WALDEN UNIVERSITY
A higher degree. A higher purpose.

Walden University
ScholarWorks

Walden Dissertations and Doctoral Studies

Walden Dissertations and Doctoral Studies Collection

2022

# Clinical Practice Guideline for Treating Depression in LGBTQ+ Patients in Primary Care

Shantrice Bernice Nichols-Bates
*Walden University*

Follow this and additional works at: https://scholarworks.waldenu.edu/dissertations

Part of the Nursing Commons, and the Psychiatric and Mental Health Commons

This Dissertation is brought to you for free and open access by the Walden Dissertations and Doctoral Studies Collection at ScholarWorks. It has been accepted for inclusion in Walden Dissertations and Doctoral Studies by an authorized administrator of ScholarWorks. For more information, please contact ScholarWorks@waldenu.edu.

# Walden University

College of Nursing

This is to certify that the doctoral study by

Shantrice Nichols-Bates

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee
Dr. Camilla Jaekel, Committee Chairperson, Nursing Faculty
Dr. Catherine Garner, Committee Member, Nursing Faculty
Dr. Anna Valdez, University Reviewer, Nursing Faculty

Chief Academic Officer
Sue Subocz, Ph.D.

Walden University
2022

Abstract

Clinical Practice Guideline for Treating Depression in LGBTQ+ Patients in Primary Care

by

Shantrice Nichols-Bates

MSN, Walden University, 2015

BSN, Chamberlain University, 2013

ADN, Hinds Nursing and Allied Health Centers, 2005

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

Walden University

May 2022

Abstract

The lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ+) population is at increased risk for depression, poor mental health outcomes, and higher instances of suicidality and reluctance to seek care for mental health issues in comparison to their non-LGBTQ+ peers. The identified gap in practice was the need for an evidence-based clinical practice guideline (CPG) for managing mild to moderate depressive disorder in the LGBTQ+ patient at a primary care clinic located in the southeastern United States. The purpose of this project was to develop a CPG to aid primary care providers in screening for, identifying, and managing mild to moderate depression in LGBTQ+ patients. The practice question was guided by the best available evidence and questioned if a multidisciplinary group in the primary care setting could develop an evidence-based CPG that meets the AGREE II criteria for managing mild to moderate depression in LGBTQ+ patients. The Johns Hopkins nursing evidence-based practice (EBP) model framework was selected to guide in the development, structure, process, and outcomes of the project. Three board certified nurse practitioners and one board certified registered nurse served as the expert panelists for this project. The recommended guideline was validated and accepted based on AGREE II criterion. Using a scale of 1-7 (*strongly disagree* to *strongly agree*), the project team selected a score of 5 or higher for each criterion within the six domains of the AGREE II tool with an average final guideline assessment score of 6.64. Use of the CPG may promote positive social change by promoting access to LGBTQ+ competent mental health care in the primary care setting.

Clinical Practice Guideline for Treating Depression in LGBTQ+ Patients in Primary Care

by

Shantrice Nichols-Bates

MSN, Walden University, 2015

BSN, Chamberlain University, 2013

ADN, Hinds Nursing and Allied Health Centers, 2005

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

Walden University

May 2022

# Dedication

I would like to dedicate this project to my loving spouse, Nicole, daughter, Jaidyn, and our family; without your love, encouragement, support, and sacrifices, none of this would have been possible. I love you big, deeply, and infinitely! I would also like to dedicate this project to the LGBTQ+ person struggling with depression; you are seen. You are heard. You are valued. And more importantly, even if and/or when it seems you are alone or without a voice, please know that you are not. You are stronger and more powerful and courageous than you may have ever fathomed.

## Acknowledgments

I would like to thank my project chairperson, Dr. Camilla Jaekel, my committee member, Dr. Catherine Garner, and my URR Dr. Anna Valdez; I am eternally appreciative for the support, encouragement, patience, and guidance each of you have provided me during this process, and for every ounce of knowledge each of you poured into me along this journey. You have all helped to develop my skills as a researcher, and have also made me a stronger clinician, and I am forever grateful.

Table of Contents

List of Tables .......... iv

List of Figures .......... v

Section 1: Nature of the Project .......... 1

Introduction .......... 1

Problem Statement .......... 4

Purpose Statement .......... 5

Nature of the Doctoral Project .......... 5

Definition of a Clinical Practice Guideline .......... 6

Purpose of Clinical Practice Guideline .......... 6

Procedural Steps for Developing the Practice Guideline .......... 7

Significance .......... 8

Summary .......... 9

Section 2: Background and Context .......... 11

Introduction .......... 11

Concepts, Models, and Theories .......... 11

Clinical Practice Guidelines .......... 11

Evidence-based Practice Framework .......... 12

Consensus Based Decision Making .......... 13

Relevance to Nursing Practice .......... 15

Prevalence of LGBTQ+ People in the United States .......... 15

Health Issues .......... 16

Culturally Competent Practice ..................................................................... 19

Relevance to Nursing Practice ..................................................................... 21

Local Background and Context .....................................................................21

Role of the DNP Student.....................................................................................22

Role of the Project Team .....................................................................................23

Summary .....................................................................................................23

Section 3: Collection and Analysis of Evidence...................................................25

Introduction.....................................................................................................25

Practice-Focused Question(s) ......................................................................25

Sources of Evidence...........................................................................................26

Procedures ..................................................................................................... 27

Subject Protections.............................................................................................28

Summary .....................................................................................................29

Section 4: Findings and Recommendations.........................................................30

Introduction.....................................................................................................30

Patient Centered Care Considerations for Recommended Guideline ..........................33

Findings and Implications.................................................................................36

Evidence Appraisal ........................................................................................ 37

Implications.................................................................................................... 41

Findings.......................................................................................................... 42

Recommendations.............................................................................................43

Strengths and Limitations of the Project...........................................................44

Section 5: Dissemination Plan ....................................................................................46

Self-Analysis ...........................................................................................................46

Summary .................................................................................................................48

References ....................................................................................................................50

Appendix A: Review of Literature Table ............................................................57

Appendix B: AGREE II Tool ....................................................................................61

Appendix C: Final Clinical Practice Guideline ..................................................64

Appendix D: Current Available Guidelines.........................................................66

List of Tables

Table 1. Johns Hopkins EBP Model Level of Evidence and Ratings ............................... 13

Table 2. Fineout-Overhold Hierarchy of Evidence Scale ................................................ 27

Table 3. AGREE II Tool Domains Alignment ................................................................ 43

List of Figures

Figure 1. Consensus Model........................................................................................ 14

# Section 1: Nature of the Project

## Introduction

Despite the existing treatment options for depressive disorder, it is estimated that more than 350 million individuals globally suffer from depression and are untreated or undertreated for this mental health disorder (Rutter et al., 2016). It has also been revealed that the estimated percentage of persons who are undertreated or untreated for depression worldwide is around 75% globally, and somewhere around 50% in the United States (Rutter et al., 2016). Of the noted percentages, a substantial number is comprised of persons who are amongst the sexual minority (persons who identify as lesbian, gay, bisexual, transgender, queer/questioning, nonbinary, gender queer, and gender diverse [LGBTQ+]).

The LGBTQ+ community encompasses a wide range of individuals with separate and overlapping challenges regarding their health care needs as well as access to quality LGBTQ+ competent health care. The LGBTQ+ population is at increased risk for mental health issues (such as depression) and poor mental health outcomes, has a higher risk for suicidality, and is also more reluctant to seek care for mental health issues than their heterosexual peers (Rutter et al., 2016). This is due to fear of being dismissed and/or experiencing discrimination, stigmatization (external and/or internal), bias (conscious or unconscious), rejection, and social prejudice from the healthcare provider and/or team. This fear-driven reluctance often presents barriers to care and can unintentionally cause harm or result in the LGBTQ+ patient having a negative healthcare experience and

avoiding seeking care in the future (Ortelli, 2020). Reluctance to seek care also has great potential to result in poor mental health outcomes.

A Healthy People 2020 goal is that the health (both physical and mental), safety, and well-being of LGBTQ+ individuals be improved (Office of Disease Prevention and Health Promotion [ODPHP], 2020). The specific health care needs for this population include LGBTQ+ competent health care for both physical and mental health issues. Primary care providers (PCPs) should strive to create a practice environment that demonstrates awareness/inclusion of and respect for LGBTQ+ patients. To accomplish this, primary care clinicians must be able to thoroughly address and traverse any recognized barriers to LGBTQ+ care, and appropriately manage the patient's mental health needs to achieve optimal mental health outcomes through primary care intervention. Despite legalities set in place to protect LGBTQ+ persons, discrimination still occurs in health care settings (Hannah et al., 2016). The LGBTQ+ community encompasses a wide range of individuals with separate and overlapping challenges regarding their health care needs as well as access to quality LGBTQ+ competent health care, and these barriers to care occur for various reasons (i.e., race, economic status, personal bias of healthcare professionals who do not identify as LGBTQ+, etc.).

Both internal and external stigma along with discrimination continue to be a significant problem facing the LGBTQ+ minority. Persons who identify as LGBTQ+ may develop an internalized homophobia that can contribute to problems with self-acceptance, difficulty forming intimate relationships, and being open about what sexual orientation of gender identity one has (National Alliance on Mental Illness [NAMI],

2021). Externally, stigma may be exhibited by the surrounding society and in some instances from within the LGBTQ+ community itself with respect to exclusion (especially of bisexuals and transgendered persons) from organizations designed to support the LGBTQ+ individual. Also, most LGBTQ+ persons are not raised by people who identify as LGBTQ+ and therefore may lack the support from parents and/or peers who may understand as well as support them in their unique struggles (American Psychological Association [APA], 2021). Adding to the burden, research also suggests that LGBTQ+ individuals face disparities as it relates to receiving adequate health care secondary to societal stigma, discrimination, lack of knowledge or misinformation regarding persons who identify as LGBTQ+, bias regarding the belief system of non-LGBTQ+ healthcare professionals, and in some instances a denial of their civil human rights (APA, 2021). Because of these barriers, positive social change in the form of improving access to quality health care (both physical and mental) is necessary.

Walden University (2020) has identified its mission to "provide a diverse community of career professionals with the opportunity to transform themselves as scholar-practitioners so they can effect positive social change" (para. 1). With respect to emerging LGBTQ+ persons, social support from humans has been identified as an extremely protective factor (Matijczak et al., 2021). This DNP project which focuses on developing a clinical practice guideline can result in positive social change by providing evidence-based guidance to clinicians about how to provide optimal care for members of the LGBTQ+ community.

## Problem Statement

The evidence strongly suggests that LGBTQ+ persons have a much higher instance of mental health conditions than their heterosexual peers- especially depression (NAMI, 2021). Despite the many recent advances regarding LGBTQ+ rights and acceptance, stigma (both internal and external), discrimination, and in some instances a denial of civil human rights continue to be a significant problem facing sexual and gender minorities. These factors are considered stressors for persons who identify as LGBTQ+ and can contribute significantly to the onset of mental health disorders and suicidality. Additionally, societal stigma, discrimination, lack of knowledge, and/or bias of heterosexual healthcare professionals are amongst common factors that largely contribute to LGBTQ+ individuals experiencing disparities in access to care, which in turn adversely impacts mental health outcomes (Ortelli, 2016).

There is a need for increased access to LGBTQ+ specific health care via competent and knowledgeable PCPs who are tasked with managing depression and improving mental health outcomes in this patient population. The clinical staff at a primary care clinic located in the southeastern United States identified a gap in practice as the need for an evidence-based clinical practice guideline for managing depressive disorder in the LGBTQ+ patient. The clinicians at this primary care location are very skilled in providing medical care, but, not extremely comfortable or knowledgeable regarding the specific needs of the LGBTQ+ population as it relates to managing mental health disorders such as depression. This newfound awareness led to the discussion of the need for a practice guideline to address this gap in practice, and ultimately improve the

management and care of LGBTQ+ persons affected by depressive disorder. This doctoral project is of significance as it will provide an evidence-based practice guideline as well as current resources to empower primary care clinicians via the development of LGBTQ+ specific care standards for managing depressive disorder in the identified population and care setting.

## Purpose Statement

The purpose of the clinical practice guideline project was to use an interprofessional team to develop a clinical practice guideline for managing the LGBTQ+ patient with depressive disorder in the primary care health setting. The practice-focused question was "Can a multidisciplinary group in the primary care setting develop an evidence-based clinical practice guideline that meets the AGREE II criteria for the treatment and management of LGBTQ+ persons diagnosed with mild to moderate depressive disorder?" An evidence-based clinical practice guideline can enhance the care of the LGBTQ+ patient population by providing guidance to the primary care team with respect to caring for this population in a manner that is competent, ethical, equitable, professional, and based on best practice guideline recommendations.

## Nature of the Doctoral Project

This doctoral project used the Walden University *DNP Manual for Clinical Practice Guideline Development (CPGD)*. Clinical practice guidelines (CPG) have been upheld as an essential part of quality health care practice for several decades (O'Rourke et al., 2016). Since having been adopted more than 50 years ago, multiple medical societies and organizations around the world have published CPGs (Bierle et al., 2020).

The purpose of CPGs is to positively impact patient care in nursing by bridging the gap between practice and currently available evidence (Dillard, 2019). Evidence-based practice integrates best available research with clinical expertise and the patient's unique values and circumstances (Dahlen et al., 2021). High-quality CPGs support high-quality healthcare delivery and can also guide clinicians and policymakers to improve care and reduce variation in clinical practice, thereby affecting patient safety and outcomes (Dahlen et al., 2021, p. 1). Evidence-based CPGs are critical to improving quality of care, but many CPGs are not developed for ready use by clinicians. As with all individuals, LGBTQ+ persons require high-quality, evidence-based care that addresses general as well as specific/holistic health care needs (Dahlen et al., 2021).

**Definition of a Clinical Practice Guideline**

CPGs were first defined as "systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances" (IOM, 1990, p. 38). The Institute of Medicine (IOM) noted the need to incorporate new evidence and best practices into the healthcare setting in a timely and efficient manner. The IOM defined clinical practice guidelines as "statements that include recommendations intended to optimize patient care that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options" (para. 1).

**Purpose of Clinical Practice Guideline**

Guidelines translate best evidence into best practice and are developed within a healthcare organization to provide care providers with the evidence and knowledge

needed to deliver safe, effective care to specific populations (American Academy of Family Physicians [AAFP], 2020). According to American Academy of Audiology [AAOA] (2019), The eight defining principles of CPGs include the following:

- describing appropriate care based on the best available scientific evidence
- reducing preventable variations in practice
- providing a rational basis for referral
- providing focus for continuing education
- promoting efficient use of resources
- providing a focus for quality control, including audit
- highlighting gaps in the existing literature
- suggesting appropriate areas for future research

**Procedural Steps for Developing the Practice Guideline**

After the clinical practice problem was identified, criteria for evidence selection were developed including a way to track and organize the evidence while assuring the integrity of the evidence. Once the evidence criteria were selected, the next step was to review/search all available best practice peer reviewed literature. The evidence obtained from the literature review/search was critically appraised as well as synthesized. After the evidence was critically appraised and synthesized, a table of evidence was constructed prior to developing the clinical guideline using the Grading of Recommendations, Assessment, Development and Evaluations (GRADE) criteria. GRADE is a transparent framework for developing and presenting summaries of evidence and provides a systematic approach for making clinical practice recommendations (Siemieniuk &

Guyatt, 2021). GRADE proposes to consider four domains: estimates of effect for desirable and undesirable outcomes, confidence in the estimates of effect, values and preferences, and resource use (Ciapponi et al., 2020). Guideline panels must integrate these factors to make a strong or weak recommendation for or against an intervention. After the table of evidence was constructed, I developed the guideline and an expert panel was identified to review the guideline and validate guideline content using the AGREE II tool. Once the expert panel reviewed the guideline and provided feedback, the recommended revisions were made. After revisions requirements were met, key stakeholders/end-users/local experts were identified, and the guideline was presented this group for feedback as it related to content validity and usability. Once the solicited feedback was received, a final report was developed and disseminated amongst the key stakeholders and was used to address the practice focused question.

## Significance

The state of Georgia is home to 425,000 persons who identify as LGBTQ+; of this population, 4.5% are adults, 5% (271,000) persons are in the workforce, and 27% of the identified adult population are raising children (Movement Advancement Project ([MAP], 2021). Despite these growing trends, Georgia is one of 29 U.S. states where LGBTQ+ people are not fully protected from discrimination in areas such as adoption and family services, nondiscrimination/antibullying for LGBTQ+ youth in the school or child welfare systems, credit and lending services, fair employment and/or housing opportunities, public accommodations, private health insurance, and equal access to competent and quality healthcare services (MAP, 2021). My goal with this project was to

develop a CPG to support primary care health professionals in meeting the mental health needs of the LGBTQ+ patient via the identification and culturally informed management of depressive disorder. The development of a patient focused CPG, based on available best practice evidence, has the potential to increase healthcare provider knowledge and competency with respect to barriers that LGBTQ+ people face in receiving competent care, eradicating such barriers, and effectively managing depression in the LGBTQ+ patient population. The development and use of this CPG also has the potential to impact positive social change by promoting access to LGBTQ+ competent mental health care in the primary care setting. Key stakeholders with respect to this project are inclusive of the patients and their families/loved ones, the respective primary health care clinic and its providers, support staff, other disciplines/roles that are integral to the healthcare team, and all communities in which LGBTQ+ persons solicit health care services.

## Summary

The purpose of this project was to develop a CPG for healthcare providers in the primary care setting to promote evidence-based care practices for LGBTQ+ persons affected by depressive disorder. The guideline was based on current evidence, and guided by the clinical practice question "Can a multidisciplinary group in the primary care setting develop an evidence-based clinical practice guideline for the treatment and management of LGBTQ+ persons diagnosed with mild to moderate depressive disorder?" This project aligns with the Healthy People 2030 goals of addressing the need for better management of depressive disorder in the LGBTQ+ population, promoting better mental health outcomes, and impacting positive social change via the promotion of increased

access to LGBTQ+ competent mental health care. I aimed to help the primary care clinic to create a care environment that demonstrates awareness of LGBTQ+ specific mental health needs, and one that is inclusive as well as respectful of LGBTQ+ patients in the primary care setting. Section 2 will address the background and context for this project.

# Section 2: Background and Context

## Introduction

The purpose of this project was to develop a CPG that will assist medical providers in a primary care clinic identify and manage mild to moderate depressive disorder in persons who identify as LGBTQ+. The clinical practice question was “Can a multidisciplinary group in the primary care setting develop an evidence-based clinical practice guideline that meets the AGREE II criteria for the treatment and management of LGBTQ+ persons diagnosed with mild to moderate depressive disorder?” In this section, I will identify the model used as the framework for this project, discuss the evidence which supported the development of a CPG for treating mild to moderate depression in LGBTQ+ persons and explore my role as the DNP project lead and the role of the project team.

## Concepts, Models, and Theories

### Clinical Practice Guidelines

CPGs are statements that include recommendations that aim to optimize patient care (AAFP, 2020). CPGs are guided by a systemic review of evidence along with an assessment of the associated benefits and/or risks of alternative care options (AAFP, 2020). CPGs are an integral component of patient centered care and serve as a framework to aide clinicians with respect to making care decisions, and CPGs also guide best practices. CPGs should be developed using a meticulous evidence-based approach with the strength of the evidence for the guideline clearly stated. CPGs should be feasible, measurable, and achievable (AAFP, 2020). CPGs should also follow a sound, transparent

methodology to translate evidence into best practice for improved patient outcomes. With respect to implementation in the clinical setting, research should be conducted to determine how to effectively implement CPGs, and how the development and use of CPGs impact both quality measures and patient outcomes.

In the clinical setting, implementation of CPGs that are based on the best available evidence should be prioritized. CPGs that are based on best available evidence and best practice help the clinician to improve the quality of patient care via utilization of interventions with proven benefit and ensure patient safety by discouraging the use of ineffective or potentially harmful practices (AAFP, 2020). CPGs also reduce deviation from best practice and allows the clinician to empower patients and lessen health care disparities. Evidence-based CPGs are critical to improving quality of care, but many CPGs are not developed for ready use by clinicians. The purpose of this project was to develop a CPG that will assist medical providers in a primary care clinic identify and manage depressive disorder in persons who identify as LGBTQ+.

## Evidence-Based Practice Framework

The evidence-based practice (EBP) framework selected to guide the development of a CPG for the identified primary care clinic was the Johns Hopkins nursing EBP model. This model is clinician focused and allows provision for the rapid as well as the appropriate application of best practices based on the most up to date evidence (Howe & Close, 2016). There are three overall steps within this model: (a) formulating a practice question, (b) researching/finding the best available evidence and (c) translating said evidence into practice (Howe & Close, 2016). The first step is formulating the practice

question, the nature of the problem, the importance of correcting the identified problem, and current practice (Howe & Close, 2016). The second step is researching/finding the best available evidence and the professional sources of evidence that will help to answer the practice question (Howe & Close, 2016). Table 1 summarizes the levels of evidence criteria and ratings. In the last step of translating evidence into practice, the evidence is critically appraised/graded, and implemented.

**Table 1**

*Johns Hopkins EBP Model Level of Evidence and Ratings*

| Level of evidence | Criteria | Quality Rating | Criteria |
|---|---|---|---|
| Level I | Systematic review of relevant randomized controlled trials (with meta-analysis where possible). | A | Consistent results, sufficient sample size, adequate control, and definitive conclusions; consistent recommendations based on extensive literature review that includes thoughtful reference to scientific evidence. |
| Level II | One or more well designed randomized controlled trials. | B | Reasonably consistent results, sufficient sample size, some control, and fairly definitive conclusions; reasonably consistent recommendations based on fairly comprehensive literature review that includes some reference to scientific evidence |
| Level III | Well designed nonrandomized controlled trials OR from well designed cohort or case-control analytical studies, preferably multicenter or conducted at different times. | C | Little evidence with inconsistent results, insufficient Sample size, conclusions cannot be drawn. |

*Note.* Adapted from Johns Hopkins University School of Nursing. (2018). *Johns Hopkins nursing evidence-based practice: Models & guidelines*. (D. Dang & S. Dearholt, Eds.) (3rd ed.). Sigma Theta Tau International.

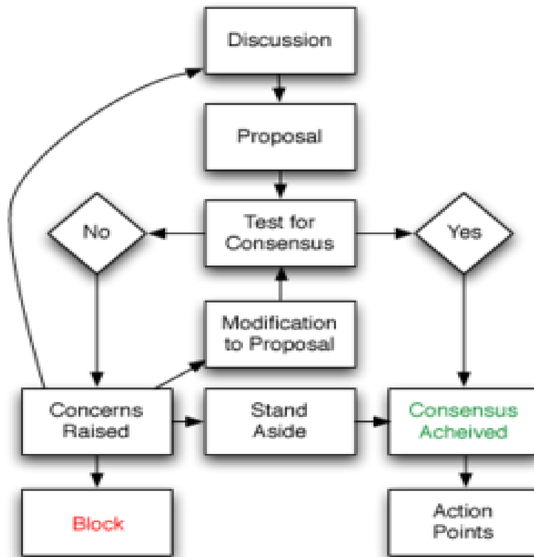
## Consensus Based Decision Making

A consensus based decision-making process is an effort in which stakeholders seek to reach agreement on a course of action to address an issue or set of related issues

(American Heart Association [AHA], 2017). In a consensus process, the stakeholders work together to find a mutually acceptable solution (AHA, 2017). By using consensus guidelines, the ideas of all group members are considered and employed. Through the combining of the ideas of all group members, the potential to develop a higher-quality decision is created versus that of a single decision and/or vote (AHA, 2017). Decisions that are acceptable to all are most likely to be implemented. Consensus building processes require active listening, open communications, and patience, and demands an elevated level of trust among the members of the group (AHA, 2017). Figure 1 summarizes the processes of consensus building.

**Figure 1**

*Consensus Model*




*Note.* Adapted from Wikipedia (2021). *Consensus Decision-Making*. https://en.wikipedia.org/wiki/Consensus_decision-making

## Relevance to Nursing Practice

Equity, quality, and patient-centered care are three top priorities of culturally competent LGBTQ+ care, and nurses can play a significant role in that regard (Carlson, 2020). Daily in the practice setting, advanced practice nurses encounter questions, problems, and patient needs that require effective clinical decision making for appropriate intervention. As the largest profession in the nation's workforce, nurses can help reshape and improve the standards of care for persons who identify as LGBTQ+.

### Prevalence of LGBTQ+ People in the United States

In the United States, it is estimated that 10 million adults identify as LGBTQ+ (Valerio & Gurrentz, 2019). Per the 2020 U.S. Census, it is estimated that there are 543,000 LGBTQ+ married households, and 469,000 LGBTQ+ unmarried partner/cohabitating households. This is a small number in comparison to the 61.4 million opposite-sex married and 8 million opposite-sex unmarried partner households (Valerio & Gurrentz, 2019). Probing deeper, traditional images of family often are of a husband and wife with their biological children, but America's families are much more diverse than that. Same-sex families reflect growing diversity and living arrangements in the United States; the U.S. Census Bureau reported that in 2020, there are 191,000 children who have been reported as living with two same-sex parents (Valerio & Gurrentz, 2019).

More than half (54.6%) of LGBTQ+ adults identify as bisexual. About a quarter (24.5%) identify as gay, with 11.7% identifying as lesbian, 11.3% identifying as transgender, and an additional 3.3% prefer nonheterosexual terminology to describe their sexual orientation, such as queer or same-gender-loving (Jones, 2021). One significant

reason LGBTQ+ prevalence has increased over time is that younger generations (about one in six adult members of Generation Z [those aged 18 to 23 in 2020]) are far more likely to consider themselves as something other than heterosexual (Jones, 2021).

Most Generation Z adults who identify as LGBTQ+ (which is about 72%) consider themselves bisexual. Thus, 11.5% of all Gen Z adults in the United States say they are bisexual, with about 2% each identifying as gay, lesbian or transgender (Jones, 2021). About half of millennials (those aged 24 to 39 in 2020) who identify as LGBTQ+ identify as bisexual (Jones, 2021). In older age groups, expressed bisexual preference is not significantly more common than expressed gay or lesbian preference; LGBTQ+ identification is lower in each older generation, including 2% or less of Americans born before 1965 aged 56 and older in 2020 (Jones, 2021).

**Health Issues**

More than 350 million individuals globally suffer from depression and are untreated or undertreated for this mental health disorder (Rutter et al., 2016). Per the American Psychiatric Association (APA, 2013), LGBTQ+ individuals are more than twice as likely as heterosexual and/or cisgender persons to have a mental health disorder in their lifetime. Also, per the APA (2013), LGBTQ+ individuals are 2.5 times more likely to experience depression, anxiety, and substance misuse compared with heterosexual individuals, and the rate of suicide attempts is four times greater for lesbian, gay, and bisexual youth and two times greater for questioning youth than that of heterosexual youth. Ortelli (2020) indicated that youth who identify as LGBTQ+ have a higher instance of homelessness and suicide attempts while adults who identify as

LGBTQ+ may experience disparities such as isolation, inadequate social services, and healthcare providers who are not culturally competent and perpetuate (purposely and/or nonpurposely) bias, social stigma, and discrimination which causes LGBTQ+ persons to delay seeking care for mental health disorders such as depression, or avoid seeking care altogether.

Despite the many recent advances regarding LGBTQ+ rights and acceptance, stigma (both internal and external), discrimination, and in some instances a denial of civil human rights continue to be a significant problem facing sexual and gender minorities (Office of Disease Prevention and Health Promotion [ODPHP], 2020). Additionally, older LGBTQ+ adults face several unique challenges, including the combination of anti-LGBTQ+ stigma and ageism (APA, 2013). Gender minority/trans persons may experience continuing, sometimes complex, life-long healthcare needs whether they undergo medical transition or not, and like all individuals, gender minority/trans people require high-quality evidence-based healthcare addressing general and specific needs (Dahlen et al., 2021, p. 2). Gender minority/trans people may experience more mental health issues such as mood and anxiety disorders, substance use, and higher rates of suicidal ideation (Dahlen et al., 2021, p. 2). They may seek assistance with sexual health, mental health, substance use disorders, prevention and/or management of HIV as well as usual general health inquiries; however, they may encounter difficulties in accessing healthcare, reporting negative healthcare experiences, discrimination, and stigma (Dahlen et al., 2021, p. 2) These factors are considered stressors for persons who identify as LGBTQ+ and can contribute significantly to the onset of mental health disorders and

suicidality. Mental health professionals have also suggested that LGBTQ+ persons have a much higher instance of mental health conditions than their heterosexual peers, particularly depression (NAMI, 2021). This community also has a suicidal risk that is three times higher for LGBTQ+ individuals than that of a non-LGBTQ+ identifying individuals. Per NAMI (2021),

> The evidence suggests that adults and youth who identify as LGBTQ+ are more than twice as likely as their heterosexual peers to experience persistent feelings of sadness and/or hopelessness, and persons who identify as transgender are more than four times likely as cisgender persons to experience depressive symptoms, and seriously consider/attempt suicide in comparison to cisgender, lesbian, gay, and bisexual persons. (para. 5)

According to the APA (2013), approximately 31% of LGBTQ+ older adults report depressive symptoms, and 39% report serious thoughts of taking their own lives. Research suggests that sexual minorities, such as people who identify as being lesbian, gay, or bisexual, are at greater risk for substance use and mental health issues compared with the majority population that identifies as being heterosexual or "straight" (Medley et al., 2016). Sexual minorities face multiple challenges in coming to terms with their sexuality and handling social reactions that are not faced by the majority population that identifies as being heterosexual or straight (Medley et al., 2016). Sexual minorities also are at greater risk of experiencing harassment or violence compared with the sexual majority population (Medley et al., 2016). These types of stressors can place sexual minorities at increased risk for substance use and mental disorders (Medley et al., 2016).

Per Medley et al. (2016), research also suggests that sexual minority adults are also more likely than sexual majority adults to have any mental illness (AMI), serious mental illness (SMI), and major depressive episodes (MDE). Based on these findings, primary care clinicians should be able to appropriately identify and manage depression in LGBTQ+ persons, and LGBTQ+ patients should be able to seek and receive care for depression from a culturally competent primary care provider (PCP) without fear of bias, discrimination, or stigma associated with their sexual orientation and/or gender identity as these are all barriers to care.

**Culturally Competent Practice**

Despite the increasing numbers in Americans who identify as LGBTQ+, there is still a significant gap in research regarding standards of care. In response to the deficit, several reports have been published in an attempt to address the lack of available data. One particular report was published by the National Academies in 2011- *The Health of Lesbian, Gay, Bisexual, and Transgender People*. This report serves as a landmark and is frequently used by a wide range of disciplines (i.e., health care professionals, researchers, federal agencies, educators, lawmakers, etc.) to guide new research pathways and practices with respect to LGBTQ+ specific standards of care.

Another report titled *Understanding the Well-Being of LGBTQ+I+ Populations* reviews the available evidence and identifies future research needs related to the well-being of the LGBTQ+ population across the life span with the goal of helping researchers and/or clinicians to translate the new research into best practice (Patterson et al., 2020). This report focuses on the following: domains of well-being, the effect of the

legal system has on LGBTQ+ specific health care (i.e., public policies, structural stigma), family and social relationships, physical and mental health, etc. and how they impact health care access and LGBTQ+ specific health interventions (Patterson et al., 2020). The recommendations of this report aim to identify knowledge deficits and further knowledge of how sexual orientation and/or gender identity impact health care access, delivery, and outcomes over the lifespan.

The need for LGBTQ+ competent health care is also validated as the LGBTQ+ population has an increased risk for poor health outcomes compared to their heterosexual and/or cisgender peers, especially as it relates to mental health disorders such as depressive disorder (Lampariello, 2020). Studies have shown that lesbian, bisexual, and queer women specifically suffer higher rates of mental health disorders than their heterosexual counterparts, and this is linked to increased instances of substance abuse (Pennay et al., 2018). Research also suggests that persons who are queer, questioning, or transgender may encounter additional/unique barrier to healthcare than their lesbian, bisexual, gay, and cisgender counterparts (Macapagal et al., 2016).

Pennay et al. (2018) cite significant issues relevant to healthcare services for LGBTQ+ persons as heterosexism (defined as discriminatory/prejudiced attitudes and practices against sexual minorities), poor clinician communication skills and knowledge base, and a lack of LGBTQ+ resources and referral networks (p. 35, para. 2). Additionally, LGBTQ+ patients often feel judged and/or dismissed when trying to get help for their mental health concerns, and the unconscious bias of health care

professionals can unintentionally cause harm or result in the LGBTQ+ patient having a negative healthcare experience and avoid seeking care in the future (Ortelli, 2020).

### Relevance to Nursing Practice

Nursing consists of the largest group of health care professionals, placing nurses in a position to significantly influence patient health care experiences and outcomes (especially for people in the LGBTQ+ community) via education and evidence-based care. By addressing LGBTQ+ health needs and working to eliminate disparities by implementing guidelines for best practice, nurses can help reduce disease transmission and/or delay the progression of disease if already present, increase mental health, physical well-being, longevity, and decrease overall health care costs (Ortelli, 2020). The development of high-quality, evidence-informed CPGs offer a way of bridging the gap between policy, best practice, local contexts, patient choice, and culturally appropriate care as CPGs draw on synthesized research findings to set forth recommendations for state-of-the-art care (O'Rourke et al., 2016). Promoting uptake and use of CPGs at the point of care delivery represents a final translation hurdle to move scientific findings into best practice (Graham et al., 2011).

## Local Background and Context

LGBTQ+ identity has been associated with high rates of psychiatric disorders and substance abuse (ODPHP, 2020). The setting for this doctoral project is a local primary care clinic that is heavily populated with LGBTQ+ identifying persons who have limited access to clinicians who are prepared to provide competent and culturally informed care, especially as it relates mental health care. The development and implementation of a CPG

based on available best evidence/best practice for managing the LGBTQ+ patient with disorder in the primary care health setting would be beneficial to this respective agency as this local clinic is utilized by LGBTQ+ patients. Additionally, the clinic's holistic model focuses on serving the uninsured as well as the underinsured via discounted out of pocket costs for a wide array of medical services. By creating an environment that is welcoming and inclusive of meeting LGBTQ+ specific health needs (especially as it relates to managing mental health disorders such as depression), the local primary care clinic would be providing an essential service to a marginalized and underserved population.

## Role of the DNP Student

Persons who identify as lesbian, gay, bisexual, transgender, and queer/questioning are an underserved population that is adversely impacted by inadequate medical and psychological treatment and are frequently victimized in medical settings with inappropriate and disrespectful conduct or language (Kahn, 2016; Lutwak, 2017). Considering these findings, my personal motivation for this doctoral project was to serve as a leader and/or agent to change to help address the disparities faced by this underserved community. Through preparation in organizational leadership, Doctor of Nursing Practice (DNP) clinicians are empowered to create unique approaches to the complex issues facing modern health care (American Academy of Colleges of Nursing [AACN], 2006). The AACN DNP essentials focuses on the conferred DNP's role of assuring accountability of quality of care, patient safety, and critically examining ethical issues inherent in patient care (AACN, 2006). The AACN DNP essential also equips the

conferred DNP with the necessary skills to facilitate meaningful changes in the health care delivery system. My professional motivation for this project was to develop and recommend a CPG to guide the primary care providers at this clinic location who are treating LGBTQ+ patients suffering from mild to moderate level depression. With respect to managing depression in persons who identify as LGBTQ+, I have no individual (personal and/or professional) bias or conflict.

## Role of the Project Team

The project team consisted of two board certified Family Nurse Practitioners (FNP) who practice in the primary care department and are currently serving as advocates and primary care clinicians for LGBTQ+ persons, one board certified Psychiatric Mental Health Nurse Practitioner (PMHNP) who identifies as a member of the LGBTQ+ community and actively practices in a psychiatric clinical setting and treats the identified population, and one board certified Registered Nurse (RN) with both primary care and psychiatric experience/background. The expert panel reviewed the table of evidence and the initial draft of the guideline. They then reviewed and edited subsequent versions of the CPG draft until consensus was reached. After consensus was reached, the panel analyzed the CPG using the AGREE II tool.

## Summary

This section provided a review of current evidence to support the use of CPGs for the treatment of depressive disorder in persons who identify as lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ+). The section also described the Johns Hopkins model as a framework for synthesizing evidence to develop the CPG. However,

the last step of implementing evidence into practice will go beyond the scope of this project which focuses solely on the development of the CPG. Section 3 will describe the collection and analysis of evidence.

# Section 3: Collection and Analysis of Evidence

## Introduction

Despite the existing treatment options for depressive disorder, it is estimated that more than 350 million individuals globally suffer from depression and are untreated or undertreated for this mental health disorder (Rutter et al., 2016). The identified gap in practice at the local primary care clinic is that the practice does not have a CPG in place to assist with meeting the mental health needs of the LGBTQ+ patient. The purpose of this project was to address this gap in practice by developing a CPG to support primary care health professionals in meeting the mental health needs of the LGBTQ+ patient via the identification and management of mild to moderate depressive disorder, and ultimately improve the management and care of LGBTQ+ persons affected by depressive disorder. Section 3 outlines the development process of this project by following the first two steps of the Johns Hopkins EBP model for translating evidence into practice: (a) formulating a practice question, and (b) researching/finding the best available evidence. The third step of the Johns Hopkins EBP model, which is the implementation of evidence into practice, was beyond the scope of this project.

## Practice-Focused Question

Can a multidisciplinary group in the primary care setting develop an evidence-based clinical practice guideline that meets the AGREE II criteria for the treatment and management of LGBTQ+ persons diagnosed with mild to moderate depressive disorder?

## Sources of Evidence

To develop the CPG, the identified guideline development process from the Walden University *DNP Manual for CPGD* was followed as well as guided by the Johns Hopkins EBP model. A literature review was performed using the Walden University online library via the Cumulative Index of Nursing and Allied Health Literature (CINAHL), Cochrane Library, Embase, Medline, and PubMed. The review was also inclusive of online literature obtained from the American Medical Association (AMA) and existing published clinical practice guidelines per the Annals of Family Medicine, the APA, and the Substance Abuse and Mental Health Services Administration (SAMSHA). Search parameters were set to only review sources of evidence published within the last 10 years.

Inclusion criteria consisted of data from peer-reviewed journals, professional organizations, and expert opinions- all of which were composed in English. Search keywords were inclusive of *clinical practice guidelines, depressive disorder, LGBTQ+ depression, LGBT depressive disorder, LGBTQ+ depression clinical practice guidelines, LGBTQ+ health disparities, LGBTQ+ health needs, LGBTQ+ inclusive health programs, LGBTQ+ health statistics, LGBTQ+ mental health,* and *LGBTQ+ policies and laws*. Concerning key terminology, the acronym *LGBTQ+* encompasses a wide range of individuals/is inclusive of all persons who identify as lesbian, gay, bisexual, transgender, queer/questioning, nonbinary, gender queer, and gender diverse). Once credible evidence was located, I then thoroughly evaluated the sources, annotating the similarities as well as differences and organized this information. I also annotated common/recurrent themes.

After synthesizing the literature, a Table of Evidence was constructed as a prerequisite for developing the clinical guideline (Table A1). The Fineout-Overholt et al. (2010) hierarchy of evidence scale was used then used to appraise the evidence. Table 2 summarizes the hierarchy scale.

**Table 2**

*Fineout-Overhold Hierarchy of Evidence Scale*

| Type of Evidence | Level of Evidence | Description |
|---|---|---|
| Systematic Review or meta-analysis | I | Synthesis of evidence from relevant RCT's |
| RCT | II | Experiments randomized subjects |
| Controlled trial without randomization | III | Experiments nonrandomly assigned subjects |
| Case-control or cohort study | IV | Comparison groups or observations of groups |
| Systematic review of qualitative or descriptive studies | V | Gathering data on human behavior or describing background of an area of interest |
| Qualitative or descriptive study | VI | Gathering data on human behavior or describing background of an area of interest |
| Expert opinion or consensus | VII | Opinions of experts or consensus of experts |

*Note.* Adapted from Fineout Overhold E., Melynk, B., Stillwell, S., & Williamson, K. (2010). Critical Appraisal of the Evidence: Part 1. American Journal of Nursing, 110(7). The analysis of evidence will inform an initial draft of the CPG.

**Procedures**

The expert panel consisted of two board certified family nurse practitioners (FNP) who practice in the primary care department and are currently serving as advocates and primary care clinicians for LGBTQ+ persons, one board certified psychiatric mental health nurse practitioner (PMHNP) who identifies as a member of the LGBTQ+ community and actively practices in a psychiatric clinical setting and treats the identified

population, and one board certified registered nurse (RN) with both primary care and psychiatric experience/background. The team meetings were held via teleconferencing due to current COVID precautions. The document was placed into Google Docs, which allows multiple individuals to comment on and edit a single document. Once consensus was reached, the team reviewed the guideline and validate guideline content using the AGREE II tool. The AGREE II tool consists of 23 items within six domains:

1. Domain 1: Scope and Purpose
2. Domain 2: Stakeholder Involvement
3. Domain 3: Rigor of Development
4. Domain 4: Clarity of Presentation
5. Domain 5: Applicability
6. Domain 6: Editorial Independence (Brouwers et al., 2010)

Once consensus was achieved, the final guideline was submitted to the clinic leadership for formal approval prior to implementation.

## Subject Protections

There was no direct patient contact during the development of the proposed CPG. The expert panel were volunteers from this primary care practice. While their names were included in the guideline for internal validation and approval, their names were not used in the Walden document. Once the guideline was formalized after the AGREE process, the Google Doc was erased from the internet and the final hard copy was maintained according to Walden Institutional Review Board (IRB) guidelines. This project was

submitted to the Walden IRB for approval, and approval was granted with approval number 01-25-22-0431591 noted.

## Summary

Section 3 of this doctoral project included an overview of the collection and analysis of evidence to develop a CPG. The section also provided an overview of the expert panel and the use of the AGREE II tool as a method to evaluate the CPG. The development of a patient focused CPG based on available best practice evidence has immense potential to increase healthcare provider knowledge and competency with respect to barriers to LGBTQ+ competent care, eradicating such barriers, and effectively managing depression in the LGBTQ+ patient population. Improved mental health in LGBTQ+ individuals has the potential to improve their quality of life and decrease the risk of suicidal ideation.

# Section 4: Findings and Recommendations

## Introduction

The purpose of the CPG project was to use an interprofessional team to develop a CPG for managing the LGBTQ+ patient with mild to moderate depressive disorder in the primary care health setting following the *Walden DNP Manual for CPGD*. The LGBTQ+ population is at increased risk for mental health issues (such as depression) and poor mental health outcomes, has a higher risk for suicidality, and is also more reluctant to seek care for mental health issues than their heterosexual peers (Rutter et al., 2016). The LGBTQ+ community encompasses a wide range of individuals with separate and overlapping challenges regarding their health care needs as well as access to quality LGBTQ+ competent health care. The LGBTQ+ population is at increased risk for mental health issues (such as depression) and poor mental health outcomes, has a higher risk for suicidality, and is also more reluctant to seek care for mental health issues than their heterosexual peers (Rutter et al., 2016). The evidence reinforces the need for increased access to LGBTQ+ specific health care via competent and knowledgeable primary care providers who are tasked with managing mild to moderate depression and improving mental health outcomes in this patient population.

The clinical staff at a primary care clinic located in the southeastern United States identified a gap in practice as the need for an evidence-based clinical practice guideline for managing mild to moderate depressive disorder in the LGBTQ+ patient. The clinicians at this primary care location are very skilled in providing medical care but verbalized a lack of knowledge regarding the specific needs of the LGBTQ+ population

as it relates to managing mental health disorders such as depression. This newfound awareness led to the discussion of the need for a practice guideline to address this gap in practice, and ultimately improve the management and care of LGBTQ+ persons affected by mild-moderate depressive disorder. The practice-focused question was “Can a multidisciplinary group in the primary care setting develop an evidence-based clinical practice guideline that meets the AGREE II criteria for the treatment and management of LGBTQ+ persons diagnosed with mild to moderate depressive disorder?

A literature search was conducted using the Walden University online library via the CINAHL, Cochrane Library, Embase, Medline, and PubMed. The review was also inclusive of online literature obtained from the AMA and existing published clinical practice guidelines per the Annals of Family Medicine, APA, and SAMSHA. Search parameters were set to only review sources of evidence published within the last 10 years. Each article was reviewed to determine relevance to the clinical question. Seven articles met the inclusion criteria and informed the development of the CPG. Lastly, an expert panel analyzed the quality of the developed guideline using a conceptual model to adopt the specified guideline.

Depression affects an estimated 8% of persons in the United States and accounts for more than $210 billion in health care costs annually (Maurer et al., 2018). Regarding depression screening guidelines, the U.S. Preventive Services Task Force (USPSTF) and AAFP recommend screening for depression in the general adult population; additionally, the USPSTF recommends screening children and adolescents 12 to 18 years of age for major depressive disorder (Maurer et al., 2018). All screening should be implemented

with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up; the two-item and nine-item patient health questionnaires (PHQs) are commonly used validated screening tools (Maurer et al., 2018). The PHQ-2 has sensitivity comparable with the PHQ-9 in most populations. If the PHQ-2 is positive for depression, the PHQ-9 or a clinical interview should be administered. If the PHQ-9 screening is positive for possible depression, the diagnosis should be administered. Also, screening must be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up (Maurer et al., 2018).

With respect to depression screening and management, there are risk factors that are unique to and/or must be considered for the LGBTQ+ population in comparison to those of other patient populations, such as social stigma, lack of family/social support, health disparities/poorer health outcomes, institutional discrimination (school, places of worship, workplace, healthcare, etc.), societal discrimination, socioeconomic barriers, microtraumas and aggressions (i.e., racism, PTSD, internalized homophobia), and physical trauma (i.e., domestic and/or intimate partner violence, rape). Considering this, these factors must also be considered with respect to interviewing/history taking and planning for depression management in LGBTQ+ persons. Bearing this in mind, the American Psychiatric Society's "Stress & Trauma Toolkit for Treating LGBTQ" was used as the conceptual model for the guideline as the toolkit provides various tools (i.e., interview guides/parameters) for the clinician screening for depression in the LGBTQ+ population.

The "Stress & Trauma Toolkit for Treating LGBTQ" aides health care providers to identify as well as understand the unique circumstances that historically marginalized populations (such as the LGBTQ+) encounter, and the impact of these circumstances on their mental health (APA, 2022). The toolkit aims to provide the clinician with a deeper understanding of cultural concepts of distress, and of how the social determinants of mental health affect these vulnerable populations. The toolkit also suggests recommendations for the screening and treatment of depression to assist the primary care provider in delivering integrated care and provides evidence-based recommendations for providing culturally competent mental health care for the LGBTQ+ population. The outlined general treatment recommendations are inclusive of interventions (i.e., creating an inclusive environment, screening for trauma, providing trauma-informed care, planning for continuity of care, etc.) and resources are applicable to other populations who are experiencing stress/trauma as well and assists health care clinicians in connecting the patient population to applicable community resources (i.e., counseling/therapy; APA, 2022). Providers will be trained on how to use and interpret the depression screening interview guide and other relevant tools in the toolkit for managing depression in this patient population. The expert panel then analyzed the quality of the developed guideline using the AGREE II Tool.

## Patient-Centered Care Considerations for Recommended Guideline

Using the Picker domains (Australia Commission on Safety and Quality in Healthcare, 2011; Sedlak et al., 2016) for patient-center care (PCC), the following aspects were considered with respect to guideline proposal:

1. ***Respect for patient's values, preferences, and expressed needs***- This concept is implemented by the clinician reflecting on how the attitudes and knowledge of the health care clinician regarding gender identity and gender expression may affect the quality of care they provide to LGBTQ+ persons. This is translated in practice via the primary care providers' exhibiting their understanding of how stigma, prejudice, discrimination, and violence affect the physical and mental-health and well-being of patients who identify as LGBTQ+.
2. ***Provision of information and education-*** This concept is implemented by the clinician promoting current evidence to support the use of CPGs for the treatment of depressive disorder in persons who identify as LGBTQ+. This is translated into practice by the clinician ensuring the inclusion of the LGBTQ+ patients and their families, providing handouts with current resources in a variety of formats (written, web based, etc.) and languages, and by the provider ensuring that he or she is well informed about local and national resources.
3. ***Management of physical comfort-*** This is translated into practice by the clinician understanding the various physiological and psychological issues specific to LGBTQ+ persons, staying current on guidelines and resources relevant to depression in LGBTQ+ persons, and reinforcing to patients, families, and other providers that primary care is an essential component of overall healthcare (both physical and mental) for LGBTQ+ patients.

4. ***Emotional support-*** To implement, the clinician must understand that basic communication skills are essential to providing a healthcare environment that is inclusive, positive, safe, and welcoming. The clinician must also educate all staff to solicit and use the preferred pronouns and names of the LGBTQ+ patient, to adhere to confidentiality and respect the patients' privacy, and avoid asking questions and/or using language/terminology that is perceived as disrespectful or offensive to LGBTQ+ persons.
5. ***Involvement of family and friends-*** To translate this concept into practice, the clinician must be aware that the family dynamic(s) of the LGBTQ+ patient may be comprised differently than a traditional family unit and respect the need for patients to include family and/or significant others in decision making and care management.
6. ***Continuity and access to care***- Understanding the need to promote social change that reduces the negative effects of stigma on the health and wellbeing of the LGBTQ+ population is a key aspect of translating this concept into practice. Also, encouraging patients and their families/significant others to seek appropriate healthcare in this safe environment is also key
7. ***Interdisciplinary approach to care***- Recognizing the potential benefits of an interdisciplinary approach when providing care to the LGBTQ+ patient

population and strive to work collaboratively with other providers is critical to translating this into practice

It is pivotal that providers follow the IOM recommendations for PCC when developing and implementing clinical practice guidelines for the care of the LGBTQ+ population. There are available resources to assist providers in providing compassionate, competent, and safe health care for LGBTQ+ patients (Sedlak et al., 2016).

## Findings and Implications

To develop the CPG, I followed the identified guideline development process from the Walden University *DNP Manual for CPGD*. More specifically, the following steps were taken:

1. The identification of the clinical practice problem to be addressed with the guideline.
2. The development of the practice focused question.
3. The development of evidence selection criteria.
4. A search of the literature.
5. Critical appraisal of the evidence from the literature using the Fineout-Overholt et al. (2010) hierarchy.
6. Synthesis of the evidence from the literature.
7. Development of the proposed guideline.
8. Defense of the proposal.
9. Obtaining approval of the IRB and site.

10. Guideline review per the expert panel members via utilization of the AGREE II tool.
11. Revision of the guideline based on expert panel recommendations.
12. Development of the final guideline.
13. The results will be disseminated to the stakeholders.

Seven articles were retrieved from the literature search, and all seven subsequently met the inclusion criterion for the development of the CPG. The next section will detail the appraisal of the evidence.

## Evidence Appraisal

### *Level 1: Systematic Review or Meta-Analysis*

Over the past 5 years, researchers have completed systematic reviews relevant to the practice question. The goal of the meta-analysis, per Macapagal et al.al. (2016), was to explore the additional and/or unique barriers to healthcare for persons who identify as queer, questioning, or transgender in comparison to their lesbian, bisexual, gay, and cisgender counterparts. Macapagal et al.al. assessed study quality by using the mixed methods appraisal tools and a qualitative synthesis. Studies were included if participants were 18-29 years of age and self-identified as LGBTQ. The review included studies representing 206 participants. Significant health disparities between LGBTQ individuals and their heterosexual counterparts were suggested by the findings. Additionally, the results also suggested that persons who identified as queer/questioning and/or transgender faced additional healthcare disparities as compared to persons who identified as lesbian, gay, bisexual, or cisgender (Macapagal et al.al., 2016). The findings of this study also

provide key information for the design of plans and programs to improve the quality of mental health and substance abuse treatment for lesbian, bisexual, and/or queer (LBQ) women including best practices for creating clinician guidelines to treat this population of patients.

Pennay et al. (2018) explored barriers in the mental health care for women who identified as LBQ. In the meta-analysis of their qualitative study, the researchers explored the barriers perceived by LBQ women seeking care for concurrent mental health and substance abuse disorders. The review included studies representing LBQ participants ages 18-27 seeking care for mental health disorders (i.e., depression) and substance abuse issues caused by unmet mental health care needs. Researchers concluded that while the causal relationship is not definitive, both stress and discrimination have been suggested to be closely associated with hazardous drinking, which is in turn associated with higher instances of depression in LBQ women (Pennay et al.al., 2018). The findings revealed that the population of interest experienced greater treatment barriers and were less satisfied with their treatment plans than their heterosexual counterparts secondary to heteronormative conventions and discrimination, language, and disclosure (Pennay et al., 2018). The findings also subsequently revealed that women who identify as LBQ do not receive care that adequately addresses their mental health needs and recommends guidelines that promote culturally competent mental health care.

Matijczak et al. (2021) explored the gap in knowledge regarding the roles of stressors and social support in the emerging LGBTQ adult population. In this systematic review of qualitative studies, the researchers examined the barriers perceived by LGBTQ

persons when they seek social and emotional support, and how perceived stressors and barriers to social support and/or emotional comfort impact mental health outcomes in this population. The findings concluded that emotional comfort and social support significantly impact/are considered a protective factor with respect to mitigating the negative impact of depressive symptoms in LGBTQ persons (Matijczak et al., 2021). The findings of this systematic review also highlight the importance of health care professionals evaluating available social support and/or personal relationships when managing depressive disorder in the emerging LGBTQ population.

***Level II: Randomized Control Trials***

In a RCT conducted per Baptiste-Roberts et al. (2017), evidence of health disparities faced by the sexual minority in comparison to their cisgender counterparts was demonstrated. Additionally, per Baptiste-Roberts et al. (2017), there is an urgent need for health care provider training that is targeted, culturally sensitive, and intervention focused to adequately address this disparity as most research and training has been geared towards sexually transmitted infection (STI) such as human immunodeficiency (HIV)/acquired immunodeficiency syndrome (AIDS) in the LGBTQ population. In the qualitative study per Rutter et al. (2016), the objective was to explore and identify the moral and ethical challenges of healthcare professionals working in a specialized, multidisciplinary care center for transgendered (TG) persons. The findings of this study revealed that when providing care to TG clients, clinicians may draw from international and/or local guidelines and standards; however, these guidelines are typically expert opinion consensus statements offering rough clinical guidelines in the absence of robust

empirical research and the extent to which these guidelines can assist clinicians who struggle with moral and/or ethical challenges in TG affirming medical care (Rutter et al., 2016). The researchers also suggest that the development of clinical practice guidelines that are LGBTQ/TG specific is vital to establishing a reference for equitable health care-especially considering instances of moral distress reported by health care providers opposing the values of the multidisciplinary health care team or TG patients (Rutter et al., 2016).

***Level VII: Expert Opinions or Consensus***

In the United States, an estimated 10 million adults identify LGBTQ, and this number is growing (Ortelli, 2020). Persons who identify as LGBTQ represent a significantly underserved population, and the importance of improving the care provided to the LGBTQ community cannot be understated (Ortelli, 2020). To achieve this, primary care health care clinicians must be able to not only identify depression in LGBTQ patients; the clinician must also be willing to address any barriers to care, navigate these barriers, and appropriately manage the patient's mental health needs to achieve optimal mental health outcomes through primary care intervention. Despite recent advances regarding lesbian, gay, bisexual, transgendered, and queer/questioning (LGBTQ) rights and acceptance, stigma (both internal and external), discrimination, and in some instances a denial of civil human rights continue to be a significant problem facing sexual and gender minorities. These factors are considered as stressors for persons who identify as LGBTQ and can contribute significantly to the onset of mental health disorders.

A significant amount of the literature which is relevant to best practices in the mental health care of patients who identify as LGBTQ falls under the category of expert opinion, and this literature also supports the claim that the LGBTQ population continue to be disadvantaged when it comes to receiving patient centered health care. One of the largest contributing barriers to LGBTQ competent/specific care is provider lack of knowledge. The American Medical Association (AMA) published a clinical guide on the topic authored by health care experts from the Vanderbilt University School of Medicine. The guide, titled *"Lesbian, Gay, Bisexual, and Transgender Healthcare: A Clinical Guide to Preventive, Primary, and Specialist Care"* was birthed due to the growing recognition of the gap between the unique health care needs of LGBTQ patients and what most clinicians understand (Eckstrand & Ehrenfeld, 2016). The text was also created due to the need for better LGBTQ health care training material for practicing clinicians in order to equip said clinicians with the needed knowledge, skills, and tools to adequately provide care to LGBTQ patients when they present to outpatient clinics and hospital settings. The clinical guide provides insight and guidance as it relates to LGBTQ specific health care for practicing health care providers, medical students, and educators.

**Implications**

CPGs translate best evidence into best practice and are developed within a healthcare organization to provide care providers with the evidence and knowledge needed to deliver safe, effective care to specific populations. The development of a patient focused CPG based on available best practice evidence has immense potential to increase healthcare provider knowledge and competency and improve healthcare

processes and patient outcome. This social project also aims to promote positive social change by promoting access to LGBTQ competent mental health care in the primary care setting via the development a CPG that is based on available best practice evidence. Scoring the quality of the project guidelines by using the Agree II tool as an appraisal tool may help future users. The panel found the guidelines helpful and necessary for serving the LGBTQ+ patient population. The identified appraisal tool found the guidelines to be successful, useful, and recommended. The Agree II tool is reliable and valid when assessing the quality of CPGs.

## Findings

A panel of four experts (three advanced practice nurses and one registered nurse) evaluated the proposed CPG. These experts provide primary and/or mental health care for LGBTQ+ patients, and one expert identifies as a member of the LGBTQ+ community. Each panelist reviewed the proposed CPG and completed the AGREE II tool to rate the guideline. The AGREE II tool consists of 23 criteria measured in six domains. Table 3 describes each domain and alignment to proposed CPG.

**Table 3**

*AGREE II Tool Domains Alignment*

| Domain | Description |
|---|---|
| 1. Scope and purpose | Project question and CPG aligns with the Picker domains of patient centered care. |
| 2. Stakeholder involvement | Four expert panelists involved in review. |
| 3. Rigor of development | Best practices, current guidelines and evidence used in development. |
| 4. Clarity of presentation | CPG, and resources were clear and supported with evidence. |
| 5. Applicability | CPG and resources can be applied in a variety of settings. |
| 6. Editorial Independence | Each panelist completed an individual review and presented individual comments. |

Participants rated each criterion with two final overall rating assessments at the end of tool. Each criterion was appraised on a 7-point scale (1 = ***strongly disagree*** to 7 = ***strongly agree***). Each domain score was summed by totaling the individual item scores and dividing this score by the maximum possible score. Total scores ranged from 5 to 7 for each criterion within the domain. The AGREE II scores for the panel are described in Appendix B. The final CPG is presented in Appendix C. Current available guidelines are presented in Appendix D.

## Recommendations

Four expert panelists completed the review of the proposed CPG using the AGREE II tool. The final overall for the quality of the guideline was 6.64. The panelists accepted the proposed CPG as presented. In addition, they made several recommendations and comments:

- Continue to implement guidelines for provider and support staff education.
- Continue to work with administration and clinical staff to create a clinic that is more welcoming and promotes a safe environment with a comfortable space.
- Diversify staff (hire diverse staff).
- This practice guideline is beneficial as it focuses on an at-risk patient population. Given the potential deficits in "on the job" training programs regarding the identification and management of depressive disorder in LGBTQ+ patients, such guidelines are beneficial in providing clinically meaningful education for healthcare providers to ensure that all patients receive the highest possible quality of care with respect to the identification and management of depressive disorder, ultimately improving the management and care of LGBTQ+ persons affected by depressive disorder.

## Strengths and Limitations of the Project

One of the strengths of this project was the sharing of evidence with respect to available data and/or resources for primary care providers who are tasked with managing depression and improving mental health outcomes in the LGBTQ+ population. The sharing of this information enables health care practitioners to address the gaps in care by increasing knowledge, improving access to care, building rapport and trust between patients and clinicians, and adequately managing depression and improving patient outcomes. The proposed CPG also enhances the opportunities to address health disparities and create a welcoming LGBTQ+ patient environment simultaneously. A

limitation of the project is that it was developed for one clinical site in a specific region of the country. It may not be applicable to other sites.

# Section 5: Dissemination Plan

The goal of research dissemination is to ensure that the clinical practice remains up to date with the latest and most efficient practices to optimize the quality of care provided. With regards to dissemination of this CPG, the primary objective is to increase, as well as promote, the spread of knowledge regarding this guideline based on best practice in hopes of enhancing application and maximizing the impact of the research as well as positive patient outcomes. With respect to dissemination of the developed CPG, I plan for this information to be shared with other health care providers within the agency by having it included with new provider training/onboarding, and annual training. I also plan to continue dissemination of this information via the following means: professional publications (i.e., statewide publications and/or national nursing journals), and professional presentations (i.e., local stakeholders, local/national conferences, professional association meetings).

## Self-Analysis

Persons who identify as LGBTQ+ are an underserved population that is adversely impacted by inadequate medical and psychological treatment and are frequently victimized in medical settings with inappropriate and disrespectful conduct or language (Kahn, 2016; Lutwak, 2017). Bearing these facts in mind, my professional motivation for this project was to serve as a leader and/or agent to change to help address the disparities faced by this underserved community by developing and recommending a CPG to guide the primary care providers at this clinic location who are treating LGBTQ+ patients suffering from depression.

With respect to managing mild to moderate level depression in persons who identify as LGBTQ+ via this project, I have found that provider education regarding LGBTQ+ mental health needs help to eradicate biases that create barriers to competent and equitable health care and enables health care clinicians to create environments of care that are accessible, diverse/inclusive, safe, and welcoming, which is extremely critical to ultimately eradicating mental health disparities for this underserved/at-risk patient population. Additionally, this culturally competent guideline has the potential to serve as a guide for other health care clinics serving LGBTQ+ patients.

Through preparation in organizational leadership, DNP clinicians are empowered to create unique approaches to the complex issues facing modern health care (AACN, 2006). The AACN DNP essentials focuses on the conferred DNP's role of assuring accountability of quality of care, patient safety, and critically examining ethical issues inherent in patient care (AACN, 2006). The AACN DNP essentials also equip the conferred DNP with the necessary skills to facilitate meaningful changes in the health care delivery system. Via this CPG, the local clinical site will be creating an environment that is welcoming and inclusive of meeting LGBTQ+ specific health needs (especially as it relates to managing mental health disorders such as depression) and providing an essential service to an underserved population.

The DNP functions as leader with respect to developing and implementing practice models, standards of care, and other scholarly projects (AACN, 2006). With respect to self-growth as it relates to the DNP essentials, I feel that my clinical knowledge base, organizational, and leadership skills have been enhanced via the development of the

best practice guideline in a way that allows me to serve as a leader in helping to addressing the disparities faced by the underserved LGBTQ+ community. The DNP essentials have also promoted my self-growth with respect to my having the opportunity to serve as a real change agent via the enhancement of the delivery, quality, efficiency, and effectiveness of mental health care outcomes in a marginalized population by developing this best practice CPG. DNP Essential VI, which is interprofessional collaboration for improving patient and population health outcomes, is embodied by the development of the CPG.

## Summary

The LGBTQ+ community encompasses a wide range of individuals with separate and overlapping challenges regarding their health care needs as well as access to quality LGBTQ+ competent health care. This population is at increased risk for mental health issues (such as depression) and poor mental health outcomes, has a higher risk for suicidality, and is also more reluctant to seek care for mental health issues than their heterosexual peers due to fear of being dismissed and/or experiencing discrimination, stigmatization (external and/or internal), bias (conscious or unconscious), rejection, or social prejudice from the healthcare provider and/or team (Rutter et al., 2016). The development of a patient focused CPG based on available best practice evidence has potential to increase healthcare provider knowledge and competency with respect to barriers to LGBTQ+ competent care, eradicating such barriers, and effectively managing mild to moderate depression in the LGBTQ+ patient population.

Improved mental health in LGBTQ+ individuals has the potential to improve their quality of life and decrease the risk of suicidal ideation. To accomplish this, primary care clinicians must be able to thoroughly address and traverse any recognized barriers to LGBTQ+ care, strive to create a practice environment that demonstrates awareness/inclusion of and respect for LGBTQ+ patients, appropriately manage the patient's mental health needs in order to achieve optimal mental health outcomes through primary care intervention, and ultimately facilitate positive social change by providing evidence-based guidance to clinicians about how to provide optimal care for members of the LGBTQ+ community and improve access to both physical and mental quality health care.

References

American Academy of Audiology. (2021). *Clinical practice guidelines development process*. https://www.audiology.org/practice-resources/practice-guidelines-and-standards/clinical-practice-guidelines-development-process/

American Academy of Colleges of Nursing. (2006). *AACN Essentials.* https://www.aacnnursing.org/AACN-Essentials

American Academy of Family Physicians. (2020*). Clinical practice guideline manual*. https://www.aafp.org/family-physician/patient-care/clinical-recommendations/cpg-manual.htm

American Heart Association. (2017). *Consensus-based decision-making process.* https://www.heart.org/idc/groups/heart-public/@wcm/@mwa/documents/downloadable/ucm_454080.pdf

American Psychiatric Association. (2013). *Mental health disparities: LGBTQ+*. https://www.psychiatry.org/File%20Library/Psychiatrists/Cultural-Competency/Mental-Health-Disparities/Mental-Health-Facts-for-LGBTQ.pdf

American Psychological Association. (2021). *Practice Guidelines for LGB Clients*. https://www.apa.org/pi/lgbt/resources/guidelines

American Psychiatric Association. (2022). *Stress & trauma toolkit for treating LGBTQ in a changing political and social environment*. https://www.psychiatry.org/psychiatrists/cultural-competency/education/stress-and-trauma/lgbtq

Australia Commission on Safety and Quality in Healthcare. (2011). *Patient-centered Care - Improving quality and safety through partnerships with patients and consumers*. https://www.safetyandquality.gov.au/publications-and-resources/resourcelibrary/patient-centred-care-improving-quality-and-safety-through-partnershipspatients-and-consumers

Bierle, D. M., Raslau, D., Regan, D. W., Sundsted, K. K., & Mauck, K. F. (2020). Preoperative testing before noncardiac surgery. *Thematic Review on Perioperative Medicine, 95*(4), 807-822. https://doi.org/10.1016/j.mayocp.2019.04.029

Brouwers, M., Kho, M. E., Browman, G. P., Cluzeau, F., Feder, G., Fervers, B., Hanna, S., & Makarski, J. on behalf of the AGREE Next Steps Consortium. (2010). AGREE II: Advancing guideline development, reporting and evaluation in healthcare. *Canadian Medical Association Journal, 182*, E839-842. https://doi.org/10.1503/cmaj.090449

Ciapponi, A., Tapia Lopez, E., Virgilio, S., & Bardach, A. (2020). The quality of clinical practice guidelines for preoperative care using the AGREE II instrument: a systematic review. *Systematic Reviews, 9*(159), 2-16. https://doi.org/10.1186/s13643-020-01404-8

Dahlen, S., Connolly, D., Arif, I., Muhammad-Hyder, J., Bewley, S., & Meads, C. (2021). International clinical practice guidelines for gender minority/trans people: systematic review and quality assessment. *BMJ Open,11*(4), 1-11. https://doi.org/10.1136/bmjopen-2021-048943

Dillard, K. (2019). *Capnography ENA clinical practice guidelines.* https://ncena.nursingnetwork.com/nursing-news/143091-capnography-ena-clinical-practice-guidelines

Institute of Medicine (1990). *Clinical practice guidelines: Directions for a new program* (M. J. Field & K. N. Lohr, Eds.). National Academic Press. https://doi.org/10.17226/1626

Fineout-Overholt E., Melnyk, B. M., Stillwell, S. B., & Williamson, K. M. Evidence-based practice step by step: Critical appraisal of the evidence: Part I. *American Journal of Nursing, 110*(7), 47-52. https://doi.org/10.1097/01.NAJ.0000383935.22721.9c

Gerritse, K., Hartman, L., Antonides, M. F., Wensing-Kruger, A., de Vries, A., & Molewijk, B. C. (2018). Moral challenges in transgender care: A thematic analysis based on a focused ethnography. *Archives of Sexual Behavior, 47*(8), 2319–2333. https://doi.org/10.1007/s10508-018-1287-3

Graham, R., Mancher, M., & Miller-Wolman, D. (2011). *Clinical practice guidelines we can trust* (6th ed.). National Academic Press.

Howe, C. J. & Close, S. (2016). Be an expert: Take action with evidence-based practice. *Journal of Pediatric Nursing, 31*(3), 360-362. https://www.pediatricnursing.org/article/S0882-5963(16)00056-7/fulltext

Institute of Medicine. (2011). *The future of nursing: Leading change, advancing health*. Washington, D.C.: The National Academies Press. https://doi.org/10.17226/12956

Jones, J. M. (2021). *LGBT identification rises to 5.6% in latest U.S. estimate.* https://news.gallup.com/poll/329708/lgbt-identification-rises-latest-estimate.aspx

Kahn, F. (2016, November 16). A history of transgender health care. *Scientific America*. https://blogs.scientificamerican.com/guest-blog/a-history-of-transgender-healthcare/

Lampariello, M. (2020). Disparities in LGBT health outcomes improved through primary care intervention. *Clinical Advisor, 18*(4), 292-302. https://www.clinicaladvisor.com/home/topics/practice-management-information-center/disparities-lgbt-health-outcomes-improved-through-primary-care-intervention/

Lutwak, N. (2017) Improving care of transgender patients. *Academic Emergency Medicine, 24*(8), 1034-1035. https://doi.org/10.1111/acem.13236

Macapagal, K., Bhatia, R., & Greene, G.J. (2016). Differences in healthcare access, use, and experiences within a community sample of racially diverse lesbian, gay, bisexual, transgender, and questioning emerging adults. *LGBT Health. 3*(6), 434-442. https://doi.org/10.1089/lgbt.2015.0124

Maurer, D. M., Raymond, T. J., Davis, B. N. (2018). Depression: Screening and Diagnosis. *American Family Physician 98*(8), 508-515. https://www.aafp.org/afp/2018/1015/p508.html

McNair, R.P., & Hegarty, K. (2010). Guidelines for the Primary Care of Lesbian, Gay, and Bisexual People: A Systematic Review. *Annals of Family Medicine Journal, 8*(6), 533-541. https://doi.org/10.1370/afm.1173

Medley, G., Lipari, R. N., Bose, J., Cribb, D. S., Kroutil, L. A., & McHenry, G. (2016). *Sexual orientation and estimates of adult substance use and mental health: Results from the 2015 National Survey on Drug Use and Health*. NSDUH Data Review. https://www.samhsa.gov/data/

Movement Advancement Project (MAP). (2021). *Georgia's LGBTQ+ Laws and Policies*. https://www.lgbtmap.org/equality_maps/profile_state/GA

National Alliance of Mental Illness. (2021). *Your Journey-LGBTQ+I*. https://www.nami.org/Your-Journey/Identity-and-Cultural-Dimensions/LGBTQ+I

Office of Disease Prevention and Health Promotion. (2020). *Healthy People 2020: Lesbian, Gay, Bisexual, and Transgender Health*. https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health/objectives

O'Rourke, T., Higuchi, K. S., & Hogg, W. (2016). Stakeholder Participation in System Change: A New Conceptual Model. *Worldviews on Evidence-Based Nursing, 13*(4), 261-269. doi.org/10.1111/wvn.12165

Ortelli, T. (2020). Improving LGBTQ+ Health and Well-Being. *American Journal of Nursing (120)*6, 1-4. https://doi.org/10.1097/01.NAJ.0000668780.88139.1c

Patterson, C. J., Sepulveda, M.-J., & White, J. (Eds.). (2020). (rep.). *Understanding the Well-Being of LGBTQ+I+ Populations* (pp. 1–422). Washington, D.C.: The National Academies Press.

Pennay, A., McNair, R., Hughes, T.L., Leonard, W., Brown, R., & Lubman, D.I. (2018). Improving Alcohol and Mental Health Treatment for Lesbian, Bisexual, and Queer Women: Identity Matters. *Australian and New Zealand Journal of Public Health (42)*1, 35-42. https://onlinelibrary.wiley.com/doi/epdf/10.1111/1753-6405.12739

Rutter, T. M., Flentje, A., Dilley, J. W., Barakat, S., Liu, N. H., Gross, M. S., Munoz, R. F., & Leykin, Y. (2016). Sexual orientation and treatment-seeking for depression in a multilingual worldwide sample. *Journal of Affective Disorders, 206*. 87-93. https://doi.org/10.1016/j.jad.2016.07.003

Sedlak, C. A., Veney, A. J., & Doheny, M. O. B. (2016). Caring for the transgender individual. *Orthopaedic Nursing, 35*(5), 301-306. https://doi.org/1097.NOR.0000000000000275

Siemieniuk, R. & Guyatt, G. (2021). What is GRADE? *BMJ Best Practice*. https://bestpractice.bmj.com/info/us/toolkit/learn-ebm/what-is-grade/

Sigma Theta Tau International, & Johns Hopkins University. School of Nursing. (2018). Johns Hopkins nursing evidence-based practice: model & guidelines. (D. Dang & S. Dearholt, Eds.) (Third). Sigma Theta Tau International. https://daemen.on.worldcat.org/v2/oclc/1001968494

Substance Abuse and Mental Health Services Administration [SAMSHA]. (2012). *Top Health Issues for LGBT Populations Information & Resource Kit.* https://store.samhsa.gov/sites/default/files/d7/priv/sma12-4684.pdf

Valerio, B. & Gurrentz, T. (2019). *More than 190,000 Children Living with Two Same-Sex Parents in 2019.* https://www.census.gov/library/stories/2019/11/first-time-same-sex-couples-in-current-population-survey-tables.html

Walden University. (2020). *Walden and Social Change*. https://academicguides.waldenu.edu/social-change/mission#:~:text=Walden%20and%20Social%20Change.%20Walden%20University%27s%20Mission%20is,of%20individuals%2C%20communities%2C%20organizations%2C%20institutions%2C%20cultures%2C%20and%20societies.

# Appendix A: Review of Literature Table

| Author(s) Date | Purpose | Research Question(s)/ Hypotheses | Methodology | Analysis Type & Results | Conclusions | Implications for practice, research, theory | Implications for future research |
|---|---|---|---|---|---|---|---|
| Macapagal Bhatia Greene<br><br>(2016) | The impact that birth sex, sexual orientation, and gender identity have on receiving equitable and adequate mental health and substance abuse care. | Are there health disparities for and additional/unique barriers to adequate mental health and substance abuse care for persons who identify as queer, questioning, or transgender in comparison to their lesbian, bisexual, gay, and cisgender counterparts? | Mixed Methods Appraisal tool and qualitative synthesis of the health care experiences of 206 participants ages 18-29 who self-identified as LGBTQ+. | Meta Analysis<br><br>ANOVAs Examined differences in overall physical and mental health, and chi-square and Fisher's exact tests examined health care access, use, and experiences by birth sex, sexual orientation identity, and gender identity. Over half of the participants who self-identified as LGBTQ+ reported being depressed, abusing substances, and had no usual place of care. | Significant health disparities and barriers to care exist between LGBTQ+ individuals and their heterosexual counterparts seeking care for mental health and substance issues. Additional disparities and barriers may exist for persons who identified as queer/questioning and/or transgender in comparison to persons who identified as lesbian, gay, bisexual, or cisgender. | Key information for the design of plans and programs to improve the quality of mental health and substance abuse treatment for LGBTQ+ patients. | Improving best practice guidelines for clinicians treating the LGBTQ+ population of patients for mental health disorders. |
| Pennay McNair Hughes | Stress and discrimination's association with | What are the causes of and barriers to | Qualitative synthesis of the barriers to | Meta Analysis | LBQ women experienced greater treatment barriers and were less satisfied with | Key information for the design of plans and | Recommending clinical guidelines and |

| Leonard<br>Brown<br>Lubman<br><br>(2018) | depression and hazardous drinking in self-identified lesbian, bisexual, and queer (LBQ) women. | mental health care and substance abuse treatment for LBQ women in comparison to their heterosexual counterparts? | co-current mental health (depression) and substance abuse care (onset by depression) for 102 female participants ages 18-27 who self-identified as LBQ. | ALICE (Alcohol and Lesbian/bisexual women) tool which explored experiences of alcohol use, mental health, and treatment among same sex attracted women. | their treatment plans than their heterosexual counterparts due to heteronormative conventions/discrimination, language, and disclosures. | programs to adequately meet the mental health needs and provide culturally competent mental health and care to LBQ women. | promoting culturally competent mental health care and substance abuse treatment. |
|---|---|---|---|---|---|---|---|
| Matijczak<br>McDonald<br>Tomlison<br>Murphy<br>O'Connor<br><br>(2021) | The knowledge gap related to the role of stressors and social support in the emerging LGBTQ+ adult population. | What are the perceived barriers to social and emotional support for emerging LGBTQ+ adults, and how do these barriers impact mental health outcomes? | Qualitative study comprised of 134 LGBTQ+ emerging adults aged 19-31 who suffer from depression. | Systematic Review<br><br>Cross sectional study design which measured the impact of social and emotional support in self-identified, emerging LGBTQ+ adults. | Emotional comfort and social support significantly impact/are considered a protective factor with respect to mitigating the negative impact of depressive symptoms in LGBTQ+ persons. | The findings highlight the importance of health care professionals evaluating available social support and/or personal relationships when managing depressive disorder in the emerging LGBTQ+ population. | Improving best practice guidelines for clinicians treating the LGBTQ+ population of patients for mental health disorders. |
| Baptiste-<br>Roberts<br><br>(2017) | The knowledge gap regarding LGBTQ+ specific health. | Where is the most focus placed with respect to LGBTQ+ specific health care needs? | Quantitative study of sexual minorities' general healthcare experience. | Randomized Control Trial which evaluated the overall health care experience of LGBTQ+ persons. | There is an urgent need for health care provider training that is targeted, culturally sensitive, and intervention focused to adequately address the disparity that exists with respect to LGBTQ+ specific health care as most research and training has | Findings validate the need for the development of LGBTQ+ specific CPGs. | Improving best practice guidelines and care delivery for LGBTQ+ patients. |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | been geared towards sexually transmitted infection (STI) such as human immunodeficiency (HIV)/acquired immunodeficiency syndrome (AIDS) in the LGBTQ+ population. | | |
| Rutter Dilley Barakat Liu Gross Munoz Leykin<br><br>(2016) | Moral and ethical challenges of healthcare professionals employed in multidisciplinary care center for transgendered (TG) persons | What are the moral and ethical challenges of healthcare professionals employed in multidisciplinary care center for transgendered (TG) persons, and how do they impact health care delivery and outcomes? | Qualitative study of health care professional caring for TG/LGBTQ+ patients. | Meta Analysis<br><br>Screening tool which evaluated 3,695 participants who provide care for TG/LGBTQ+ persons diagnosed with mental health conditions such as depression, and their personal moral/ethical bias. | When providing care to TG clients, clinicians may draw from international and/or local guidelines and standards; however, these guidelines are typically expert opinion consensus statements offering rough clinical guidelines in the absence of robust empirical research and the extent to which these guidelines can assist clinicians who struggle with moral and/or ethical challenges in TG affirming medical care | The development of CPGs that are LGBTQ+/TG specific is vital to establishing a reference for equitable health care- especially considering instances of moral distress reported by health care providers opposing the values of the multidisciplinary health care team or TG patients | Improving best practice guidelines and care delivery for LGBTQ+/TG patients |
| Ortelli<br><br>(2020) | The LGBTQ+ community is a significantly underserved population. | What is the importance of improving the care provided to the LGBTQ+ community? | Clinical Guide | Expert Opinion | Primary care health care clinicians must be able to not only identify depression in LGBTQ+ patients; the clinician must also be willing to address any barriers to care, navigate these barriers, and appropriately manage the patient's mental health needs to achieve optimal | | Improving health care equity for the LGBTQ+ population. |

| | | | | | mental health outcomes through primary care intervention. | | |
|---|---|---|---|---|---|---|---|
| Eckstrand Ehrenfeld<br><br>(2016) | Addressing the growing recognition of the gap between the unique health care needs of LGBTQ+ patients and what most clinicians understand. | Is there a need for better LGBTQ+ health care training material for practicing clinicians in order to equip said clinicians with the needed knowledge, skills, and tools to adequately provide care to LGBTQ+ patients when they present to outpatient clinics and hospital setting? | Clinical Guide | Expert Opinion | One of the largest contributing barriers to LGBTQ+ competent/specific care is provider lack of knowledge. | Provides insight and guidance as it relates to LGBTQ+ specific health care for practicing health care providers, medical students, and educators. | Improving best practice guidelines and care delivery for LGBTQ+ patients in the hospital and clinic settings, and the competence and knowledge fund of the clinicians providing care. |

Appendix B: AGREE II Tool

| AGREE II Domains | AGREE II Criteria | 1 | 2 | 3 | 4 | 5 | Total |
|---|---|---|---|---|---|---|---|
| Scope and purpose | The overall objective(s) of the guideline is (are) specifically described. | 7 | 5 | 7 | 7 | 7 | 6.6 |
| | The health question(s) covered by the guideline is (are) specifically described. | 7 | 5 | 7 | 7 | 7 | 6.6 |
| | The population (patients, public, etc.) to whom the guideline is meant to apply is specifically described. | 7 | 6 | 7 | 7 | 7 | 6.8 |
| Stakeholder involvement | The guideline development group includes individuals from all the relevant professional groups. | 7 | 5 | 7 | 7 | 7 | 6.6 |
| | The views and preferences of the target population (patients, public, etc.) have been sought. | 7 | 5 | 7 | 7 | 7 | 6.6 |
| | The target users of the guideline are clearly defined. | 7 | 6 | 7 | 7 | 7 | 6.8 |
| Rigor of development | Systematic methods were used to search for evidence. | 7 | 6 | 7 | 7 | 7 | 6.8 |
| | The criteria for selecting the evidence are clearly described. | 7 | 6 | 7 | 7 | 7 | 6.8 |
| | The strengths and limitations of the body of evidence are clearly described. | 7 | 5 | 7 | 7 | 7 | 6.6 |
| | The methods for formulating the recommendations are clearly described. | 7 | 5 | 7 | 7 | 7 | 6.6 |
| | The health benefits, side effects and risks have been considered in formulating the recommendations. | 7 | 5 | 7 | 7 | 7 | 6.6 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | There is an explicit link between the recommendations and the supporting evidence. | 6 | 6 | 7 | 7 | 7 | 6.8 |
| | The guideline has been externally reviewed by experts prior to its publication. | 7 | 5 | 7 | 7 | 7 | 6.6 |
| | A procedure for updating the guideline is provided. | 7 | 5 | 7 | 7 | 7 | 6.6 |
| Clarity of presentation | The recommendations are specific and unambiguous. | 7 | 6 | 7 | 7 | 7 | 6.8 |
| | The different options for management of the condition or health issue are clearly presented. | 6 | 6 | 7 | 7 | 7 | 6.8 |
| | Key recommendations are easily identifiable. | 7 | 5 | 7 | 7 | 7 | 6.6 |
| Applicability | The guideline describes facilitators and barriers to its application. | 7 | 5 | 7 | 7 | 7 | 6.6 |
| | The guideline provides advice and/or tools on how the recommendations can be put into practice. | 7 | 5 | 7 | 7 | 7 | 6.6 |
| | The potential resource implications of applying the recommendations have been considered. | 7 | 5 | 7 | 7 | 7 | 6.6 |
| | The guideline presents monitoring and/ or auditing criteria. | 7 | 5 | 7 | 7 | 7 | 6.8 |
| Editorial independence | The views of the funding body have not influenced the content of the guideline. | 7 | 6 | 7 | 7 | 7 | 6.8 |
| | Competing interests of guideline development group | 7 | 5 | 7 | 7 | 7 | 6.6 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | members have been recorded and addressed. | | | | | | |
| Overall Guideline Assessment | | 7 | 5 | 7 | 7 | 7 | 6.6 |
| Overall Guideline Assessment | | 6.9 | 5.33 | 7 | 7 | 7 | 6.64 |

Appendix C: Final Clinical Practice Guideline

Managing Minor to Moderate Level Depression in the LGBTQ+ Patient

| **Recommended Guideline** | **Justification** |
|---|---|
| The clinician shares decision-making with the patient regarding consideration of the following:<br><br>• Psychotherapy<br>• Second generation antidepressant, or<br>• Combination therapy including both options. | - Shared decision-making facilitates respect of the values, preferences, and expressed needs of the LGBTQ+ patient.<br>- Promotes current evidence to support the use of CPGs for the treatment of depressive disorder in persons who identify as LGBTQ+.<br>- Promotes interdisciplinary approach to care.<br>- Based on the literature reviewed that met the IOM requirements, comparative effectiveness research finds either similar effects between treatments or insufficient evidence to determine that one treatment can be offered over another. |
| For LGBTQ+ patients in which relationship stress (family, significant other, etc.) has been identified as the source of depression, if the recommended treatment above is not acceptable or available, then the clinician should offer a problem-focused intervention (i.e., family or couples therapy).<br>When selecting between treatments the clinician should considering the following options:<br>• Behavioral therapy vs. antidepressant medication as a monotherapy.<br>• If considering combined treatment, cognitive therapy and antidepressant medication are recommended to increase likelihood of effective treatment.<br>• Acupuncture is also recommended as an adjunct to antidepressant therapy. | - Promotes current evidence to support the use of CPGs for the treatment of depressive disorder in persons who identify as LGBTQ+.<br>- Helps to facilitate emotional support.<br>- Promotes interdisciplinary approach to care.<br>- Promotes respect of the need for patients to include family and/or significant other(s) in decision making and care management. Additionally, involvement of family and/or significant other(s) can lead to decreased instances of depression and suicidality.<br>- Based on the literature reviewed that met the IOM requirements, comparative effectiveness research finds either similar effects between treatments or insufficient |

| | |
|---|---|
| | evidence to determine that one treatment can be offered over another. |
| For LGBTQ+ patients in which psychotherapy and/or antidepressant pharmacotherapy are not viable options, complementary and alternative treatments should be considered as follows:<br>• Exercise Monotherapy<br>• Yoga<br>• St. John's Wort<br>• Bright Light Therapy | - Promotes current evidence to support the use of CPGs for the treatment of depressive disorder in persons who identify as LGBTQ+.<br>- Considers physiological and psychological issues/needs of the patient.<br>- Promotes interdisciplinary approach to care.<br>- Based on the literature reviewed that met the IOM requirements, evidence indicates no difference in effects between St. John's Wort and second-generation antidepressants and indicates some small to medium benefits of the other suggested complementary and alternative treatments. |

Appendix D: Current Available Guidelines

| Guideline Link | Explanation |
| --- | --- |
| https://www.aacap.org/AACAP/Member_Area/Member_Resources/AACAP/Member_Resources/Home.aspx?hkey=e2a810a9-aa3e-47a4-9352-43d0ce6096b4 | Provides primary care providers and health systems with the tools and knowledge to provide appropriate mental health care for gender non-conforming patients of all ages. |
| https://www.aafp.org/afp/2018/1201/p645.html | Caring for such a diverse community will be dependent on a diverse multidisciplinary team – guidelines are set for to help clinicians treat these patients while understanding their care disparities and barriers to care. |
| https://www.apa.org/depression-guideline/guideline.pdf | Provides clinical practice guidelines for managing depression across three age cohorts. |
| https://www.apa.org/pi/lgbt/resources/guidelines | Provides clinical practice guidelines for psychological practice with lesbian, gay, and bisexual clients. |
| https://www.apa.org/practice/guidelines/transgender.pdf | Expansion on the importance of guidelines to help professionals and clinicians toward nonjudgmental attitude toward people who may have a different experience of gender identity and gender expression from their own. |
| https://www.psychiatry.org/psychiatrists/cultural-ompetency/education/stress-and-trauma/lgbtq | Provides various tools for depression screening in the LGBTQ+ population. Also aides in identifying /understanding the unique circumstances that the LGBTQ+ population may encounter and the impact of these circumstances on their mental health. Suggests recommendations for the screening/ treatment of depression, and |

| | |
|---|---|
| | delivering integrated, evidence-based, culturally competent mental health care. |
| https://psychiatryonline.org/guidelines | Use of a systematic format to treat patients by developing patient care strategies. |
| https://www.psychiatry.org/psychiatrists/cultural-competency/education/best-practice-highlights/working-with-lgbtq-patients | Best practices and highlights for developing guidelines to improve care of the diverse LGBTQ+ patient population with respect to mental health issues. |
| https://focus.psychiatryonline.org/doi/10.1176/appi.focus.20200021 | Provides recommendations for improving psychiatric care for the LGBTQ+ patient population. |
| https://www.psychiatrictimes.com/view/lgbtq-mental-health-what-every-clinician-needs-know | Provides education and insight for health care clinicians with respect to improving mental health care for the LGBTQ+ patient. |
| https://www.samhsa.gov/behavioral-health-equity/lgbt | Provides recommendations for behavioral health equity as it relates to the diverse LGBTQ+ patient population. |