

Implementing Behavioral Health Services at a Community-Based LGBTQ+ Clinic

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ABSTRACT

INTRODUCTION: Lesbian, gay, bisexual, transgender, and queer (LGBTQ+) individuals face significantly more behavioral health disease burden than their heterosexual counterparts. Improved access to behavioral health services is urgently needed. We describe developing and implementing a comprehensive integrated behavioral health (IBH) program at a community-based clinic in Rhode Island, where primary care, behavioral health, and psychiatric providers work in a coordinated setting to support patients' whole health.

METHODS: We reviewed demographic and clinic data from 2023 to 2025 of an IBH program at Open Door Health in Providence, Rhode Island. We compared implementation outcomes between Year 1 and Year 2 of the program.

RESULTS: During the two-year study period, N=2,914 behavioral health visits were conducted among N=684 unique adult patients (N=212 in Year 1; N=548 in Year 2). The average patient age was 34.8 years (range: 18-77 years). Among these patients, 70.2% identified as White, 13.7% as Black/African American, 15.9% as Hispanic/Latino, 41.81% as transgender/gender diverse/nonbinary, and 81.4% as LGBTQ+. Patient volume increased 200% in Year 2 compared to Year 1 (723 versus 2,191 visits). LGBTQ+ patients utilized a greater volume of IBH services, with 20.11% having five or more visits compared to 10.2% of non-LGBTQ+ patients.

CONCLUSION: IBH services increased dramatically year over year. Offering behavioral health services during primary care visits at a community-based LGBTQ+ clinic resulted in significant uptake of behavioral health services for patients who might not otherwise have access to these services.

KEYWORDS: LGBTQ+ Health; Integrated Behavioral Health; Mental Health; Primary Care; Implementation

INTRODUCTION

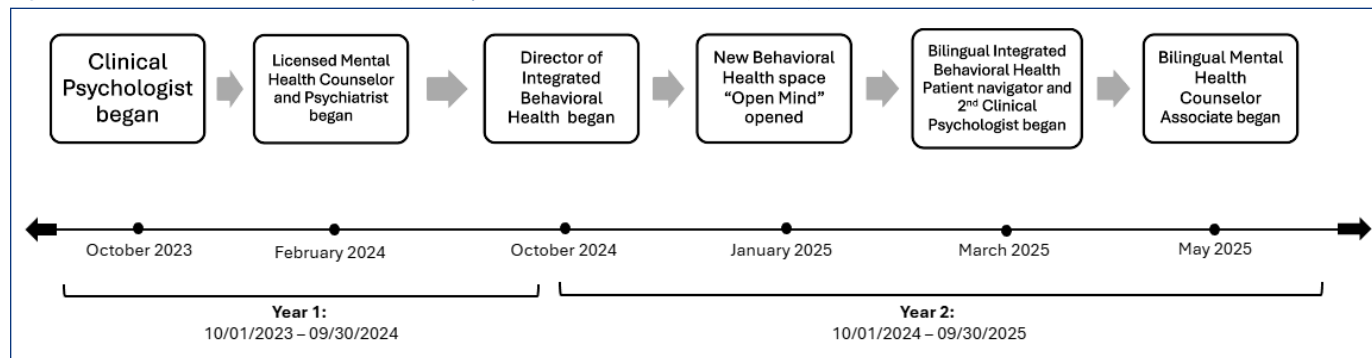
In the United States, lesbian, gay, bisexual, transgender, and queer (LGBTQ+) individuals are disproportionately affected by mental health conditions compared to their non-LGBTQ+

counterparts. A 2025 national study of more than 430,000 adults found that cisgender sexual minority men had significantly higher odds of being diagnosed with multiple psychiatric diagnoses compared to cisgender heterosexual men, including elevated odds of anxiety (adjusted odds ratio [AOR] 1.64), depression (AOR 1.86), bipolar disorder (AOR 1.87), obsessive-compulsive disorder (AOR 1.56), and five other major mental health conditions.¹ Another cross-sectional analysis of adults in the United States found that sexual minority respondents screened positive for depression and anxiety at approximately four times the rate of heterosexual respondents, with roughly half of sexual minority adults meeting GAD-7 or PHQ-9 criteria for depression or anxiety.² The mental health burden is particularly acute among transgender and gender non-conforming individuals. One study found that transgender individuals were at 19-fold greater risk of dying by suicide than the general population,³ and more recent data suggest that 82% of transgender individuals have considered suicide and 40% have made at least one lifetime attempt.⁴

The elevated mental health burden in LGBTQ+ populations is further exacerbated by increased substance use. LGBTQ+ adults in the United States report substantially higher prevalence of tobacco use (27.4% vs. 18.4% among heterosexual adults) and cannabis use (40.8–42.9% among gay and bisexual men vs. 23.9% among heterosexual men).^{5,6} Illicit stimulant use, including methamphetamine, is also more prevalent among men who have sex with men (MSM) compared to non-MSM populations,⁷ with important public health implications given methamphetamine's role as a risk factor for HIV acquisition. Persistent methamphetamine use among gay and bisexual men has been associated with a 14% incidence of HIV seroconversion over 12 months, corresponding to a four- to seven-fold increase in HIV acquisition odds compared to men without persistent use.⁸ Sexual minority women also use alcohol at higher rates than their heterosexual counterparts; one study found that lesbian women were approximately seven times more likely, and bisexual women nearly 6.5 times more likely, than heterosexual women to meet clinical criteria for alcohol dependence.⁹

Access to affirming, culturally tailored behavioral health services is challenging for many LGBTQ+ individuals. Although 67% report needing mental health care compared

Figure 1. Integrated Behavioral Health Program Expansion Timeline (October 2023–May 2025)



Timeline depicts key programmatic milestones across a two-year implementation period from October 2023 to May 2025.

to 39% of non-LGBTQ+ individuals, fewer than half of LGBTQ+ individuals actually receive it.¹⁰ Some of the most commonly cited structural barriers for accessing behavioral health services include long wait times, insurance limitations, and fear of discrimination or stigma. Forty-two percent of individuals report delays exceeding a month for appointments and 8% of LGBTQ+ individuals and 22% of transgender individuals avoid care altogether.¹⁰ These challenges reveal the growing demand for novel approaches to address barriers to accessing behavioral health care among LGBTQ+ populations.

One effective approach to addressing this burden is offering integrated behavioral health (IBH) services in primary care settings. IBH refers to a healthcare model in which primary care, behavioral health, and psychiatric providers work together in a coordinated and integrated setting.¹¹ The model incorporates universal behavioral health screening, in which all patients are systematically assessed for mental and behavioral health conditions and substance use disorders at each visit using validated, standardized tools. Patients who screen positive are then offered a referral to behavioral health providers for further evaluation and treatment. Additionally, the IBH model enables primary care providers to directly refer patients internally to IBH services, enabling “warm handoffs,” which refer to internal referrals within a care team for same day access to consultations, therapy, or psychiatric support without external referrals. The goal is to provide comprehensive and cohesive care through seamless internal referrals, shared communication between care teams, and recurring measurement-based assessments to monitor and manage behavioral health conditions.

Previous studies demonstrate that IBH services can significantly improve behavioral health outcomes. For example, one IBH program in Louisiana reported significant improvements in depression and anxiety.¹² Another large healthcare system in North Carolina found that after implementing an IBH model, approximately half of the patients with mood disorders achieved a 50% reduction in depression and anxiety symptoms, and an 82% reduction or elimination of suicidal thoughts.¹³ Similarly, the American Medical Association depicted a medical practice where 60%

of PHQ-9 scores and 63% of GAD-7 scores decreased by half within six months.¹⁴ Given these demonstrated benefits, primary care clinics serving populations with higher behavioral health needs, such as LGBTQ+ communities, are well-positioned to implement such evidence-based IBH models.

Open Door Health is a community-based LGBTQ+ clinic in Providence, Rhode Island, established in 2020 as an initiative of the Rhode Island Public Health Institute (RIPHI). Open Door Health is a non-profit clinic that provides affirming and accessible primary care to all persons, and offers specialty services for LGBTQ+ individuals. The clinic provides comprehensive primary care, sexual health services, gender-affirming medical care, HIV prevention and treatment, and behavioral health services. In response to overwhelming demand for behavioral health services among its LGBTQ+ patient population, Open Door Health launched an IBH program in 2023 [Figure 1]. This analysis describes outcomes from the first two years of the program’s implementation.

METHODS

This study was a descriptive, retrospective analysis of IBH services implemented at Open Door Health, a community-based LGBTQ+ primary care and sexual health clinic in Providence, Rhode Island. We reviewed electronic medical records across two time periods: Year 1 (October 1, 2023 to September 30, 2024) and Year 2 (October 1, 2024 to September 30, 2025). We assessed demographic information and service utilization for all patients accessing IBH services during the study period, including the frequency and types of behavioral health visits provided by various providers. Behavioral health visits were categorized as triage visits (initial assessment visits) or other behavioral health visits (follow-up and treatment visits for psychotherapy or psychiatry). Visit frequency was compared between LGBTQ+ and non-LGBTQ+ individuals, categorizing visits as 1, 2, 3, 4, or 5 or more visits per patient during the evaluation period. Finally, frequencies and percentages were used to assess changes in behavioral health service utilization across Year 1 and Year 2. Retrospective review of medical records was approved by the Brown University Institutional Review Board.

RESULTS

During the two-year study period (Year 1 and Year 2), a total of N=2,914 behavioral health visits were conducted among N=684 unique adult patients (N=212 in Year 1 and N=548 in Year 2). The average patient age was 34.8 years

Table 1. Demographic Characteristics of Patients Receiving Integrated Behavioral Health Services (N=687)

Age group: Mean: 34.8 (Range: 18–77)	N	%
Race		
White	480	70.18%
Black/African American	94	13.74%
Other race	52	7.60%
Asian	30	4.39%
Patient Declined	17	2.49%
American Indian/Alaska Native	11	1.61%
Ethnicity		
Not Hispanic or Latino	553	80.85%
Hispanic/Latino	109	15.94%
Patient Declined	21	3.07%
Not recorded	1	0.15%
Gender Category		
Cisgender Man	245	35.82%
Cisgender Woman	115	16.81%
Genderqueer/Gender non-conforming	126	18.42%
Transgender Woman	85	12.43%
Transgender Man	75	10.96%
Choose not to disclose	28	4.09%
Unable to determine	10	1.46%
LGBTQ+ Identity		
LGBTQ	557	81.43%
Not LGBTQ	127	18.57%
Sexual Orientation		
Lesbian, gay, or homosexual	242	35.38%
Something else	156	22.81%
Bisexual	104	15.20%
Straight or heterosexual	101	14.77%
Choose not to disclose	65	9.50%
Don't know	16	2.34%
Insurance Type		
Private	326	47.66%
Medicaid (MMP)	267	39.04%
Self-pay	54	7.89%
Medicare	30	4.39%
Other	7	1.02%

Demographic characteristics of 687 unique adult patients receiving integrated behavioral health services at Open Door Health (2023–2025). Values are N (% of total, N+684)

(range: 18–77 years). Demographic characteristics of the population included: N=480 patients (70.2%) identified as White, N=94 (13.7%) as Black or African American, N=109 (15.9%) as Hispanic or Latino, N=286 (41.8%) as transgender, gender diverse, or nonbinary, and N=557 (81.4%) as LGBTQ+. Approximately half the sample (326, 47.66%) had private insurance. Detailed demographic characteristics of all unique patients receiving integrated behavioral health services are presented in **Table 1**.

Year 1 included a total of N=723 behavioral health visits, comprising 91 triage visits and 632 other behavioral health visits. Year 2 demonstrated substantial growth to N=2,191 total visits, including 423 triage visits and 1,768 other behavioral health visits, representing a 200% increase in visit volume from Year 1 to Year 2. The increase in visit volume reflected programmatic expansion during the study period [**Figure 1**]. Year 1 included the addition of one clinical psychologist, one licensed mental health counselor (LMHC), and one psychiatrist. Year 2 expansion included the appointment of a Director of Integrated Behavioral Health Services, a new clinical venue for service provision called “Open Mind,” which refers to a dedicated space for LGBTQ+-competent mental health care in a private and secure setting connected to the main Open Door Health facility. We also added bilingual patient navigation services, a second clinical psychologist, and a bilingual mental health counselor associate (MHCa).

LGBTQ+ patients demonstrated higher engagement in IBH services with repeat visits compared to non-LGBTQ+ patients. Among LGBTQ+ patients, 44.7% had one visit, 21.18% had two visits, and 20.11% had five or more visits during the study period. In contrast, non-LGBTQ+ patients more frequently had single visits (59.84%), with only 10.24% having five or more visits, indicating greater treatment engagement among LGBTQ+ patients receiving IBH services [**Table 2**].

Table 2. Behavioral Health Visit Frequency by LGBTQ+ Status (N=684)

Number of Barriers	LGBTQ		Non-LGBTQ	
	N	%	N	%
1	249	44.70%	76	59.84%
2	118	21.18%	30	23.62%
3	51	9.16%	4	3.15%
4	27	4.85%	4	3.15%
5+	112	20.11%	13	10.24%
Total	557	100.00%	127	100.00%

Number and percentage of unique patients by number of visits during two-year IBH program (2023–2025). LGBTQ+ patients: n=557; non-LGBTQ+ patients: n=127. Percentages sum to 100% within groups.

DISCUSSION

This analysis represents among the first descriptions of implementation of IBH services at a community-based LGBTQ+ primary care clinic in Rhode Island. Previous studies have documented the effectiveness of the IBH model in improving key behavioral health indicators, such as anxiety, depression, and substance use. This study adds to the literature by demonstrating the feasibility and success of IBH implementation in a community clinic setting.

Over the two-year study period, our IBH program showed significant growth, evidenced by increased patient visits, clinical staff expansion, and effective engagement with historically marginalized populations. The program evolved from a primary care service with one licensed mental health psychologist to a comprehensive, culturally tailored IBH program supporting patients at every care stage [Figure 1], from patient navigator consultations through long- and short-term psychiatric and psychotherapy services. Year 1 added a clinical psychologist, LMHC, and psychiatrist. Year 2 brought a Director of Integrated Behavioral Health Services, the dedicated “Open Mind” LGBTQ+-competent space, a bilingual patient navigator, a second clinical psychologist, and a bilingual LMHC. The 200% increase in patient volume from Year 1 to Year 2 (723 to 2,191) reflects both demand for behavioral health services among the LGBTQ+ community and the effectiveness of our strategic expansion.

Previous studies have documented the effectiveness of the IBH model in improving key behavioral health indicators, such as anxiety, depression, and substance use.¹⁵⁻¹⁷ This study adds to the literature by demonstrating the feasibility and success of IBH implementation in a community clinic setting. LGBTQ+ individuals experience well-documented mental health challenges and unmet needs due to stigma, economic vulnerabilities, and lack of affirming services.¹⁸⁻²³ Integrating IBH services within primary care removes barriers common among LGBTQ+ individuals and present in traditional siloed systems, where differing EMRs, billing, and care teams lead to lost referrals and poor follow-up. Embedding behavioral health providers facilitates clearer communication with primary care via shared EMRs and enables timely same-team referrals. This aligns with prior literature showing improved screening, diagnosis, and treatment when mental health providers share clinical information and streamlined workflows.

In support of this model, we hired an IBH patient navigator to conduct initial consultations, review screening data, perform intakes for flagged patients, and facilitate warm handoffs to internal or external services. Navigators reduce key barriers, including bridging primary care and behavioral health, managing appointments, and navigating insurance.²⁴⁻²⁶ These roles prove especially valuable for LGBTQ+ patients wary of unvetted specialty mental health. Similarly critical was Year 2's appointment of a Director of Integrated Behavioral Health Services [Figure 1], whose leadership

drove staffing expansion, billing integration, and the “Open Mind” dedicated space, ensuring clinical scalability and the 200% volume growth.

IBH models improve engagement, with 75% of patients achieving diagnosis and treatment initiation within 6 months versus less than 25% in fragmented systems.²⁷ These effects prove even stronger for stigmatized LGBTQ+ individuals who often delay care.^{28,29} Affirming, integrated settings eliminate the need to navigate unknown specialty systems. We intentionally hired bilingual and LGBTQ+-identifying staff to foster patient-provider trust, yielding a diverse cohort: 81.4% LGBTQ+ (41.9% transgender/gender diverse) with substantial Black/African American and Hispanic/Latino representation. These results show that providers who reflect patients' identities help overcome access barriers, advancing equity for marginalized groups. LGBTQ+ patients showed higher repeat visit rates (20.11% with five or more visits) than non-LGBTQ+ patients (10.2%), suggesting affirming integrated care sustains engagement. Evidence confirms culturally competent care boosts retention among LGBTQ+ populations.³⁰⁻³³ Together, these findings position LGBTQ+-affirming IBH as a promising solution to care disengagement.

This study has several limitations. This study was conducted at a single primary care clinic, which limits the generalizability of these findings to regions of the country that may be more restrictive of LGBTQ+ focused or culturally tailored services. Additionally, although this study included service utilization frequency, it did not include standardized clinical measurements such as GAD-7 or PHQ-9 scores. This limits our ability to determine whether the IBH model improved clinical outcomes compared to traditional health-care approaches. Finally, our two-year study period during the investment in IBH program development represents an early implementation phase, and as such, longer-term follow-up would be needed to assess program sustainability and success beyond the initial growth period. Despite these limitations, this work provides important preliminary evidence that integrated behavioral health delivery within LGBTQ+-affirming primary care is feasible and effective at reaching and engaging marginalized populations in Rhode Island.

In conclusion, implementing an IBH program at a community-based LGBTQ+ clinic resulted in significant uptake of services over a two year period. There's a public health opportunity to enhance access and uptake of behavioral health services by integrating them with primary care.

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