ youth and adults (Hepburn, 2004; Goode & Sockalingam, 2000). Survey items were preliminarily tested in a network of seven SBHCs in New York City as part of a quality improvement project to assess care provided to transgender and gender-fluid youth (Ayres, Garbers, Catallozzi, & Gold, 2016). The survey was structured to collect data on three components of providing culturally competent care to LGBTQ patients (Wilkerson et al., 2011): interpersonal (eight questions on trainings for providers and/or frontline staff on the health needs of and/or communicating with LGB and/or TGF students), systemic (three questions on whether intake forms collect data on preferred pronoun, sexual orientation, or gender identity), and structural (seven questions on whether health education digital and print materials are reviewed to ensure that they represent and address the needs of diverse LGBTQ youth). The data collection protocol and instruments were reviewed by the institutional review boards at both institutions; all respondents provided informed consent.

### Data Analyses

Variable transformation preceded statistical analysis. SBHCs were grouped by region using U.S. Census classifications (<https://www.census.gov/geo/reference/webatlas/regions.html>). Provided health-care services were collapsed to reflect three categories of care (primary care, mental health services, and other services). School size was collapsed into quartiles (0–500, 501–990, 991–1500, and 1501 or more students). Responses to questions on materials review variables were dichotomized to capture whether a SBHC did a task (always, sometimes) or not (rarely, never). Those responding “don’t know” were excluded from item analyses. For 15 items (all 7 items from a national advocacy organization on school climate, 6 items on future training plans, and 2 items on orientation and training for new staff), more than 25% responded don’t know; these items were excluded from analyses. Differences in actions taken by region were tested using Pearson’s  $\chi^2$ , Fisher’s exact, and analysis of variance (ANOVA) tests, with  $\alpha = .05$ .

## Results

The 66 SBHCs were geographically dispersed and predominantly in large schools (half with 1,000+ students). Almost all (93.8%) provided comprehensive services (mental health and other services in addition to primary care). As shown in Figure 1, 97% ( $n = 64$ ) SBHCs addressed at least one element within each of three competency components



**Figure 1.** Overlap of the number of school-based health centers surveyed that took at least one action within the three components of culturally competent care for lesbian, gay, bisexual, transgender, and queer patients ( $N = 66$ ).

(structural, interpersonal, and systemic), 41% ( $n = 27$ ) addressed all three, and only two SBHCs took no steps to provide culturally competent care. Looking at specific steps within these components (Table 1), SBHCs most frequently addressed the structural component, with 86.4% of SBHCs conducting at least one type of review of the disseminated printed or multimedia educational materials to ensure that they were inclusive of and relevant LGBTQ youth, a recommended step to create a welcoming environment and medically accurate care. Over one fourth (27.3%) took all seven steps of materials review, ensuring materials included images of racially, ethnically, and culturally diverse of both LGB and TGF youth. While 22.7% of SBHCs reported conducting all of the eight trainings in the last academic year for frontline staff and providers around health needs of and communicating with LGB and TGF youth, 45.5% conducted no medical provider trainings and 54.5% conducted no general staff trainings. Climate and setting varied in steps to affirm transgender or gender-fluid patients: 85.4% included patient's chosen name on SBHC registration forms, but only 23.5% included preferred gender pronoun; 82.8% provided gender-neutral bathrooms in the SBHC.

Significant regional variations in culturally competent practices were observed. Only 46.2% of SBHCs in the South conducted any materials review compared to 91.3% in the West and all SBHCs in the East and Midwest ( $\chi^2, p < .001$ ). Training varied by region, but some differences were not statistically significant. The number of trainings offered and the number of materials review steps did not differ significantly by school size as measured in quartiles (ANOVA  $F$  test,  $p = .170, p = .112$ , respectively). The needs assessment asked about the types of training providers and staff received in the previous academic year. Respondents were asked about training participants (providers, frontline staff), the

topic (health needs, communication), and the population (LGB, TGF) for a total of eight different trainings that could be offered. In total, 15 SBHCs (22.7%) offered all eight types of training, while 28 (42.4%) offered no trainings. Of those who offered some trainings, 11 (16.6%) offered more trainings on serving LGB youth compared to trainings on serving TGF youth, whereas only 3 (4.5%) offered more trainings on serving TGF youth compared to trainings on serving LGB youth. Culturally competent practices did not differ significantly by school size (in quartiles) for any of the steps listed in Table 1.

## Discussion

This needs assessment revealed that while almost all SBHCs surveyed take at least one step to provide culturally competent care (Wilkerson et al., 2011), and avoided some, but not all, common pitfalls of providing care for transgender patients (Wylie & Wylie, 2016), gaps and variation were observed. Materials review was the domain where regional differences were most stark. There is a clear need for dissemination of materials representing youth of all identities, specifically in the South, where none of the SBHCs surveyed reported having any materials representing transgender or gender-fluid youth.

Some limitations should be noted. The small sample size rendered some large absolute regional differences statistically insignificant, and no differences by school size were detected. The sampling approach and low response rate, particularly in the South (representing only 1.3% of SBHCs in the region), limit generalizability. The sample may disproportionately include SBHCs active in promoting LGBTQ health, or, in the case of the low response rate in the South, may reflect response patterns, and therefore the potential for response bias, that may vary by region. The majority of responding SBHCs were located in urban areas (consistent with the distribution of SBHCs nationally as documented in the 2013–2014 Census, <http://censusreport.sbh4all.org>); as a result, analyses comparing urban versus suburban or rural SBHCs lacked statistical power. To limit the potential for missing data, eligibility was restricted to administrators and medical directors; these eligibility criteria further constrained our sample size. School climate features, such as having a gay-straight alliance, which have been shown to have a buffering effect for LGBTQ youth (Goodenow et al., 2006), were not reported on by sufficient numbers of respondents, most likely because SBHCs are operated independently by clinical entities, rather than the school. And, finally, this needs assessment is based on self-report: The extent to which these culturally competent practices were conducted with fidelity or accuracy could not be verified.

Despite the limitations of this needs assessment, the findings suggest specific ways that training, technical assistance, and advocacy can be targeted to support LGBTQ youth. These steps can be taken by SBHCs, by school nurses

**Table 1.** Number and Proportion of SBHCs, by Region, That Sometimes or Always Take Actions to Create an Affirming Environment for LGBTQ Students in Domain of Materials Review, Training, and SBHC Climate and Setting.

	West ( <i>n</i> = 23)	Midwest ( <i>n</i> = 14)	Northeast ( <i>n</i> = 16)	South ( <i>n</i> = 13)	Total ( <i>N</i> = 66)	$\chi^2$ Significance Test of Difference
Actions taken by cultural competency component	<i>n</i> (%)	<i>n</i> (%)	<i>n</i> (%)	<i>n</i> (%)	<i>n</i> (%)	<i>p</i> Value
<b>Structural: Materials review</b>						
Conducted at least one of the seven types of materials review listed below	21 (91.3)	14 (100)	16 (100)	6 (46.2)	57 (86.4)	.002 <sup>a</sup>
A staff member reviews books, movies, and other media resources for negative stereotypes about LGBT persons before sharing them with youth and their parents/families	15 (65.2)	8 (57.1)	10 (62.5)	2 (15.2)	35 (53.0)	.024 <sup>*</sup>
<b>LGB</b>						
Pictures, posters, and other materials that are inclusive of LGB youth and their families are displayed	15 (65.2)	10 (71.4)	11 (68.8)	2 (15.4)	38 (57.6)	.008 <sup>*</sup>
A staff member ensures that LGB youth across diverse racial, ethnic, and cultural groups have access to magazines, brochures, and other printed materials that are of interest to them	19 (82.6)	12 (85.7)	11 (68.8)	4 (30.8)	46 (69.7)	.007 <sup>a</sup>
A staff member ensures that LGB youth across racial, ethnic, and cultural groups are reflected in media resources (e.g., videos, films, CDs, DVDs, and websites) for health and behavioral health prevention, treatment, and other interventions	19 (82.5)	7 (50.0)	11 (68.8)	5 (38.5)	42 (63.6)	.036 <sup>a</sup>
<b>TGF</b>						
Pictures, posters, and other materials that are inclusive of TGF youth and their families are displayed	13 (56.5)	10 (71.4)	9 (56.3)	0 (0)	32 (48.5)	.001 <sup>*</sup>
A staff member ensures that TGF youth across diverse racial, ethnic, and cultural groups have access to magazines, brochures, and other printed materials that are of interest to them.	17 (73.9)	9 (64.3)	11 (68.8)	3 (23.1)	40 (60.6)	.019 <sup>*</sup>
A staff member ensures that TGF youth across racial, ethnic, and cultural groups are reflected in media resources (e.g., videos, films, CDs, DVDs, and websites) for health and behavioral health prevention, treatment, and other interventions	16 (69.6)	6 (42.9)	9 (56.3)	2 (15.4)	33 (50.0)	.016 <sup>*</sup>
Conducted at least one of the trainings listed below in the last academic year	12 (52.2)	8 (57.1)	12 (75.0)	6 (46.2)	38 (57.6)	.392
<b>In last academic year, conducted training for clinical provider staff on</b>						
The health needs of LGB youth	10 (52.6)	7 (53.8)	10 (71.4)	4 (33.3)	31 (53.4)	.287
Communicating with LGB youth in a clinical setting	9 (45.0)	7 (53.8)	9 (69.2)	5 (41.7)	30 (51.7)	.481
The health needs of TGF youth	10 (50.0)	6 (50.0)	9 (64.3)	3 (27.3)	28 (49.1)	.334
Communicating with TGF youth in a clinical setting	9 (47.4)	6 (50.0)	9 (69.2)	1 (11.1)	25 (47.2)	.062 <sup>a</sup>
<b>In last academic year, conducted training for frontline staff on</b>						
The health needs of LGB youth	7 (33.3)	5 (41.7)	8 (61.5)	4 (33.3)	24 (41.4)	.389 <sup>a</sup>
Communicating the health needs of LGB youth in a health setting	7 (35.0)	4 (33.3)	9 (63.4)	3 (27.3)	23 (40.4)	.231 <sup>a</sup>
The health needs of TGF youth	5 (29.4)	4 (36.4)	8 (57.1)	2 (18.2)	19 (35.8)	.248 <sup>a</sup>
Communicating the health needs of TGF youth in a health setting	8 (42.1)	4 (36.4)	8 (61.5)	1 (11.1)	21 (40.4)	.139 <sup>a</sup>
<b>Systemic: SBHC climate and setting</b>						
Intake form collects at least one point of information: Preferred pronoun, sexual orientation, and/or gender identity	16 (69.6)	11 (78.6)	9 (56.3)	10 (76.9)	46 (69.7)	.562 <sup>a</sup>
Asks patients their preferred pronoun on registration forms	4 (22.2)	4 (30.8)	2 (18.2)	2 (22.2)	12 (23.5)	.937 <sup>a</sup>
Collects data on sexual orientation	14 (73.7)	8 (66.7)	7 (53.8)	6 (54.5)	35 (63.6)	.616 <sup>a</sup>
Collects data on gender identity	13 (81.3)	7 (58.3)	5 (50.0)	6 (50.0)	31 (62.0)	.259 <sup>a</sup>
Has a nondiscrimination policy that includes sexual orientation, gender identity, and gender expression	21 (100)	14 (100)	13 (86.7)	11 (100)	59 (96.7)	.137 <sup>a</sup>
Has a single-stall gender neutral bathroom	19 (82.6)	10 (76.9)	15 (93.8)	9 (75.0)	53 (82.8)	.516 <sup>a</sup>
Asks patients their preferred name on registration forms	15 (100)	7 (87.5)	8 (72.7)	5 (71.4)	35 (85.4)	.075 <sup>a</sup>

Note. SBHC = school-based health centers; LGBTQ = lesbian, gay, bisexual, transgender, and queer; LGB = lesbian, gay, and bisexual; TGF = transgender, gender-fluid.

<sup>a</sup>Fisher's exact test. Missing data excluded.

\*Significance  $p < .05$ .

working in collaboration with SBHCs (an effective approach advocated by both the National Association of School Nurses and the School-Based Health Alliance), and by school nurses working in schools without an SBHC. Providing a welcoming environment, starting in the waiting room, with intake forms that recognize various identities and with inclusive and medically accurate and relevant materials, are key structural and systemic elements of cultural competency (Wilkerson et al., 2011). There is a documented need for culturally competent, medically accurate health education material with diverse representations of LGBTQ youth. Many federally funded health promotion interventions—such as the Office of Adolescent Health’s teen pregnancy prevention initiative—require a review of health education materials for medical accuracy and inclusiveness of youth of color and LGBTQ youth, yet the findings here suggest that such reviews do not necessarily happen. A recent qualitative study among gay and bisexual adolescents of color indicated that limited health information materials were available about their health needs, and school nurses were shown to have limited information about the sexual health needs of LGBTQ youth (Rose & Friedman, 2016).

Interpersonal cultural competence in interactions from the first encounter with check-in through nurse/patient interactions is also essential, yet we found that frontline staff infrequently received training on communicating with LGBT and TGF youth (only 40.4% of SBHCs reported conducting frontline staff training in the last academic year). Frameworks and resources for delivering (and monitoring the delivery of) culturally competent care have been developed and disseminated by professional societies, and these can be used by school nurses, including those not working in SBHCs, to guide ongoing improvements in care. These frameworks include those developed by the Gay and Lesbian Medical Association (<http://www.glma.org>), including an online webinar addressing the needs of LGBTQ patients, and by the National Association of School Nurses, which includes checklists and apps for cultural competency more broadly (<https://www.nasn.org/nasn-resources/practice-topics/cultural-competency>). Specifically, training for nurses in school settings on communicating with LGBTQ patients has previously been identified as a need (Bakker & Cavender, 2003). In this needs assessment, consistently across all three components, steps were less frequently taken to address the needs of TGF, compared to LGB, youth. With the proportion of high school students who identify as transgender or gender-fluid increasing (Rosenthal, 2016), documented mental health disparities among TGF youth (Connolly, Zervos, Barone, Johnson, & Joseph, 2016), and less than half of SBHCs report conducting training for providers on communicating with TGF youth, there is a clear need for training about how to talk with TGF youth about their specific health needs. Such trainings are readily accessible online (e.g., the National LGBT Health Education Center at [www.lgbthealtheducation.org](http://www.lgbthealtheducation.org)).

Overall, these findings indicate that some work is needed at the clinic level to create a more inclusive environment. The variability observed in this small sample suggests that a large-scale investigation is necessary to understand the full extent of these differences. Given this and previous research (Strolin-Goltzman et al., 2014), future inquiry should examine the extent and mechanisms by which SBHCs that are responsive, culturally competent, and affirming for LGBTQ youth increase school connectedness and utilization, specifically for LGBTQ youth. Given the significant regional differences observed, research is needed with a representative sample of schools with and without SBHCs and in regions with a variety of sociopolitical climates, particularly in states, localities, and school districts without safeguards such as anti-LGBTQ discrimination laws. Specifically, an examination of whether, and to what extent, culturally competent care is available for LGBTQ youth without access to an SBHC is warranted.

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## Author Biographies

**Samantha Garbers**, PhD, is an Assistant Professor at the Heilbrunn Department of Population and Family Health, Columbia University Mailman School of Public Health, New York, NY, USA.

**Craig J. Heck**, MPH, is a Research Assistant at the Heilbrunn Department of Population and Family Health, Columbia University Mailman School of Public Health, New York, NY, USA.

**Melanie A. Gold**, DO, DABMA, DMQ, is a Professor at the Heilbrunn Department of Population and Family Health, Columbia University Mailman School of Public Health, New York, NY, USA.

**John S. Santelli**, MD, MPH, is a Professor at the Heilbrunn Department of Population and Family Health, Columbia University Mailman School of Public Health, New York, NY, USA.

**Melina Bersamin**, PhD, is a Senior Research Scientist at the Prevention Research Center, Pacific Institute for Research and Evaluation, Oakland, CA, USA.

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