LGBT CULTURAL COMPETENCE TRAINING: WHAT DOES IT REALLY ACCOMPLISH?

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Impacts of LGBT Cultural Competency Training of Health Care and Social Service Professionals: Studies to Date

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Whitman-Walker Health

• Federally Qualified Health Center in Washington, DC, with a special mission to the LGBTQ community and to people living with HIV.
• Outpatient medical, behavioral health, legal and community health services.
• More than 16,000 patients in 2016.
• Whitman-Walker staff and volunteers conduct numerous trainings for medical students, residents, mental health and substance abuse treatment professionals, social service providers, elder and youth service providers and lawyers.
Survey and Analysis of 21 Reported Studies of LGBT Cultural Competency Trainings*

- Most in the past decade.
- Trainees included: medical, nursing and counseling students (9); medical residents (3); health care and social service providers (9); health care providers and other staff of a correctional system (1).
- Focus of trainings: general LGBT (6); lesbian, gay and bisexual persons (6); transgender and gender nonconforming persons (5); LGBT elders (4).
- Wide range of training formats:
  - Brief sessions – one hour or less (2).
  - One-time session of 2-3 hours (7).
  - 5 hours to a full day (3).
  - Multiple sessions over a semester or other period of time (3).
  - Not specified (2).

* List of studies available on request.
Study Types

- Evaluations of specific training programs (17).
- Surveys of students or practitioners, correlating hours of training with self-reported knowledge, attitudes and skills (3).
- Impacts of a training program as one element of comprehensive institutional reform of the NYC correctional system’s treatment of transgender inmates (1).
Evaluation Methodologies

- Pre-training and post-training questionnaire only – usually a 5-point Likert Scale (9).
- Pre-training and post-training questionnaire + narrative questions or in-person interviews with a sample of participants (3).
- Follow-up questions to participants several weeks to 90 days later (4).
- Attempts to assess impacts on patients (transgender inmates in a correctional system) (1).
- Comparison of impacts of different training formats (1-2 hours vs. 6-hours) (1).
Results

- Modest, significant improvements in knowledge, attitudes and self-reported comfort level/self-efficacy.
  - One study: 6-hour trainings yielded greater comfort with LGBT patients than 1-hour and 2-hour trainings.
  - Participants also tended to become more aware of health-related legal/social/institutional barriers faced by LGBT people – e.g., insurance discrimination against transgender persons; legal challenges faced by LGBT families.

- Longer-term outcomes less clear: 1 study showed continued improvements; another showed regression to baseline levels; a third had insufficient participation to draw conclusions.

- One survey of residents at Boston-area hospitals: curricular hours had less impact on comfort levels than clinical exposure to LGBT patients.
Results

- Only one study attempted to assess impacts on patients: the NYC correctional system found a 50% drop in complaints 3 months after staff training, and complaints dropped to zero within 6 months.

- Note that the trainings were only one component of a multi-faceted effort at institutional reform.
Some Implications From Responses of Participants

- Importance of incorporating racial/ethnic diversity, issues of intersectionality, and a wider range of gender identities.
  - Participants may not be aware of racial and other intersectional challenges if trainings do not explicitly highlight them.
  - Participants may assume that all transgender people are like the particular individual(s) they saw during the training.
- Trainees report that they appreciate interactive sessions.
- Longer trainings may be more effective than very short trainings, but short CME sessions are the norm, especially for physicians.
  - Some studies of racial/ethnic cultural competency interventions suggest that interventions focused on nurses are likely to yield the most positive results.
Many study authors worry about selection bias. Selection bias may be difficult to eliminate in the absence of mandates:

- Requirements in medical schools, nursing schools, other educational programs.
- Legal mandates for CME for licenses/certifications.
Given the diversity of sexual orientations and gender identities, and racial and ethnic diversity within those communities, focusing on a basic set of concepts and practice guidelines has limitations and may mislead practitioners.

- May be more productive to focus on skills (listening, communication).
- “Cultural humility” vs. “cultural competence.”
- Some studies of trainings to improve physician listening and communication skills have shown improvements in patient satisfaction, engagement in care, and health indicators.
Trainings to improve the knowledge, attitudes and skills of individual providers will have limited impacts on health inequities in the absence of institutional reform.

But cultural competency/humility trainings for providers can increase provider awareness of legal and institutional barriers (e.g., discrimination faced by transgender patients) and motivate them to advocate for institutional and legal change.
Evaluating the Effectiveness of LGBT Cultural Competence Trainings

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Cultural Competency Coordination

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2013-2018
DO YOU WANT TO TAKE THEM?

HOW WILL YOU KNOW WHEN YOU’RE THERE?
Our goals:

Knowledge  Attitude  Behavior

Our measures of success:

Evaluations
THE FIVE UNITS IN THE TRAINING

**Unit 1- Introduction**
Sets the stage for the group to be able to work, safety

**Unit 2- The Basics**
Defines the terms and defines WHY it’s important to identify which clients/patients are LGBT.

**Unit 3- Intersectionality**
Places LGBT identities into a broader context and asks participants to look at the public/private, privileged/oppressed parts of their own identities.

**Unit 4- LGBT Health Disparities**
Teaches facts about LGBT health and, cumulatively, brings about changes in attitude, once participants see the difficulties LGBT people face.

**Unit 5- Creating a Welcoming Environment**
Addresses behavior and systemic changes that health and
UNIT III
INTERSECTIONALITY
Diversity within the community

The Intersectionality unit builds on the terminology section by expanding the participants’ understanding of LGBTQ identities and experiences. After stressing the importance of identifying LGBTQ patients and clients in the previous section, the information in this unit suggests that for some members of this community, it may not be the most important piece of their identity. Through explanations and exercises, participants are helped to recognize public and private aspects of identities and the privilege and discrimination that accompany different aspects. We strongly recommend that some time be allotted to this unit, even in trainings that must be kept short.

UNIT III GOALS
1. To distinguish between various forms of oppression experienced by LGBTQ people and how these levels are interconnected.
2. To understand the concept of unearned privilege and its relationship with oppression.
3. To reflect on and identify one’s own privilege and types of oppression in professional settings and how their privilege/oppression affects their client/provider relationship.

There is no single correct way to teach participants the Intersectionality unit. Choose the means below to match the time allotted to the unit, the number of participants present and the comfort they have in exposing themselves with the others.

8 Slides
3 Activities

1. TRASH THAT MYTH

**Equiptmets**
10 sheets of paper, each with one myth/act printed on it for each group and one copy of the answer sheet for each group. Marking tape.

**Time:** 15 minutes

**Activity styles**
Large, Small, Formal, Intimate, Self-reflection

**Activity goals**
1. To test participant knowledge of LGBTQ health disparities
2. Encourage group interaction and physical movement before a potentially long lecture on health disparities

**Myth or Fact?**
1. Everyone has a sexual orientation.
2. If a person has not had sex with someone of the same sex, it means they are not lesbian or gay.
3. The majority who live with at least one same-sex partner.
4. Lesbians have a greater risk for breast cancer.
5. The average age of coming out for lesbian, gay & bisexual people is 21 years.
6. The majority of adults who molest boys are gay men.
7. More than 25% of LGBTQ students drop out of school because of harassment, verbal abuse & isolation.
8. One out of 5 transgender people have been refused care by a health provider.
9. Most LGBTQ nurses report that they feel safe coming out to their peers.
10. Gay marriage laws have an impact on LGBTQ health in those states.

Stepping on toes is the unintentional pain caused by a **NEWFOUND WILLINGNESS** to be close with people who are different.

It is also OK to make an error. People appreciate that providers are trying. If a provider makes a mistake in referring to someone’s name, pronoun, significant other or body part, simply apologize and move on. Try to avoid explanations about WHY the mistake was made.
Evaluating the Effectiveness of LGBT Cultural Competence Trainings

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Jack Burkhalter, Ph.D. also supported by NIH/NCI Cancer Center Support Grant P30 CA008748
Our training goals are to boost:

**Knowledge** of LGBT health concerns and disparities.

**Positive Attitudes** towards working with LGBT client/patients.

**Self-efficacy** (confidence) in communicating with and helping LGBT clients/patients.

**Intentions** to apply cultural competence knowledge and skills in interactions with LGBT clients or patients.

Our measure of training impact:

Pre- and post-training self-report measures of KASI
Measures Administered
Pre and Post Training

Knowledge: 7 items
Ex: If a man identifies as straight and has sex with another man, then he is gay or bisexual. (T or F)

Attitudes: 3 items
Ex: I would be comfortable if I became known among my peers as someone who supports LGBTQ clients/patients, and/or colleagues.

Self-efficacy: 2 items
Ex: When meeting a new patient, how confident are you in your ability to ask gender identity questions that are appropriate to your job?

Intention: 2 items
Ex: How likely are you to intervene in a homophobic interaction at your workplace?
Model For Examining Covariates Of Behavioral Intentions

Assessed in the C3 training:
- Knowledge
- Attitudes
- Self-efficacy

Not Assessed in the C3 training:
- Behavior
Evaluation Data

- Most from trainings across Staten Island
- Three different trainers
- All were community trainings of health and human service providers
### Trainee Sociodemographics: N=324

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age:</strong></td>
<td></td>
</tr>
<tr>
<td>17-30</td>
<td>105 (38.5%)</td>
</tr>
<tr>
<td>31-50</td>
<td>117 (42.9%)</td>
</tr>
<tr>
<td>&gt;51</td>
<td>51 (18.6%)</td>
</tr>
<tr>
<td><strong>Education:</strong></td>
<td></td>
</tr>
<tr>
<td>&lt;High school</td>
<td>37 (13.6%)</td>
</tr>
<tr>
<td>Associates (2 yr.) CASAC/Technical training</td>
<td>52 (19.1%)</td>
</tr>
<tr>
<td>Bachelors (4 yr.)</td>
<td>69 (25.3%)</td>
</tr>
<tr>
<td>Masters</td>
<td>103 (37.7%)</td>
</tr>
<tr>
<td>Doctorate/JD</td>
<td>12 (4.4%)</td>
</tr>
<tr>
<td><strong>Race:</strong></td>
<td></td>
</tr>
<tr>
<td>African American/Black</td>
<td>77 (28.6%)</td>
</tr>
<tr>
<td>Asian/S. Asian/PI</td>
<td>13 (4.8%)</td>
</tr>
<tr>
<td>Caucasian (non-Hispanic)</td>
<td>120 (44.6%)</td>
</tr>
<tr>
<td>Latino/Hispanic</td>
<td>51 (19.0%)</td>
</tr>
<tr>
<td>Multi-racial</td>
<td>14 (5.2%)</td>
</tr>
<tr>
<td><strong>Gender ID:</strong></td>
<td></td>
</tr>
<tr>
<td>Cis-Female</td>
<td>190 (77.6%)</td>
</tr>
<tr>
<td>Cis-Male</td>
<td>46 (18.8%)</td>
</tr>
<tr>
<td>Transgender :including: genderqueer/ non-gender/ questioning/ Two-spirit</td>
<td>51 (18.6%)</td>
</tr>
<tr>
<td><strong>Sexual orientation:</strong></td>
<td></td>
</tr>
<tr>
<td>Heterosexual</td>
<td>199 (76.2%)</td>
</tr>
<tr>
<td>LGB</td>
<td>25 (10%)</td>
</tr>
<tr>
<td>Asexual/ pansexual/ Queer Questioning/ Two-spirit</td>
<td>37 (14%)</td>
</tr>
</tbody>
</table>
Changes in Knowledge Scores from Pre- to Post-Test

**Results:** Knowledge improved significantly pre- to post-test. (Wilcoxon signed ranks test, p < 0.001)

**Note:** Score range from 0 to 7 correct responses on knowledge items.
Results: attitudes were generally positive to begin with, but they improved significantly from pre- to post-test. (Wilcoxon signed ranks test, \( P = .001 \))

Note: score range from 0 to 15 on attitude items.
Results: self-efficacy was generally high to begin with, but it improved significantly from pre- to post-test. (Wilcoxon signed ranks test, p<0.001)

Note: score range from 0 to 8 on self-efficacy items.
Changes In Behavioral Intention Scores From Pre- To Post-test

Results: behavioral intentions were generally high to begin with, but they improved significantly from pre- to post-test. (Wilcoxon signed ranks test, P<.001)

Note: score range from 0 to 8 on self-efficacy items.
Variables Associated KASI changes in Pre- To Post-test

Tested association of education, age, SOGI on pre-post KASI changes using mixed-effects logistic and cumulative logistic regression models

- **Knowledge**: None were associated
- **Attitudes**: GI significantly associated with pre-post improvement in attitude, with cisgender men less likely to show pre-post attitude improvement compared to cisgender women ($p < 0.0001$), but were more likely to have higher scores overall, indicating a ceiling effect.
- **Self-efficacy**: Younger age ($\leq 30$ y.o.), lower education ($\leq$ standard four year college vs. more), and cisgender women (vs. cisgender men) (all $p$'s $< .0001$) were significantly and positively associated with a pre-post improvement in self-efficacy. Interpret with caution as findings could be attributed to a ceiling effect for the self-efficacy variable.
- **Behavioral intentions**: None were associated
Model For Examining Covariates Of Behavioral Intentions

Results: self-efficacy increase alone was significantly associated with pre-post improvement in intention [Odds ratio 1.49 (1.25, 1.79); p < 0.0001].
• All KASI measures showed significant positive changes from pre- to post-training

• Self-efficacy was most strongly associated with behavioral intentions to enact knowledge and skills learned from the training experience
Discussion

• Observed significant improvements in all KASI variables from pre- to post-training supports a positive short-term impact on critical behavior change variables
• Longer-term impact on behavior, i.e., actual behavior change among trainees, is difficult and costly to assess
• Some demographic variables were associated with positive changes in attitudes and self-efficacy, e.g., cisgender showed less improvement compared to cisgender women, although there were ceiling effects in these measures that suggest caution in interpreting the associations
• Evaluation items, especially knowledge items, may need further refinement to capture the range of pre-test responses as well as be sensitive to training impact