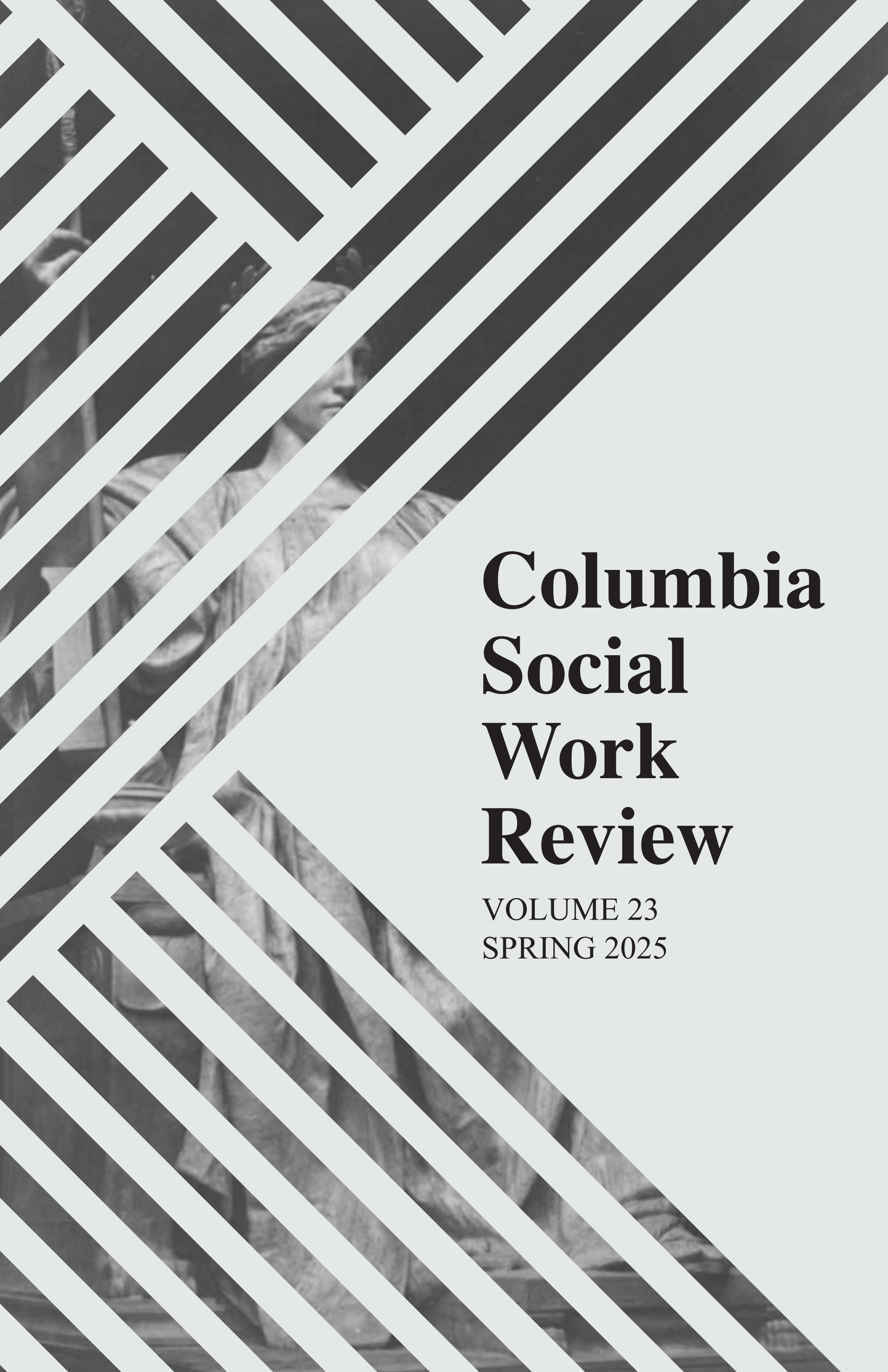

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COLUMBIA SOCIAL WORK REVIEW

The mission of the *Columbia Social Work Review* is to provide a forum for the exchange of innovative ideas that integrate social work practice, education, research, and theory from the perspective of social work students. Founded by students at Columbia University School of Social Work in 2003 as the Columbia University Journal of Student Social Work, this academic journal provides an opportunity for students and scholars in the field of social work to share their unique experiences and perspectives with fellow students, faculty, and the larger social work community.

Spring 2025

ACKNOWLEDGEMENTS

The publication of the *Columbia Social Work Review* is, as always, a deeply collaborative effort. This year's 23rd edition would not have been possible without the unwavering dedication of our editorial team and our invaluable partners.

Each year brings new challenges and opportunities, and this year was no exception. With many first-time editors joining the Review, we witnessed a remarkable ability to adapt quickly and engage rigorously with the editing process. Their commitment to thoughtful, justice-oriented scholarship has shaped this edition in meaningful ways.

Our Creative Editors expanded the reach of our blog-style platform, *The Amsterdam*, elevating the voices of students. Meanwhile, our Associate and Executive Editors worked closely with authors to foster collaborative, respectful, and critically engaged editing relationships—setting a tone of care and accountability that defines the Review.

We are grateful to our faculty advisor, Susan Witte, for her steadfast guidance throughout the year. Her experience in academic publishing and her consistent mentorship have helped navigate the complexities of the editorial process with clarity and support.

We would also like to thank:
Julie Hersh, our Copy Editor, for her precision, patience, and attention to every last detail. Savannah Brogan, our Layout and Design Editor, for crafting the visual identity of this year's Review with intention and care. Thomas Printing, for their reliable partnership in producing the physical edition. Adam Pelligrini, Director of the Writing Center, and the members of our Advisory Board, for their continued advocacy for student-led scholarship.

We are honored to share this publication with you and deeply proud of what it represents: the voices, questions, and commitments of a generation of social workers imagining and building a more just world.

Enjoy the 2025 edition of the *Columbia Social Work Review*.

EDITORIAL BOARD

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A PERSONAL REFLECTION FROM EDITOR-IN-CHIEF: HALLA ANDERSON

Over the past year, Columbia has made one thing brutally clear: students—especially those at the School of Social Work—have been targeted and punished for daring to speak out. Expulsion, suspension, eviction, and doxxing have become the cost of conscience. Those who speak out for Palestine, for abolition, for transformative change have often done so at great personal risk.

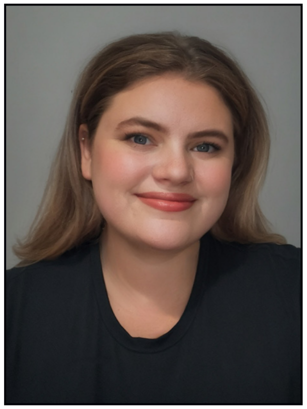
As a student at the School of Social Work, I have watched the institution fail to protect the very values it claims to teach—transparency, accountability, and justice. In a program meant to prepare us to challenge systems of oppression, students have instead faced institutional retaliation. That contradiction has fractured the relationship between the school and the students it seeks to shape into ethical practitioners.

For me, the *Review* has become more than a publication—it has become a site of resistance. A student-led space where social work is reclaimed as a radical, liberatory practice. Where we refuse the depoliticized, bureaucratic versions of the profession and instead uplift visions rooted in abolition, decolonization, mutual aid, and collective care. A space that makes room for political clarity, grief, imagination, and rage.

I dedicate my work on this issue to all students who have been punished for embodying the true ethics of social work—ethics that demand we stand with the oppressed, even when it is inconvenient or unsafe. The work within these pages uplifts the voices of those most impacted by the very systems we are taught to critique—communities our profession has historically harmed and must now learn to serve with integrity.

I believe the Columbia School of Social Work must not only reckon with its complicity in systems of violence—it must rise to the challenge of transformation. It must become a space that honors its deepest commitments to justice and to the people social work was always meant to protect.

In solidarity, and in defiance,



Halla Anderson
Editor-In-Chief, *2024-2025*
Columbia Social Work Review

**The views expressed here are solely my own and do not necessarily reflect the views of the Columbia Social Work Review, its editorial board, or the Columbia School of Social Work.*

A PERSONAL REFLECTION FROM EDITOR-IN-CHIEF: STEPHANIE CHENG

This year, our country is experiencing a significant political transition. Critical programs that support immigration, mental health, and other essential services are losing funding. At the same time, international relations are shifting and deepening the uncertainty. As divisions within society grow, it's understandable that many—especially students—may feel hesitant to speak out. In such a polarized climate, it's easy to wonder if our voices matter, or if change is possible.

The truth is, systemic oppression has always existed. The events today are the result of deep-rooted historical trauma and inequality that have shaped society for generations. This reality can make many feel powerless and exhausted. Yet, it is in these moments that the voices, passion, and commitment to social justice matter the most.

In this 23rd edition of the Columbia Social Work Review, I hope to offer a glimpse of hope—that even in difficult times, progress is possible. Our authors dive into the complexities of inequalities in mental health, disabilities, race, healthcare access, and housing—issues deeply embedded in our history. They offered policy alternatives, technological innovations, increased cultural sensitivity, and adaptive strategies to build a just and equitable future.

This journal remains committed to elevating the voices of students and alumni, critiquing the status quo, and pushing for the rights of underserved populations. I hope that the Review can continue to strive to be a platform where ideas for change can thrive, and where the fight for justice can continue, even in the smallest of steps.

As you read through this edition, I hope you are reminded that your voice matters. No matter how small the step, every effort toward justice is a step forward.

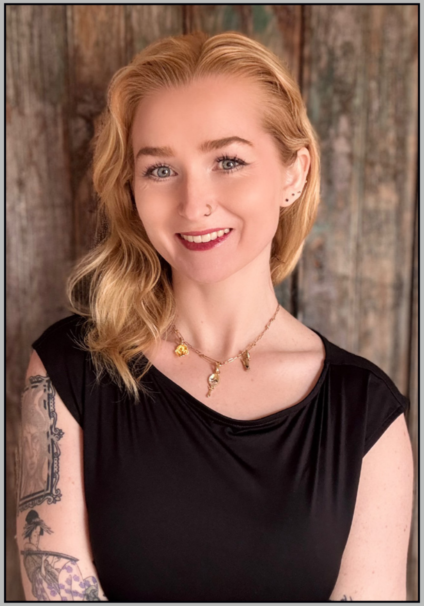
In community,

Stephanie Cheng
Editor-in-Chief, *2024-2025*
Columbia Social Work Review

Replacing Seclusion and Restraint Practices in Psychiatry With Sensory Rooms

EMMA COSTAIN

EMMA COSTAIN



Emma Costain is a 2025 graduate of the Columbia School of Social Work, specializing in policy practice and mental health. As a social worker, she is passionate about research and policy advising in the mental health field, with a particular focus on acute psychiatric inpatient care. Having grown up in a military family, she embraces the idea that home is wherever the heart is.

INSPIRATION

My inspiration for this paper stems from both personal and professional experiences. The idea to replace seclusion and restraint (S/R) practices first took shape during my generalist year practicum at a behavioral health hospital. Drawing on my background working with individuals with Autism Spectrum Disorder and my expertise in behavioral health, I developed the concept of implementing Sensory Rooms as a humane and therapeutic alternative to S/R.

I firmly believe that patients should have agency in their treatment and leave the hospital with transferable coping skills rather than traumatic memories. My work is grounded in advocating for patient rights and ensuring that individuals in acute psychiatric care are active participants in their own recovery. Through this paper, I hope to highlight the urgent need for non-coercive interventions in mental health treatment and contribute to a shift toward more compassionate, patient-centered care.

ABSTRACT

The use of seclusion and restraint (S/R) in acute psychiatric inpatient settings persists as a controversial practice, causing significant harm to patients and stress to staff. This policy brief examines the ethical, financial, and systemic implications of S/R and advocates for replacing S/R with sensory rooms—an evidence-based approach fostering emotion regulation, patient autonomy, and trauma-informed care. Recognizing that eliminating S/R may not be immediately feasible, this brief proposes an incremental approach through a hypothetical pilot program at Jackson Behavioral Health Hospital: converting an isolation room, or a room where a patient receives intervention separately from other patients, on each psychiatric inpatient unit into a sensory room, alongside incentives to reduce overall S/R usage. Sensory rooms can then be evaluated as a humane and cost-effective alternative to S/R practices. This policy brief aims to advance knowledge on patient-centered interventions in mental health care and underscores the ethical imperatives and financial incentives for legislative and organizational policy reform in psychiatric care.

Keywords: seclusion, restraint, sensory rooms, psychiatric inpatient care, policy reform, trauma-informed care, social justice

REPLACING SECLUSION AND RESTRAINT PRACTICES IN PSYCHIATRY WITH SENSORY ROOMS

The field of mental health has progressed in many regards. However, the archaic practice of seclusion and restraint (S/R) still dominates acute psychiatric inpatient care, causing unnecessary trauma and distress for both patients and providers. The Code of Federal Regulations (CFR) define seclusion and restraint as follows:

- Seclusion is “the involuntary confinement of a person alone in a room or area from which the person is physically prevented from leaving” (Condition of participation: Patient’s rights, 42 CFR 482.13(e)(1)(ii)).
- Restraint is “any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a person to move his or her arms, legs, body, or head freely” (Condition of participation: Patient’s rights, 42 CFR 482.13(e)(1)(i)(A)).

This policy brief will not only exhibit the ethical and financial costs of S/R in psychiatric settings, but will also shed light on potential policy interventions that can significantly reduce the prevalence of S/R. By applying the concept of *emotion regulation*, often used for individuals with autism spectrum disorder, and integrating it with the principles of patient autonomy, acute psychiatric inpatient hospitals can replace seclusion rooms with designated *sensory rooms* (Recovery Ways, 2022). As discussed later in this brief, sensory rooms are spaces that provide patients with efficient, transferrable, and relevant distress tolerance skills that can be used both within the hospital and in their daily lives.

BACKGROUND AND HISTORICAL CONTEXT

The use of S/R in Western psychiatric medicine has a long and troubling history, with its inhumane and traumatizing use dating back to the 1700s. While historically rooted in the control and segregation of those deemed “unmanageable,” these practices persist today, often justified as necessary for safety despite growing evidence of their harm and the availability of alternative interventions (Weiss, 1998).

EUGENICS

In the late 19th and early 20th centuries, psychiatric practices were significantly influenced by the rise of eugenics theory—a discredited form of scientific racism that posited human beings could be perfected and social ills eliminated through genetics (e.g., National Human Genome Research Institute, n.d.). Psychiatrists, frustrated by the lack of effective treatment for mental illness, turned to experimental interventions aimed at controlling and segregating individuals deemed “unfit” by societal standards (Turda, 2022).

One such intervention was the lobotomy, introduced in the 1930s as a means to manage patients with severe mental disorders. This procedure involved severing connections in the brain’s frontal lobe and was often performed without patient consent (Mashour et al., 2005). Electroconvulsive therapy (ECT; also known as “shock therapy”) also emerged during this period, initially administered under coercive circumstances and without adequate evidence of its effects, further exemplifying the era’s inhumane treatment approaches (Scull, 2022).

Similarly, S/R also originated as a means of controlling and isolating those deemed undesirable. Though lobotomies were eventually discredited and abandoned due to their devastating consequences, ECT and S/R persisted and were frequently misused as a means of social control rather than medical necessity, reflecting the broader pattern of psychiatric interventions being wielded as tools of oppression (Larson, 2018).

Marginalized populations—including immigrant populations, people of color, impoverished people, and those who were mentally or physically disabled—disproportionately became the victims of eugenics experimentation by psychiatrists, often under the guise of medical

advancement (e.g., Larson, 2018; Mashour et al., 2005). This targeting extended to the widespread and unchecked use of S/R, which was implemented as a means of control rather than care (Larson, 2018).

PSYCHIATRIC CARE TODAY

Decades later, S/R remains deeply entrenched in psychiatric treatment, disproportionately impacting the same marginalized communities that were historically subjected to these practices. Studies have found that Black patients are significantly more likely to be subjected to S/R than their white counterparts, in both emergency departments and inpatient psychiatric settings (Eswaran et al., 2023; Hawkins et al., 2022). This pattern is not incidental; it reflects the persistent biases and systemic inequities that continue to shape psychiatric care. The case of Orville Blackwood in 1991 serves as a tragic example: Blackwood, a Black psychiatric patient, died after being subjected to excessive restraint and medication. The case led to a national inquiry that revealed Black patients were more likely to be misdiagnosed, overmedicated, and subjected to coercive psychiatric interventions (Prins et al., 1993). These findings reinforce what many mental health professionals and advocates have long argued: S/R is not only a failure of psychiatric care but a practice that also reflects deeper patterns of racism, ableism, and classism embedded in the mental health system.

According to international standards (UN General Assembly, 1992), the use of seclusion rooms and restraints are permitted exclusively in instances where the patient is in imminent danger of harming or killing themselves, another patient, or a staff member. However, research has shown that seclusion rooms are more often used as a form of punishment in response to a patient being loud, disruptive, or noncompliant with medications (Substance Abuse and Mental Health Services Administration [SAMHSA], 2010, p. 1). This misuse is not random: It reflects the same systemic biases and discriminatory patterns described earlier in this section, where marginalized patients are disproportionately subjected to control and punishment under the guise of care. The widespread practice of S/R demonstrates persistent systemic biases within psychiatric care, and is in direct violation of encouraging patient autonomy, providing trauma-informed care, and respecting the human dignity of every patient (e.g., National Association of Social Workers, 2021). Research also shows that patients subjected to S/R face increased risk of extended lengths of stay in psychiatric facilities and reduced likelihood of returning home upon discharge.

Despite its persistence, S/R is neither therapeutic nor necessary—rather, it is a remnant of outdated and oppressive psychiatric models that have disproportionately harmed vulnerable populations for centuries.

WHAT THE RESEARCH ON SECLUSION AND RESTRAINT SHOWS

In addition to the well-documented evidence of bias in its application, S/R has ethical and financial consequences as well. This section highlights not only the devastating impact of S/R on patient well-being but also the significant costs it imposes on hospitals. These consequences further reinforce the urgent need to adopt more humane, evidence-based alternatives that prioritize patient dignity, safety, and autonomy.

Research illustrates how S/R practices, shaped by the systemic biases and inequities outlined in the previous section, can result in devastating consequences for patients and the healthcare system as a whole. These harms are reflected in ethical failures, clinical outcomes, patient mortality rates, and financial costs, as explored in the rest of this section (Recovery Ways, 2022).

S/R: PATIENT TREATMENT AND CONSEQUENCES

S/R can be applied to a wide range of psychiatric conditions, placing nearly any patient admitted for inpatient psychiatric care at risk regardless of their specific diagnosis. The diagnoses most commonly associated with the use of S/R include schizophrenia, schizoaffective disorder, and bipolar disorder; however, the application is not limited to those conditions (Georgieva et al., 2020). Research indicates that patients subjected to S/R face significantly worse clinical and systemic outcomes compared to those who are not restrained.

The use of S/R in psychiatric settings is not only harmful but can also have fatal consequences. The Substance Abuse and Mental Health Services Administration (SAMHSA) (2010) has reported that “an estimated 50 to 150 individuals die each year as a result of seclusion and restraint practices in facilities, and countless others are injured or traumatized” (p. 1). Other patients die from cardiac arrest triggered by the severe physiological stress of being forcibly restrained—a risk heightened for individuals with underlying medical conditions (LeBel & Goldstein, 2005). Some patients have also died due to neglect, when they were placed in seclusion rooms without proper monitoring and experienced life-threatening medical issues or engaged in self-harm.

ETHICAL ARGUMENT

The use of S/R provides “no therapeutic value, [causes] human suffering, and frequently [results] in severe emotional and physical harm, and even death” (Mental Health America [MHA], n.d., p. 1). The use of S/R exacerbates the suffering of patients who are already dealing with difficult mental health conditions. Psychiatric hospitals should not further patient suffering by placing unconsenting patients in seclusion or restraints.

Many psychiatrists argue that S/R is a necessary tool within acute psychiatric inpatient settings because it allows for the management of behavioral issues related to a patient’s mental condition, but “there is little evidence that seclusion provides long-term benefits in terms of treating symptoms or reducing aggression” (Newton-Howes, 2013, p. 422). From an ethical perspective, S/R practices disregard a patient’s autonomy and directly contradict patient-focused and trauma-informed care. Evidence of therapeutic benefits to seclusion rooms and restraints is lacking, so it is hard to ethically justify using either practice on a patient against their will. Finally, the antiquated and cruel practices of S/R are not only violations of human dignity but also direct contributors to preventable deaths, serving as glaring symptoms of the poor quality of care, inadequate staff training, and misinformed public policy that continue to enable these abuses (Grasso et al., 2007).

FINANCIAL ARGUMENT

Significant organizational and healthcare costs also contribute to the argument against S/R. A single episode of either seclusion or restraint can cost the hospital “between $302 and $354” (SAMHSA, 2010, p. 2). Beyond the economic costs, hospitals may have to consider legal costs as a consequence of using seclusion rooms and restraints, as patients or family members may take legal action against the hospital due to the harm, trauma, and in some cases preventable deaths that result from these interventions.

Hospitals must consider both patient safety and regulatory compliance when evaluating the use of S/R. Under federal regulations, “all patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff” (Condition of participation: Patient’s rights, 42 CFR 482.13(e), 2008/2025). While S/R may be used to ensure “the immediate physical safety of the patient, a staff member, or others,” it must be discontinued at the earliest possible time (Condition of participation: Patient’s rights, 42 CFR 482.13(e)(2), 2008/2025). In addition to these protections, hospitals that receive Medicare and Medicaid are required to report deaths associated with S/R to the Centers for Medicare and Medicaid Services (CMS), including “each death that occurs while a patient is in restraint or seclusion,” deaths occurring within 24 hours of removal, and cases where it is “reasonable to assume” that S/R contributed to a patient’s death (Condition of participation: Patient’s rights, 42 CFR 482.13(g)(1)(iii), 2008/2025).

CMS has emphasized the importance of preventing such adverse events, commonly referred to as never events, which are defined as “preventable medical errors that result in serious consequences for the patient” (CMS, 2008, p.1). In response, CMS has implemented payment policies that discourage preventable harm, stating that “never events cause serious injury or death to beneficiaries and result in unnecessary costs to Medicare and Medicaid due to the need to treat the consequences of the errors” (CMS, 2008, p. 1). These regulations and policies reflect both the ethical obligation to protect patients from harm and the financial consequences hospitals may face when safety standards are not upheld.

S/R can also significantly lengthen a patient’s hospital stay, placing additional financial burdens on both the hospital and the patient (LeBel & Goldstein, 2005). Patients subjected to S/R experience prolonged hospitalization due to increased psychological distress, physical injuries, and disruption in their treatment process (Newton-Howes, 2013). Instead of de-escalating crises, S/R has been found to increase agitation, aggression, and trauma symptoms in patients, leading to prolonged care requirements and, in some cases, readmissions (MHA, n.d.). These extended hospitalizations not only delay recovery but also exacerbate healthcare costs, further burdening patients, hospitals, and insurance providers. These findings underscore that S/R is not a neutral intervention but a practice that actively contributes to deteriorating patient health, prolonged institutionalization, and increased systemic costs—all of which highlight the urgency for policy change.

The use of S/R also contributes to workforce burnout and staff turnover, creating additional hidden costs for hospitals. The emotional toll on staff and the physical risks associated with managing aggressive incidents contribute to turnover rates as high as 62% in psychiatric facilities (MHA, n.d.). The costs of recruiting, training, and retaining new staff further strain hospital budgets, making the reduction of S/R a financially sound decision.

From a systemic perspective, it is clear that S/R is not only unethical but economically unsustainable. Research consistently shows that reducing the use of S/R leads to better patient outcomes, lower healthcare costs, and fewer legal and liability expenses (LeBel & Goldstein, 2005). Policy reformers must recognize that in a capitalist-driven society where financial arguments hold significant weight, demonstrating the economic inefficiency of S/R is a crucial strategy for policy change. The data overwhelmingly supports a transition toward alternative interventions, such as sensory rooms, which improve patient care, reduce hospital costs, and align with trauma-informed care principles (Björkdahl et al., 2016).

POLICY ALTERNATIVES TO SECLUSION AND RESTRAINT

Given the well-documented harm and inefficiency of S/R, psychiatric facilities must adopt alternative interventions that prioritize patient autonomy, emotion regulation, and trauma-informed care. One such evidence-based alternative is the use of sensory rooms, which provide *sensory modulation interventions* (SMIs) to help individuals regulate their emotions in a safe and controlled environment. A sensory room offers patients a safe space where they can learn to regulate their emotions and gain skills they can use outside the hospital. Sensory rooms have long been used to support individuals with autism spectrum disorder (ASD) and other behavioral conditions by helping them regulate their bodies and better adapt to their environment. These rooms are commonly found in schools and educational settings, where they not only support emotion regulation but also improve how individuals with ASD interact with teachers and peers. They foster the person's independence and help them advocate for themselves when they are feeling overstimulated or overwhelmed (National Autism Resources, n.d.).

If a hospital replaced its seclusion rooms with sensory rooms, patients could learn methods for emotion regulation that they could then easily transfer into the world outside the hospital. Patients who are being discharged would have a set of skills that allow them to regulate their emotions rather than resorting to self-harm, aggression, or withdrawal. Sensory stimulation methods empower patients by giving them the control and the autonomy to decide for themselves how they want to self-regulate, rather than confining them within prison-like isolation rooms at hospitals (Haig & Hallett, 2023).

Sensory rooms can also be used as a proactive intervention that helps prevent violent outbursts from escalating into crisis situations requiring S/R (Haig & Hallett, 2023). Eliminating the practice of S/R would improve patient outcomes, lower the financial burden on psychiatric hospitals by reducing the average length of inpatient stays, and increase the likelihood of patients' successful reintegration into their communities (Ma et al., 2021).

SENSORY MODULATION AS A RESPONSE TO COMMON S/R TRIGGERS

As mentioned earlier, S/R is applied broadly to patients exhibiting certain behaviors, regardless of diagnosis (Georgieva et al., 2020). Individuals experiencing severe agitation, self-harming behaviors, physical aggression, or extreme emotional distress are the most likely to be restrained or secluded, even when alternative interventions could have prevented escalation (Ma et al., 2021). Sensory rooms are a proactive alternative that could help patients manage these behaviors before they reach a crisis point.

The use of S/R remains prevalent across the globe, yet these practices are traumatizing for both patients and hospital staff. Sensory rooms provide a viable alternative that allows psychiatric facilities to implement *sensory modulation strategies* in place of coercive interventions. Haig and Hallett (2023) explain that "sensory modulation refers to the personalisation of sensory input by controlling the environment, and use of equipment and/or activities designed to support an individual to self-regulate by achieving their optimum level of calm or alertness" (p. 55). Patients who practice self-regulation inside a sensory room can carry those techniques into life outside the hospital and apply them in daily life to enhance healthy behavior.

Sensory modulation techniques (SMTs) can be used to help prevent behaviors that trigger S/R interventions. These techniques include:

- Tactile: Weighted blankets, fidget tools, or textured surfaces to reduce distress and ground patients.
- Auditory: Sound machines, white noise, or calming music to lower arousal levels.
- Visual: Soft lighting, visual projection tools, or soothing imagery to decrease anxiety.
- Olfactory: Aromatherapy using calming scents like lavender to help regulate mood.
- Proprioceptive: Deep pressure input through body movement, such as via rocking chairs, yoga balls, or stretching, to improve emotional control (Recovery Ways, 2022).

By offering self-directed and patient-centered regulation strategies, sensory rooms reduce the need for coercive interventions that strip patients of their agency and dignity (Haig & Hallett, 2023). These strategies are not only less harmful but are also therapeutic, as they equip patients with new coping skills that promote long-term emotion regulation and autonomy beyond the hospital setting.

SENSORY ROOMS AS A PROVEN INTERVENTION

Ongoing research within acute psychiatric care is developing the best possible interventions for reducing S/R in inpatient facilities. One intervention suggests treating "patients as active participants in seclusion reduction interventions" (Gaskin et al., 2007, p. 298). One of the many benefits of implementing sensory rooms as an intervention against S/R is that it allows the patient to remain in full control of how they choose to regulate their emotions and manage their distress, thereby making them "active participants" in their own treatment. Psychiatric staff must shift their perspective from treatment happening *to* a patient to treatment happening *with* a patient, thereby reinforcing collaborative care models rather than coercion-based interventions.

Table 1 and 2 show some of the benefits of using sensory rooms instead of S/R in psychiatric care, along with considerations when switching to this model.

While there are currently no sensory rooms in inpatient psychiatric settings in the United States, psychiatric hospitals in Sweden have begun exploring this solution. Although staff in such hospitals were initially ambivalent about implementing sensory rooms, over time they observed meaningful improvements, including patients becoming more independent in managing their emotions, building greater confidence in their ability to care for themselves, and experiencing enhanced overall well-being (Björkdahl et. al., 2016). Sensory rooms supported "the important principles of person-centered nursing and recovery-oriented mental health and the ability of staff to implement these principles" (Björkdahl et. al., 2016, p. 472). Implementing sensory rooms in psychiatric inpatient settings aims to help patients regain their individual autonomy within the treatment they receive, as they learn ways to self-soothe and choose which sensory stimulation methods and tools to use.

IMPLEMENTATION OF SENSORY ROOMS

Before implementing sensory rooms as a matter of state or federal policy in the U.S., this brief recommends identifying one acute psychiatric inpatient hospital to implement sensory rooms as a replacement for S/R. Over the course of one year, research would be conducted within the identified hospital to track the results of the sensory rooms. At the conclusion of the year-long research project, the evidence collected could be brought to governmental bodies to propose policy changes regarding seclusion and restraint practices within acute psychiatric inpatient hospital settings.

Jackson Behavioral Health Hospital (JBHH), located in Miami, Florida, could be used to implement the recommended intervention due to its existing inpatient psychiatric infrastructure. Each of the psychiatric inpatient units at JBHH has two rooms designated as observation rooms, or rooms used exclusively for S/R. For the duration of the year-long research project, one of the adult behavioral health units at JBHH could transform one of their two observation rooms into a designated sensory room. All staff within the unit would be educated on how to use the sensory room when a patient is overstimulated. The patient would be instructed to use the coping tools in the sensory room before staff considered using seclusion and restraint.

To successfully create a sensory room, the room needs to be filled with a variety of objects that appeal to the different senses. There should be multiple options for each of the five senses so that the patient can choose what works best for them as they learn emotion regulation and distress tolerance. Table 3 offers examples of different objects and tools within the sensory room that will provide a sensory experience for each of the five senses.

Given the nature of behavioral health hospitals, the objects in the sensory room cannot put the patient at risk of suicide or self-harm. For example, headphones must be wireless, and there cannot be any sharp objects. In addition to providing tools that appeal to the five senses, the sensory room can contain resources such as books, journals, and handouts that allow the patient to occupy their mind while simultaneously doing something therapeutic. The sensory room should shift away from the traditionally all-white walls of a psychiatric hospital and include decor such as soft carpets and light paint colors, which have been shown to create a calming atmosphere and support patient well-being (Eminovic et al., 2022).

Sensory rooms are not just a theoretical alternative—they represent a research-based intervention that can replace outdated and harmful S/R practices. The transition from coercive interventions to sensory modulation techniques is a necessary step toward ethical, patient-centered psychiatric care.

CONCLUSION AND POLICY RECOMMENDATIONS

The goal of acute psychiatric inpatient treatment is to ensure that the patient is stable enough to return to their community without being at risk for self-neglect or self-harm. As such, acute psychiatric care seeks to help patients reintegrate with their communities upon discharge. Giving patients access to sensory rooms while still admitted to inpatient psychiatric care will show patients the variety of ways in which they can self-soothe and self-regulate, through a variety of sensory modalities that they will be able to carry over into the world outside the hospital after being discharged. Sensory rooms can eliminate the use of seclusion and restraint in psychiatry by making the patients active participants in their treatment and equipping them with necessary distress tolerance and emotion regulation skills. Learning such skills will give patients transferable, relevant, and effective methods of coping, both inside the hospital and in their communities after discharge.

However, achieving systemic change requires collective action at all levels of psychiatric care, not just from policymakers. Social workers play a crucial role in advocating for and implementing alternative interventions within their own workplaces and communities. Even social workers who do not hold policy making roles can educate hospital administrators, clinical teams, and leadership about the proven benefits of sensory rooms. By advocating for pilot programs within psychiatric facilities, conducting data-driven evaluations of sensory room effectiveness, and documenting reductions in S/R use, social workers can generate the evidence needed to push for larger-scale policy reforms. If multiple hospitals implement sensory room interventions and gather compelling research on their impact, this evidence could influence national mental health policies and establish sensory rooms as the standard of care in inpatient psychiatry.

Sensory rooms are not just an abstract recommendation—they are a practical, evidence-based solution that can replace outdated and harmful psychiatric interventions. Through advocacy, education, and research, social workers at all levels of practice can contribute to a fundamental shift in psychiatric care, ensuring that patients receive compassionate, trauma-informed, and effective treatment.

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TABLE 1
BENEFITS RELATED TO SENSORY ROOMS

Benefits of Sensory Rooms	
Empowers patients	Sensory rooms encourage self-regulation and autonomy by allowing patients to choose their own coping mechanisms, reducing trauma from coercion-based interventions (Haig & Hallett, 2023).
Reduces aggression and violence	Sensory rooms provide a proactive, nonrestrictive intervention that can de-escalate situations before they reach a crisis leading to the use of S/R (Björkdahl et al., 2016).
Improves patient outcomes	Sensory rooms reduce the need for S/R, decrease inpatient stays, and enhance emotional well-being, leading to greater patient stability post-discharge (Georgieva et al., 2020).
Space requirements	Hospitals can use existing rooms designated for S/R to create sensory rooms.
Cost-effective for hospitals	Lower reliance on S/R reduces hospital costs associated with longer inpatient stays, lawsuits, staff injuries, and insurance penalties.

TABLE 2
CONSIDERATIONS RELATED TO SENSORY ROOMS

Considerations for Sensory Rooms	
Initial resistance from staff	Some staff members may struggle with relinquishing control and adapting to a less authoritative model of care (Björkdahl et al., 2016).
Not a one-size-fits-all solution	Sensory interventions must be tailored to individual needs, and not every patient will respond equally well to the same sensory modulation techniques (Georgieva et al., 2020).
Need for staff training	Effective implementation relies on well-trained staff who understand how to guide patients in using sensory tools effectively rather than reverting to traditional control-based interventions (Haig & Hallett, 2023).

TABLE 3
SENSORY ROOMS AND THE FIVE SENSES

Sensory Rooms and the Five Senses	
Taste	• Sour candies • Cold ice cubes • Calming tea (available upon request)
Touch	• Cold washcloths • Kinetic sand • Weighted blankets • Calm Strips • Fidget toys
Smell	• Essential oils • Scented markers • Scented Play-Doh
Sight	• TV screen with calming visuals such as nature walks, relaxing ocean waves, and gentle rain • Posters with breathing techniques
Hearing	• Ambient music • Wireless noise-canceling headphones

Technological Innovations in Dementia Care: The Role of Social Work Advocacy

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ESTHER PARK

AUTHOR'S NOTE

At the time of this paper's writing, the U.S. federal government was undergoing a presidential transition. As a result, significant changes have been made to federal government websites, including the removal or modification of policies, webpages, and datasets. These limitations in information availability, along with policy shifts under the new administration, may affect some of the resources, government programs, and funding opportunities discussed in this paper. Future research will be needed to evaluate the long-term impact of these changes on equitable access to dementia care technologies, public access to essential data for caregivers and healthcare professionals, and the role of social work advocacy in supporting affected communities.

ABSTRACT

According to the World Health Organization (2023), dementia affects over 55 million people across the globe, projected to increase to 139 million individuals by the year 2050. The caregiver burden, which compounds over the years of illness, includes emotional, physical, and financial challenges. These challenges disproportionately impact low-income and minority communities (Mickens et al., 2020). This research paper explores the role of technology in alleviating these challenges by improving the quality of life of both persons with dementia (PWDs) and their caregivers. Current technological tools, including healthcare monitoring tools, location-tracking devices, and reminiscence therapy platforms, are analyzed for their strengths in addressing the cognitive and safety needs of PWDs. I also address limitations such as financial barriers, digital literacy gaps, and accessibility challenges among older adult populations. The study emphasizes the significant role of social workers in advocating for equitable, person-centered care through policy and community-level interventions. Recommendations for social workers are provided, including promoting digital literacy programs, subsidizing assistive technology costs, and prioritizing user-centered designs to ensure equitable access to dementia care technologies.

INNOVATIONS IN DEMENTIA CARE: THE ROLE OF TECHNOLOGY AND SOCIAL WORK ADVOCACY

Dementia, a progressive neurodegenerative condition, leads to a wide array of cognitive impairments, including memory loss, difficulty with language, and a reduced ability to perform daily activities (Rahman & Howard, 2018). Globally, over 55 million people live with dementia, and this number is projected to reach 139 million by the year 2050 (World Health Organization [WHO], 2025). This significant increase emphasizes the urgent need to address the numerous challenges associated with dementia care. These concerns include ensuring the safety of persons with dementia (PWDs), alleviating the caregiving burden on their caregivers, and improving the quality of life for both groups.

UNDERSTANDING DEMENTIA

Dementia is an umbrella term for over 100 distinct conditions, with Alzheimer's disease being the most prevalent and well-known (Mace & Rabins, 2017). PWDs experience a range of cognitive and noncognitive symptoms over time. Cognitive issues, particularly in short-term memory and learning, are often early and generally well-known signs of the condition. Noncognitive symptoms include neuropsychiatric conditions such as physical aggression and restlessness, wandering behaviors, decreased sexual drive, and inappropriate social behaviors like cursing or hoarding (Biernacki, 2007).

Symptoms of dementia often begin on a mild level, such as forgetfulness or difficulty using precise diction; they eventually progress to more severe impairments. In the early stages of the condition, PWDs may maintain some independence in daily life but begin to struggle with more complex tasks. As the condition advances, they often require assistance with basic activities such as dressing and eating. In its late stages, dementia leads to complete dependence on caregivers for all aspects of daily living (Rahman & Howard, 2018). Given that these symptoms shift over time, PWDs often unwillingly experience emotional, cognitive, and social disruptions that decrease their quality of life.

CAREGIVER BURDEN AND TRENDS

The progressive and severe nature of dementia makes caregiving for PWDs particularly demanding. According to the Centers for Disease Control and Prevention (CDC; 2024), 80% of people with dementia are cared for at home, with 16 million caregivers providing care to their family members and friends. One in three caregivers is 65 or older (CDC, 2024) and thus experiences the unique social, financial, and physical vulnerabilities that impact the older adult population.

Caregivers help manage activities of daily living (ADLs) for those affected by dementia, which include essential tasks like bathing, eating, and toileting, as well as more complex tasks like managing medications, finances, and transportation. A survey of 11.5 million families and other caregivers of individuals with dementia reported that these caregivers provide approximately 31 hours of unpaid help per week (Alzheimer's Association, 2024). As a result, caregivers for PWDs experience a range of challenges that may lead to burnout, defined as a state of physical, emotional, and mental exhaustion caused by the stressors and demands of caregiving (Maslach & Leiter, 2016). As they witness the gradual decline of their loved ones, caregivers often experience emotional challenges including grief, guilt, and depression (Mace & Rabins, 2017). Physically, the caregiving role frequently leads to fatigue and health deterioration due to chronic stress and disruptions in regular sleep patterns (Mace & Rabins, 2017). Financial challenges include significant costs of medical care and the potential loss of income due to caregiving responsibilities. These challenges make dementia one of the most costly conditions to manage (Alzheimer's Association, 2019).

For marginalized communities, these challenges are further compounded by systemic inequities, including limited access to healthcare, technological tools, and caregiver support services. Research shows that racial and ethnic minority caregivers are more likely to experience higher caregiving burdens due to disparities in healthcare access and socioeconomic barriers (Mickens et al., 2020). African Americans are twice as likely as white Americans to develop dementia, and Hispanic Americans are 1.5 times more likely (Alzheimer's Association, 2019). Yet these groups often experience significantly lower access to diagnostic services, treatment options, and caregiver support programs (Gaugler et al., 2020). Additionally, caregivers in low-income households are particularly vulnerable to financial stress. They also face additional barriers to accessing paid care services (Andrén & Elmståhl, 2007), thus increasing susceptibility to caregiver burnout.

THE PRESENT STUDY

In the context of these systemic and daily challenges faced by caregivers and individuals with dementia, technology significantly enhances dementia care. Technological advancements provide increasing benefits for older individuals with dementia, as well as for their caregivers (Allen, 2020). Various technological tools, such as assistive devices and telehealth platforms (Saragih et al., 2022), are being integrated into dementia care in increasing numbers, using innovation to address the needs and demands of dementia care.

However, equitable access to such technology remains a challenge. Caregivers' willingness and ability to use these tools may be influenced by economic barriers, digital literacy, and the additional cognitive load required to learn new systems. Older caregivers in particular may struggle with adopting unfamiliar digital platforms, while underserved populations may have less access to essential assistive technologies (Leff et al., 2025). When implemented with an ethical and inclusive approach that prioritizes accessibility, affordability, and cultural sensitivity, technology can help manage the safety and cognitive symptoms of PWDs while simultaneously alleviating caregiver burdens. Thus, technology can play a significant role in increasing the quality of life of both individuals with dementia and their caregivers.

The present study first delves into the strengths of various innovative tools currently being used in dementia care, such as healthcare technologies and location-tracking devices to address the wandering behaviors of PWDs. Next, the limitations of these technologies are discussed, followed by actionable strategies for social workers on policy and community-level interventions to promote inclusive, accessible solutions for integrating technology into dementia care.

TECHNOLOGICAL INNOVATIONS IN DEMENTIA CARE

HEALTHCARE TECHNOLOGIES FOR DEMENTIA CARE

Healthcare technologies for dementia care have numerous applications in both homes and care facilities, and have been shown to play a significant role in relieving stressors for both care recipients and caregivers (Allen, 2020). From a medical standpoint, video monitoring technology supports the treatment of patients by providing useful content for care plan discussions with healthcare professionals and more immediate feedback for caregivers of individuals with dementia. Additional healthcare technologies include the following, which collectively ensure the quality of treatments, general safety, and daily care for individuals with dementia (Allen, 2020):

- Exit sensors to manage wandering behaviors
- Flood, carbon monoxide, and extreme temperature detectors to maintain environmental safety
- Bed occupancy sensors
- Medication reminders

Further technological innovations in clinical treatments for dementia have been identified in recent years, including those that address the complex socioemotional challenges associated with dementia. One such advance is the integration of technology into reminiscence therapy, a therapeutic approach used in dementia care that encourages individuals with dementia to recall and share memories from their past (Woods et al., 2018). This approach has been demonstrated to improve emotional mood, social interactions, and cognitive functioning among PWDs (Woods et al., 2018). Based on this evidence-based approach, researchers Huldtgren, Vormann, and Geiger (2015a, 2015b) have explored methods of using a specially designed computerized mapping program to facilitate reminiscence therapy for people with dementia. Tools like interactive mapping software assist in memory recall and strengthen bonds between PWDs and their caregivers, contributing to a therapeutic environment and positive social connections. These e-health platforms incorporate multimedia elements such as photos, audio, and videos to provide personalized experiences for patients (Huldtgren et al., 2015a, 2015b), further enhancing the intervention's effectiveness.

By enhancing reminiscence therapy with technology, these innovations provide significant emotional and psychological relief for both PWDs and their caregivers. For PWDs, reliving positive past experiences can improve mood, reduce anxiety, and strengthen cognitive function (Woods et al., 2018). For caregivers, these tools offer an opportunity to engage with their loved ones in a structured and meaningful way, reducing the stress and emotional burden often associated with dementia care.

These innovations play an important role in engaging PWDs emotionally and cognitively, important aspects in maintaining cognitive health and mitigating the symptoms of dementia. Meanwhile, caregivers also benefit from such technologies, as they help alleviate the physical and emotional burdens associated with caregiving. For instance, telehealth services and remote monitoring systems allow caregivers to oversee the health and safety of PWDs while maintaining their own personal and professional commitments. Smart medication dispensers ensure that PWDs adhere to prescribed treatments without requiring constant reminders from caregivers, thus reducing stress and improving time management (Patel et al., 2022). By allowing caregivers to maintain a sense of balance between personal and caregiving responsibilities, these tools support their mental health and ongoing resilience despite the strain of providing care to PWDs (Mace & Rabins, 2017).

TECHNOLOGIES TO MANAGE WANDERING BEHAVIORS

Among the safety concerns surrounding PWDs is the prevalence of wandering behaviors. Research by Algase et al. (2007) defines wandering as “a syndrome of dementia-related locomotion behaviour having a frequent, repetitive, temporally-disordered and/or spatially-disoriented nature that is manifested in lapping, random, and/or pacing patterns, some of which are associated with eloping” (p. 723). These behaviors have been observed to stem from a range of variables, such as immersion in unfamiliar environments, mood-related agitation caused by brain damage, or disorientation in general. Research shows that wandering behavior substantially increases the risk of injury and/or fatalities, caused by, for example, being struck by vehicles or succumbing to environmental hazards (Byard & Langlois, 2019). As a result, PWDs exhibiting wandering behaviors may find themselves in at-risk environments or become lost, leading to the potential for physical harm or even death.

Approximately 60% of individuals with dementia will experience wandering during the course of the disease (Alzheimer’s Association, 2022). This leads to additional challenges for a significant proportion of PWDs and their caregivers, who may experience fearfulness and anxiety as a result. To address these concerns, several low-tech strategies are often implemented, such as PWDs carrying reminders to remain calm and call home or wearing medical bracelets that provide critical health information and emergency contact numbers (Mace & Rabins, 2017). As technology has advanced, however, innovative products have been designed to both prevent and respond to wandering behaviors among PWDs.

In particular, wearable devices equipped with location tracking features, such as GPS-enabled bracelets, watches, or even shoe inserts, allow caregivers to manage the location of PWDs in real time. For example, GPS SmartSole is a water-resistant device discreetly embedded in the sole of a shoe. This technological tool was developed for individuals with dementia, autism, or traumatic brain injury who are prone to wandering. The product is recharged daily, offering real-time location updates and helping protect the safety of PWDs (Nunes, 2021).

Another innovative tool to address the risks of wandering behaviors is AngelSense, a location tracker designed to securely attach to clothing. This device offers all-day monitoring of arrivals, departures, and travel speeds, along with automatic alerts when the individual enters unfamiliar geographic areas. Additional features include a two-way voice function and a first-responder emergency alert, which enhances the safety of persons with dementia (AngelSense, n.d.).

In addition to these wearable, location-based devices, video monitoring systems have become increasingly popular. These systems allow caregivers to observe individuals remotely and intervene promptly during emergencies. Features such as motion detection and automated alerts help maintain a balance between ensuring safety and promoting independence for PWDs (Allen, 2020).

LIMITATIONS IN TECHNOLOGICAL TOOLS

However, these technological tools are not without limitations. For example, a significant barrier to technology adoption among older adults is the pervasive gap in financial resources and digital literacy, defined as competence in one’s technical understanding of technology (Vercruyssen, et al., 2023). This problem is exacerbated by insufficient access to training and resources. Many older adults, particularly those from low-income and minority populations (McCreadie & Tinker, 2005), lack the digital skills or financial resources to navigate these technological tools, which limits their ability to benefit from digital innovations. This issue is particularly concerning because one-third of caregivers are older adults themselves, leaving both caregivers and those they support at a disadvantage in accessing these digital resources (Costa & Moniz, 2024).

Additionally, these technologies present challenges in meeting the diverse needs of users, such as older adults and caregivers, who are more susceptible to physical, sensory, or cognitive limitations. These issues arise in part from the lack of accessible design of these products, including poor usability, such as lacking help and search options and limited instructions, and not tailoring features to individual impairments and disabilities (Hassan et al., 2022). Consequently, the digital tools intended to enhance support for individuals with disabilities and their caregivers are often underused (Hassan et al., 2022).

Moreover, current literature reveals a gap in examining the effectiveness of interventions, including technological tools, among communities of color. While existing academic research clearly establishes that ethnic minority caregivers of individuals with dementia experience disproportionately higher levels of caregiver burden, it also highlights significant limitations in understanding how these technological tools benefit marginalized populations, such as PWDs and caregivers of color (Kindratt et al., 2023; Liu et al., 2022). Further research is needed to analyze their unique barriers and needs related to technology utilization; only a few studies have explored how these tools can be adapted to better serve PWDs and their caregivers. Without such attention, disparities in access to and adoption of technological tools and interventions will likely persist.

Finally, implementing technological tools for PWDs and their caregivers poses ethical concerns. From data privacy and informed consent for location-tracking technologies, to obstacles in the equitable distribution of resources, these concerns call for action that is grounded in the social justice–oriented principles of social work. Social workers play a pivotal role in confronting these barriers for these vulnerable populations by promoting equitable access to caregiving technologies from program- and policy-level standpoints.

IMPLICATIONS FOR SOCIAL WORK PRACTICE

Several existing macro-level initiatives provide an excellent framework for social workers to address gaps in digital literacy and financial

resources that lead to barriers in accessing technology for dementia care. For example, California's Access to Technology program provided $48 million to communities and organizations to spearhead digital literacy initiatives, including digital literacy education programs and funding for technological devices, for adults with disabilities and older adults (California Department of Aging, n.d.). In addition, the Federal Communications Commission (2021) offers the Lifeline Program, geared toward national broadband expansion. This program advocates for affordable internet access for underserved populations and communities, making it a solid example of promoting access to telehealth and digital tools. These programs could improve the personal autonomy and quality of life among PWDs and their caregivers. Social workers can play pivotal roles in bridging gaps among tech developers, policymakers, and caregiver and PWD communities.

These programs are key examples of promoting the accessibility and affordability of assistive technologies for dementia care. Subsidizing assistive technology promotes equitable access, improving the quality of life for low-income families. By referencing the advantages of these initiatives in community-level and policy-level advocacy, social workers may play a significant role in advocating for equitable digital knowledge, education, and resources in their communities. A key entry point for policy change involves integrating assistive technology funding into existing healthcare programs, such as Medicaid and home- and community-based services, to provide financial support for families in need (KFF, 2022). Public-private partnerships between technology developers, healthcare institutions, and policymakers can facilitate the large-scale distribution of these tools, ensuring cost-effective and inclusive access.

Older adults and their caregivers who encounter physical and cognitive limitations need user-friendly technology design. When navigating these issues, social workers should turn to the model of person-centered care (National Association of Social Workers, 2021), which prioritizes the dignity and autonomy of individuals, ensuring that care plans are personalized and that the individual's voice remains central to decision-making. Technological tools like the MindMate app (2018) are designed to offer interactive memory exercises and medication reminders for individuals with dementia and Alzheimer's disease. They are also individually tailored with input from users and patients, aligning with the principles of person-centered care that emphasize the voices of populations served.

As technology plays an increasingly pivotal role in dementia care, future social work research and product development efforts must prioritize collaboration between social workers, product designers and engineers, and healthcare providers to create solutions that are not only effective in dementia care, but also equitable for marginalized populations. Many older adults, particularly those with cognitive impairments, face challenges in interacting with complex technology. Research should focus on creating intuitive, user-friendly interfaces that can accommodate the varying cognitive abilities of individuals with dementia (McCreadie & Tinker, 2005), such as designs that incorporate large fonts, clear visuals, and voice-activated systems to promote independence while minimizing confusion. Additionally, social workers may advocate for ongoing usability testing with target populations to ensure that the technology remains accessible, effective, and engaging for those with dementia, as well as their caregivers, and to ensure a person-centered care model in product development. Through approaches like cross-disciplinary partnerships, social workers can help ensure that technological tools not only address the clinical aspects of dementia care but also uplift the voices and self-reported needs of individuals with dementia and their caregivers.

To address the lack of existing research on ethnic minority engagement with technological interventions, future social work research should prioritize inclusivity in both study design and implementation. Considering that users vary across sociodemographic factors such as race, ethnicity, and socioeconomic status, as well as their unique behavioral and cognitive manifestations of dementia (Vollmer Dahlke & Ory, 2020), research must account for these complexities

when evaluating the effectiveness of technological tools. A more comprehensive approach would involve engaging not only primary users, including individuals with dementia and their caregivers, but also secondary stakeholders, such as formal and informal caregivers and family members who play a significant role in the adoption and use of these technologies (Vollmer Dahlke & Ory, 2020).

CONCLUSION

Social workers can advocate for policies and programs that ensure equitable access to these resources, working alongside community organizations and multidisciplinary professionals. The role of social workers in promoting inclusivity in both the design and distribution of dementia care technologies can contribute to a more just and supportive healthcare system for all individuals affected by dementia. By providing digital education to caregivers and PWDs in the form of digital literacy education programs and classes and enhancing the reach of technological solutions, these efforts can ensure more equitable care for individuals with dementia and other disabilities, benefiting both families and society as a whole.

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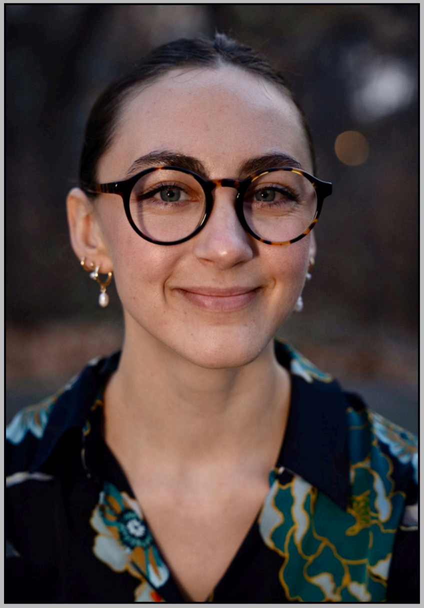
Artificial Intelligence-Driven Rent Pricing Tools & the Housing Crisis

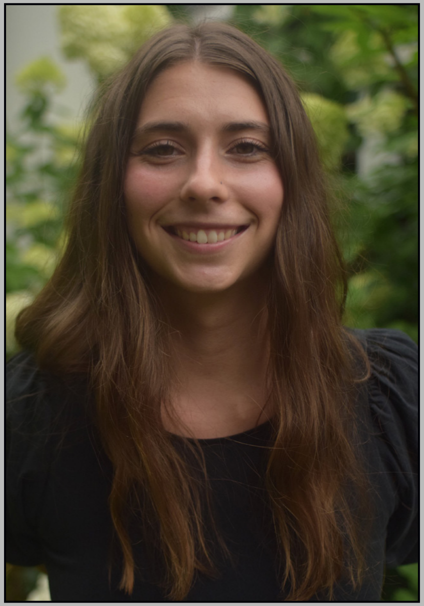
MCKYNZIE CLARK, AUSTIN NELSON,
SANJANA UTIRAMERUR

MCKYNZIE CLARK



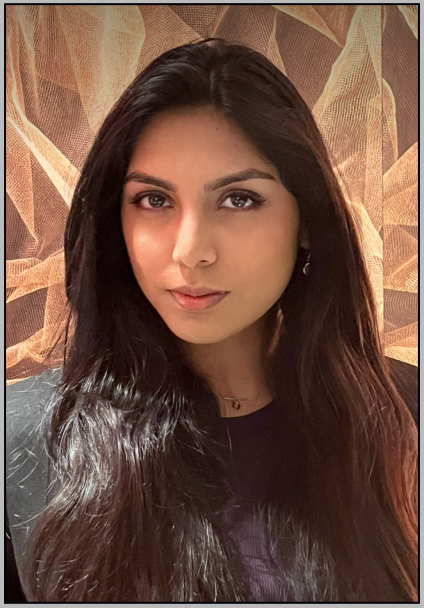
Kynzie (she/her) is a researcher and student based in New York City. Eager to understand the growing intersection between technology, law, and networks of care, Kynzie is pursuing a Master of Social Work degree at Columbia University as a Fisher Cummings Fellow. In her studies, she hopes to leverage her experience in advocacy, research, and policy work to advance equity and systems change work. Previously, Kynzie studied political science and Russian language at Yale University. Outside of classes, Kynzie interns at The Bronx Defenders and works with the Center for Intimacy Justice.

AUSTIN NELSON



Austin Nelson (she/her) is a Master of Social Work student at Columbia University with a background in research, community engagement, and data ethics. Her professional experience spans direct service with unhoused populations, trauma-informed youth programming, and nonprofit development. Austin's research interests center on the intersection of technology, equity, and housing justice, drawing from previous work on data ethics in the ICT4D space and gender-based violence interventions. She brings a critical, justice-oriented lens to examining the role of AI in rental markets, with attention to accessibility, bias, and systemic inequality.

SANJANA UTIRAMERUR



Sanjana is an MSW student on the advanced clinical practice track at the School of Social Work. She is passionate about working with diverse populations navigating systemic inequity, particularly in healthcare. In the future, she hopes to attain her LCSW license and provide accessible trauma-informed therapy to marginalized communities.

INSPIRATION

Our interest in the intersection of AI and the housing crisis emerged from my broader focus on social justice and technology. As social work students passionate about policy and ethics, we were struck by how AI tools—often promoted as neutral or innovative—are increasingly shaping access to basic human rights like housing. We were inspired to write this piece after reading about biased tenant screening algorithms and models that reinforce housing discrimination. Researching this topic was both eye-opening and frustrating. There was a wealth of information on AI development, but far less on how these tools impact low-income communities or exacerbate inequality.

ABSTRACT

This policy brief explores the use of artificial intelligence (AI) in rent pricing tools that corporate landlords and property management companies use for rental housing, and its consequences for the housing market. Across the United States, landlords have become increasingly reliant on AI-driven rent pricing tools to raise rents and boost their profits. This technology, which uses both sensitive proprietary data and publicly available information, is reducing housing accessibility, often driving tenants from their homes. As AI becomes increasingly pervasive in our everyday lives, it is essential that we interrogate its uses, especially in those that have as many collateral consequences as housing. We offer an overview of rent regulation history, the underlying AI technology, and existing policy, and make our own policy recommendations.

Keywords: artificial intelligence, housing policy, tenants' rights, data rights, privacy

ARTIFICIAL INTELLIGENCE–DRIVEN RENT PRICING TOOLS AND THE HOUSING CRISIS

Rental housing, like other societal systems, has been increasingly shaped by artificial intelligence (AI) technology in recent years. This shift, however, is not just a technological evolution—it represents a radical departure from traditional rent-setting methods and carries significant implications for privacy and equity. This article argues that artificial intelligence, particularly through rent pricing tools, has adversely affected the already competitive rental housing markets in urban settings by exacerbating discrimination and enabling collusion between landlords. We start by exploring the history of how rental prices have traditionally been set in the United States as well as the evolution of machine learning and AI. Then, we explain how AI-driven rent pricing tools, such as RealPage, affect urban rental housing markets. Finally, we look at policies regulating rental housing, data protection, and AI and offer our own policy recommendations.

I. BACKGROUND

CONTEXT REGARDING RENT IN THE U.S.

Historically, rent-setting in the United States has been shaped by a complex interplay of economic forces, housing regulations, and anti-Black racism. Before the 1930s, homeownership was less common than it is today, with most Americans renting their homes due to high down payments and short loan terms that made buying property difficult (Gordon, 2005). Traditionally, rent-setting was a localized process where individual landlords determined rental prices based on property characteristics and neighborhood demand. The first rent control laws were adopted in the 1920s in response to urbanization, housing shortages, rent increases, and growing tenant advocacy following World War I (Rajasekaran et al., 2019).

During the Great Migration, which spanned most of the twentieth century, millions of African Americans migrated to northern cities in search of economic opportunities and to obtain freedom from oppressive Jim Crow laws in the South. However, these migrants were met with discriminatory housing policies that acted as barriers to wealth accumulation and homeownership. Starting in the 1930s, the Home Owners Loan Corporation created color-coded maps that graded neighborhoods based on their perceived lending risk, which was often directly related to racial demographics (Kaplan & Valls, 2007). Predominantly Black neighborhoods were labeled “hazardous” and outlined in red, and the people living there were systematically denied access to credit, home loans, and mortgage financing. The practice led to the use of the term “redlining,” which was institutionalized by the Federal Housing Administration mortgage insurance program. The program made homeownership far more affordable for white families by offering low-down-payment, long-term loans backed by government insurance (Gordon, 2005). As a result of redlining practices, these loans were unavailable to Black families, reinforcing racial segregation and discriminatory housing practices.

Additionally, racially restrictive covenants legally prevented Black families from purchasing or renting homes in white neighborhoods (Coates, 2014). When written into property deeds, these covenants explicitly prohibited sales to nonwhite buyers. Therefore, Black families were forced into overcrowded, deteriorating areas where landlords exploited high demand by charging inflated rent prices.

Redlining and other discriminatory housing policies created the conditions for predatory practices to thrive, further preventing Black homeownership. Contract selling was a deceptive home-buying scheme in which Black families, denied access to traditional mortgages, were forced to purchase homes through high-risk installment contracts. Unlike conventional home loans, these contracts did not grant the buyer equity, and missing even a single payment could result in immediate eviction, allowing the seller to retain the property and all previous payments.

Real estate agents used the tactic of blockbusting—spreading fear that Black families moving into the neighborhood would cause property values to plummet. The tactic drove white homeowners to sell their properties at reduced prices. The agents would then resell these homes to Black buyers at inflated prices, profiting from racial segregation and housing instability (Coates, 2014; Ross, 2008).

Enabled by Federal Housing Administration loans and reinforced by these racist predatory practices, white families conducted “white flight,” moving to the suburbs to avoid integration after desegregation mandates. This practice further exacerbated economic and housing disparities. This migration deprived urban centers of crucial tax revenue, leading to deteriorating public services, housing conditions, and schools, all of which primarily impacted Black residents (Dilworth & Gardner, 2019).

The Fair Housing Act (FHA) of 1968, a direct outcome of the Civil Rights Movement, aimed to eliminate discrimination in housing based on race, religion, or national origin. Although this act made redlining illegal, the legacy of redlining continues to shape housing patterns, as Black communities still often face disinvestment, limited access to credit, lower homeownership rates, and high rental costs (Dilworth & Gardner, 2019). Many families of color remain in formerly redlined areas that suffer from underinvestment and gentrification pressures. The current renting population is increasingly diverse, with people of color, young adults, and low-income families making up significant portions (Dilworth & Gardner, 2019).

CONTEXT REGARDING ARTIFICIAL INTELLIGENCE AND DATA

Artificial intelligence refers broadly to inanimate machine operations designed to replicate human cognition. The field of AI is relatively new: The term was only coined in 1956 by Dartmouth College professor John McCarthy, who explored “thinking machines” such as Alan Turing’s Enigma (Lawrence Livermore National Laboratory, n.d.). Today, when people refer to AI, they are most often referring to a process known as *machine learning* or a specific type of machine learning called *deep learning*. According to MIT Sloan professor Thomas W. Malone, machine learning has become a critical method that has shaped most AI development for the last ten to fifteen years (Brown, 2021).

The logic behind machine and deep learning is relatively intuitive. Machine learning (ML), simply put, is the process of training a computer program or system to perform tasks without explicit instructions. It uses simplistic structures, such as (but not limited to) decision trees and linear regressions. Deep learning (DL) is more sophisticated and teaches computers to process data in a way that attempts to mimic human neural networks. DL tools require much larger datasets than their ML counterparts and can be used to recognize complex patterns in data across a number of dimensions to make new predictions or insights.

While the complexity DL offers has proved tremendously helpful in a number of applications, it presents problems for others, especially for data containing social factors (such as socioeconomic status, race, gender, or sexuality). All AI algorithms, both ML and DL, are only as good as the data they are trained on, and biased inputs result in biased outputs. The problem of bias has dominated most critiques of AI technology, and fairly so. Examples of "algorithmic bias" that either inadequately represent[1] or even adversely affect people of color[2] are in no short supply. Bias presents an even bigger challenge to DL algorithms. Bias can be deeply embedded within the training data required to make DL algorithms function, and the complexity of DL neural networks makes it extremely difficult to identify, let alone address, instances of bias.

While there are many strategies to try to calibrate algorithms fairly with respect to factors such as race and gender, completely removing bias is not possible (Kleinberg et al., 2017). In his book *The Alignment Problem*, programmer and researcher Brian Christian (2020) has referred to the impossibility of achieving perfect fairness as a "brute mathematical fact" for any means of classification, human or machine (p. 70).

HOW DOES AI AFFECT RENTAL HOUSING MARKETS?

So far, we have established two key elements of DL algorithms that will help us explain how AI affects rental markets: 1) They analyze patterns across datasets to make predictions, and 2) they can and will be biased, and that bias is practically impossible to remove.

DL algorithms are mainly used in the rental housing market through AI-driven rent pricing tools. These typically operate by analyzing data from various sources, such as recent rental listings in an area and sales data, to offer market predictions and suggest optimal rent levels to maximize landlord profits. Prima facie, the process mirrors the way that most landlords and property managers determine rental rates *without* AI: They survey the area, consider competitor rates, and calculate other factors that affect what they think is the best rate for them to charge tenants (Vicks, 2024; *Policy Memo: Rent-Setting Software Algorithms*, 2024).

However, upon closer inspection, we find that DL rent pricing tools differ from traditional rent pricing in that:

- They are able to process far higher volumes of data.
- They are accessible to multiple landlords and property managers, leading to pricing collusion.
- They bring an inflated perceived trustworthiness that AI tends to confer.
- They are more prone to hard-to-find bias that disproportionately affects renters of color.

We analyze these issues further using the RealPage/YieldStar rent pricing tool as a case study due to its popularity and impact (Vogell et al., 2022).

REALPAGE AND YIELDSTAR

RealPage is a Texas-based property management software company

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[1] For example, Google Photos facial recognition has failed to identify Black people as human.

[2] For example, the Correctional Offender Management Profiling for Alternative Sanctions (COMPAS) algorithm has produced results that disproportionately and negatively affected Black men.

that provides a technology platform that "enables real estate owners and managers to change how people experience and use rental space" across over 24 million units in North America, Europe, and Asia (RealPage, n.d.). Among the many products RealPage offers is a tool called YieldStar, an "asset optimization system that enables owners and managers to optimize rents to achieve the overall highest yield, or combination of rent and occupancy, at each property" (RealPage, n.d.). YieldStar aggregates both public and proprietary data to set rent prices across entire regions (*Policy Memo: Rent-Setting Software Algorithms,* 2024). This data includes tenants' rent data, credit checks, criminal background information, survey data from landlords and competitors, historical data, and sales transaction data (RealPage, n.d.).

The result has been a sharp and sustained increase in rental costs nationwide, especially in cities like New York, where renters are made to spend upwards of 30% of their total income on rent (Siegel & Bram, 2024). The technology has also emboldened landlords to raise rates higher than they otherwise would. In the words of RealPage executive Andrew Bowen, "I think [AI is] driving [rate increases], quite honestly … As a property manager, very few of us would be willing to actually raise rents double digits within a single month by doing it manually" (Vogell et al., 2022). Without meaningful intervention, these technologies will only deepen existing inequalities, further entrenching a system designed to prioritize profit over people's right to a stable home.

RealPage allows landlords to circumvent price-fixing regulations by enabling them to access data from other landlords and companies without direct cooperation, effectively reducing competition and inflating the housing market. In 2024, the U.S. Department of Justice, in collaboration with eight state attorneys general, filed a civil suit against RealPage for alleged unlawful monopolistic practices that reduce competition among landlords (U.S. Department of Justice, 2024). Moreover, a federal suit in North Carolina accuses the software of violating sections 1 and 2 of the Sherman Anti-Trust Act by monopolizing interstate commerce and restricting competition in the marketplace. This suit is ongoing and has been amended as of January 7, 2025, to include six apartment landlords as defendants (U.S. Department of Justice, 2025).

II. POLICY LANDSCAPE

RENTAL POLICY

Prior to the introduction of AI pricing tools such as RealPage, landlords determined rent pricing through market analysis and cost considerations, factoring in the economic climate. Traditionally, property managers rely on comparable market analysis, a process that reviews rental prices for similar properties within a given region, to determine competitive rent pricing (Pagourtzi et al., 2003). To ensure profitability, landlords and property managers must consider operational costs such as insurance, mortgage payments, and utilities. These factors, combined with a consideration of current economic conditions such as inflation and employment rates, would be used to set a rental price for each property (Dias & Duarte, 2019).

In the United States, several federal regulations exist to protect against discrimination and monopolistic practices in the housing market. The aforementioned FHA of 1986 prohibits housing discrimination on the basis of sex, race, religion, national origin, disability, or familial status (Fair Housing Act [FHA] 1968/2023). The U.S. Department of Housing and Urban Development (HUD) enforces the FHA and oversees affordability initiatives such as Section 8 vouchers, which assist low-income families seeking affordable housing.

While HUD specifies that AI tools for tenant screening, advertising, and mortgage decisions must comply with the Fair Housing Act, there are no specific federal regulations regarding rent pricing tools. Furthermore, the free housing market is largely protected by the Sherman Anti-Trust Act of 1890, which prohibits price-fixing agreements between competitors, exclusive contracts, and monopolizing a market for products or services (Sherman Anti-Trust Act, 1890). In accordance with this act, landlords and property managers are prohibited from sharing data about their rental units and colluding to inflate rental prices. But as previously mentioned, RealPage has been accused of violating the Sherman Anti-Trust Act by allowing landlords and property managers to access rental data, effectively restricting competition and increasing inflation in rent pricing.

TECH POLICY

Artificial intelligence is relatively new and thus loosely regulated by federal law, leaving the majority of regulations to the state level. Currently, the Federal Trade Commission (FTC) and the National Institute of Standards and Technology (NIST) have issued broad guidelines regarding transparency and consumer protection in AI algorithms (Federal Trade Commission, 2024). Although the NIST provides a suggested framework for transparency and data protection, no comprehensive legislation specifically addresses these concerns (NIST, 2024).

Regarding AI tools in housing, rent pricing tools are loosely regulated through sector-specific policies by HUD and the Federal Housing Finance Agency. However, concerns have risen that AI pricing tools may contribute to discrimination in the housing market by deriving algorithms that rely on historical data and patterns of discrimination against certain ethnic and socioeconomic subgroups. Moreover, the use of artificial intelligence reduces human oversight and creates a lack of transparency on how pricing decisions are made. As consumers across the United States express concern over artificial intelligence, states have begun to introduce legislation around the use of AI tools in housing.

As every state faces unique housing challenges, each state has taken a slightly different approach to regulating AI pricing tools. California is currently facing a housing crisis, as the state has one of the highest median rent and home prices in the nation. As of September 2024, the qualifications for a mortgage on a mid-tier home were more than double the median household income for the previous year (Bentz, 2024). Despite growing concerns, the state has not enacted comprehensive legislation to address AI pricing tools. Currently, the data privacy of California residents is protected by the California Consumer Privacy Act and the California Privacy Rights Act, both of which restrict data sharing by businesses and grant consumers greater control over personal data collected by AI systems (California Privacy Protection Agency, n.d.). Connecticut and Virginia have enacted similar legislation in an effort to increase transparency and protect consumers' sensitive data.

Although no specific state legislation addresses AI tools in housing, broader civil rights regulations in California prohibit discriminatory practices in housing. For example, both the California Fair Employment and Housing Act and California Government Code Section 12955 prohibit discrimination in housing and employment on the basis of race, color, religion, ancestry, national origin, disability, medical condition, marital status, sexual orientation, sex, or age (Housing discrimination, 1980). While existing legislation is broad, these regulations make it unlawful for AI pricing tools to result in algorithmic discrimination. However, more specific legislation is required to combat price increases that affect the affordability of rent in California.

As of now, Colorado is the only state to enact comprehensive legislation on the development and distribution of artificial intelligence systems: The Colorado Artificial Intelligence Act (CAIA) will become effective February 1, 2026 (Consumer Protections for Artificial Intelligence, 2024). The CAIA targets high-risk artificial intelligence systems in sectors such as education, employment, housing, and healthcare to reinforce standards set by the Fair Housing Act and protect against algorithmic discrimination, defined by unlawful differential treatment that disfavors groups based on protected classifications. The legislation imposes regulations on AI by requiring developers and deployers of high-risk AI systems to use reasonable care in protecting consumers against algorithmic discrimination. For example, developers would be required to provide documentation to deployers on data used to train the system, how it was evaluated, and its intended outputs and use. Furthermore, developers and distributors are required to clearly display the potential risks of algorithmic discrimination on websites for public use. If the AI system presents a risk for algorithmic discrimination, the developer is required to notify the Colorado attorney general within a 90-day period.

These specific limitations on AI systems are designed to combat algorithmic discrimination but do not specifically address antitrust laws or monopolization of the market. AI pricing tools such as RealPage remain in a gray area, where they must adhere to antidiscrimination laws but may still provide enough rental data that landlords and property managers may take advantage of it to manipulate rental prices. This gap in regulation raises concerns over what AI pricing tools may accomplish without stricter oversight.

Furthermore, the current administration has been very vocal about its intentions to continue using and developing AI technologies without "barriers" such as bias prevention or data protections (White House, 2025). The United States also refused to sign the international AI Action Statement at the Paris AI Action Summit earlier this year (Kleinman & McMahon, 2025).

III. POLICY OPTIONS

There are a number of options that U.S. policymakers can and should consider to address issues stemming from AI-driven rent pricing. These options address various regulatory fields involved in the problem, including transparent use of AI, access to personal data, and housing. The three most prominent policy options—strengthening federal oversight of the FHA, introducing AI and data regulation, and adopting rent controls—are outlined in this section.

STRENGTHENING FEDERAL OVERSIGHT OF THE FHA

Instituting a federal mandate stating that landlords and property owners must disclose the use of AI pricing tools and other factors contributing to rent pricing to tenants could ameliorate some of the harmful results of AI-priced housing. With ensured disclosure, renters are presented with enough information to make calculated decisions on whether to utilize AI tools. Additionally, a mandate could create a federal registry of AI systems used in the housing market, requiring developers to submit documentation to demonstrate compliance with antidiscrimination standards set by the FHA (FHA, 1968/2023). Developers and distributors of AI housing tools would be subject to annual audits under the review of HUD. The HUD would then assess potential algorithmic bias, discriminatory outcomes, and data integrity.

One advantage of a federal mandate is that it ensures a consistent national standard for AI tools and alignment with antidiscrimination laws in the housing market. A mandate in addition to a national registry would address gaps in sector-specific federal oversight. However, laws prohibiting algorithmic discrimination and requiring transparency may face lobbying or other pushback from AI developers and stakeholders, and significant federal resources may be needed to implement and enforce the mandate.

AI AND DATA REGULATION

Introducing financial incentives for states to adopt comprehensive legislation similar to CAIA could help address algorithmic discrimination and monopolization of AI pricing tools. In this scheme, federal grants would be provided to states that adopt comprehensive AI legislation. State incentives could encourage tailored solutions to state-specific issues in the housing market. However, without federal oversight, there may be inconsistent regulations and protections across states.

RENT CONTROL

Lastly, the issue of AI rent pricing tools would not exist if not for the state of the U.S. housing and rental market. One possible method for addressing the hypercompetitive nature of rental housing is through rent control and/or antigouging legislation (collectively, "rent regulations"). American cities are more susceptible to AI rent pricing tools because of the lack of policy limitations constraining the range of rent prices landlords can ask for. The U.S. housing market is relatively unregulated as a whole, especially in comparison to many Western European nations. Because AI-driven rent pricing tools encourage landlords to raise rents by higher amounts within shorter time frames, reducing the rate by which a landlord could increase rent would limit the potential impact of the AI recommendations on the rental market.

State interventions in rent controls were quite common in socialist states to maintain the competitiveness of socialist economies on a global scale (Lux et al., 2013). In postsocialist and primarily capitalist economies, state interventions in the rental housing market generally take the form of social housing or private rental-sector regulation. Since World War II, most of these interventions have been to the private rental sector. Some of the strictest systems of state intervention in rental regulations can be found in Sweden and Denmark, where the state regulates rents for all running and newly signed leases (Sardo, 2024, p. 228).

Of course, traditional rent control measures have faced criticism for their inflexibility and for their tendency to disincentivize upkeep and maintenance of units. New York City itself has a long history of rent controls that have been found to be less than successful. Researchers at the Wharton School found that a review of twentieth-century rent control policies revealed they had negative impacts on rental structure quality, especially in smaller prewar-constructed buildings (Gyourko & Linneman, 1990, p. 399). Furthermore, socialized policies often fail to achieve popular support in the U.S., a country whose historic and cultural commitment to the free market is well established.

While rent regulation policies may be difficult to enact at a federal level in the United States, it would be advisable for states or municipalities to adopt a larger role in reviewing lease agreements. Moreover, state governments may consider a liberalization of private rent contracts in combination with rental regulation and tenant protections. This would address the volatility of the rental market, collusion concerns, and ostensibly concerns over abuse of private data. Even requiring landlords to justify changes in rent would increase transparency in the rental market and could discourage opaque decision-making methods such as those fostered by rent pricing algorithms.

IV. CONCLUSION AND RECOMMENDATIONS

Addressing the impacts of AI-driven rent-setting tools, such as RealPage, requires a strategy that balances ambition with practicality, combining strengthened federal oversight, state-level incentives, and well-designed rent control measures.

Federal oversight would provide a critical foundation, setting consistent nationwide standards in data protection and aligning AI systems with the existing Fair Housing Act. Requiring transparency, establishing a registry of AI tools, and conducting regular HUD audits could create accountability and curb the negative effects of rent pricing tools. For this reason, and a host of other AI-based challenges we continue to face, it is more important than ever to develop a comprehensive policy framework addressing the use of AI and data privacy rights borrowing from the strong precedents set by the EU in the General Data Protection Regulation (GDPR), Digital Services Act (DSA), and AI Act. However, achieving comprehensive federal legislation may face steep political challenges, so it is necessary to supplement these efforts with policies that can be implemented more readily at the state and local levels.

State incentives offer a pragmatic way to drive meaningful change while respecting the unique challenges of local housing markets. By providing grants to states that adopt comprehensive AI legislation, like Colorado’s Artificial Intelligence Act, the federal government could empower states to innovate while remaining aligned with broader national goals. This approach allows for regionally tailored solutions that can be implemented without waiting for federal consensus, creating a framework where states lead the way in testing and refining policies to address algorithmic discrimination and monopolistic practices in the housing sector.

Rent control measures round out this strategy by directly addressing the immediate harms of AI-driven rent increases. These policies, which cap excessive rent hikes and require landlords to justify significant increases, protect tenants while remaining adaptable to local conditions. Paired with complementary tools like housing vouchers and incentives for affordable housing development, they provide stability in the rental market and safeguard vulnerable populations.

Together, federal oversight, state-level innovation, and rent regulations form a cohesive and actionable plan to address both the systemic and immediate challenges posed by AI-driven housing systems. These approaches, both individually and collectively, would increase housing equity and decrease exploitative data practices.

Overall, localized rent control measures provide the best first step toward addressing long-standing systemic inequities in the rental housing market *and* preventing AI-driven rent pricing tools from exacerbating these inequities in the market. The recently severely reduced size of the federal government as well as polarized views about the extent to which AI should be regulated (if at all) play heavily into this recommendation. Since rent controls have historically correlated with decreased quality of rental units, they should be introduced alongside stronger landlord accountability measures or increased enforcement of housing court decisions where rental habitability can be disputed.

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Understudied and Underserved: Advancing Inclusive Mental Health Care for Individuals with Intellectual and Developmental Disabilities

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ABSTRACT

Individuals with intellectual and developmental disabilities (IDD) face profound inequities in accessing and receiving quality mental health care despite being at increased risk for psychological distress. This paper examines the historical and systemic barriers that perpetuate these disparities—including financial limitations, imbalances within the healthcare system, provider shortages, inadequate research funding, and persistent misconceptions about the therapeutic potential of individuals with IDD. The exclusion of individuals with IDD from research and psychotherapy further exacerbates these challenges, creating significant gaps in clinical knowledge and guidance. In addition, individuals with IDD face disproportionately severe mental health challenges, including heightened exposure to trauma, diagnostic overshadowing, and the impact of social stigma.

In response, inclusive strategies are proposed to improve care by addressing the unique cognitive, communicative, and emotional needs of this population. Central to these recommendations is a shift toward person-centered, dignity-affirming care that recognizes individuals with IDD as autonomous participants in their own treatment. To advance equity in mental health care, it is imperative to pursue transformative change through inclusive research, targeted provider training, and evidence-based therapeutic adaptations. By amplifying the voices of individuals with IDD and addressing the systemic factors that have long excluded them, it will be possible to move toward a more equitable and responsive mental health care system for this underserved community.

Keywords: intellectual and developmental disabilities (IDD), mental health disparities, diagnostic overshadowing, person-centered therapy, trauma-informed care, inclusive psychotherapy, disability advocacy

UNDERSTUDIED AND UNDERSERVED: ADVANCING INCLUSIVE MENTAL HEALTH CARE FOR INDIVIDUALS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

Individuals with intellectual and developmental disabilities (IDD) are multidimensional human beings with rich emotional lives and significant capabilities, yet they are often inadequately recognized as such. Despite growing awareness and advocacy efforts, outdated perceptions continue to shape societal attitudes, policies, and clinical practices. As a result, individuals with IDD frequently encounter barriers that limit their autonomy, access to care, and overall well-being.

IDD encompasses a broad range of conditions characterized by impairments in intellectual functioning and adaptive behavior that emerge during development and persist throughout a person's lifetime (Eunice Kennedy Shriver National Institute of Child Health and Human Development [NICHD], n.d.). Per the NICHD (n.d.), these differences can impact multiple domains, including:

- Cognitive and learning abilities—reasoning, problem-solving, communication.
- Behavioral and social functioning—social skills, emotional regulation, self-care.
- Physical ability and motor skills—mobility, coordination.

IDD includes chromosomal conditions such as Down syndrome and fragile X syndrome, as well as neurodevelopmental conditions including autism spectrum disorder and fetal alcohol syndrome (NICHD, n.d.). Compared to the general population, individuals with IDD are more vulnerable to experiencing mental health challenges, including anxiety, depression, and PTSD—yet they remain far less likely to access appropriate resources and support (Lineberry et al., 2023).

Multiple factors contribute to the inequitable access to mental health care for individuals with IDD, including systemic barriers, research gaps, and long-standing misconceptions. Systemic challenges such as financial inequities, a shortage of trained providers, and a lack of accessible services create considerable obstacles to receiving appropriate care. Individuals with IDD also face a heightened risk of trauma and psychological distress, yet their mental health concerns are frequently overlooked due to diagnostic overshadowing and the impact of stigma.

These interconnected forces continue to perpetuate the disparities individuals with IDD experience in mental health care. Despite increased need, this population remains vastly underrepresented in psychological research, limiting the development of effective, evidence-based interventions. As a result, care often fails to reflect the diverse needs of the IDD community, leading to inadequate support and reinforcing an ongoing pattern of excluding them from active participation in their own care. This paper examines the systemic disadvantages that individuals with IDD experience in mental health care, highlights the intersecting barriers to equitable treatment, and proposes recommendations to foster greater inclusion and accessibility in therapeutic settings and beyond.

SYSTEMIC BARRIERS TO EQUITABLE MENTAL HEALTH CARE

Individuals with disabilities face systemic marginalization across various facets of their lives, limiting their access, opportunities, and inclusion. Deeply rooted historical discrimination and ongoing barriers have led to profound inequities—particularly in financial stability, access to mental and physical health care, and funding for research. These challenges significantly contribute to negative mental health outcomes.

HISTORICAL CONTEXT

Beginning in the 19th century and continuing well into the 20th century, the widespread institutionalization of people with disabilities led to their forced removal from society. Within these institutions, individuals were often subjected to dehumanizing conditions (Davis, 2015). This systemic othering contributed to the exclusionary view of individuals with disabilities as burdensome or even dangerous (Davis, 2015). These perceptions worsened as the eugenics movement gained traction between the 1900s and 1940s, when policymakers and medical professionals advocated for the forced sterilization of individuals with disabilities, further entrenching the belief that they were inherently flawed (O'Brien, 2023, chapter 3).

This deprivation of fundamental human rights had a detrimental impact on the mental health of individuals with IDD, though their psychological well-being was largely disregarded by institutions at the time (Burns, 2009). While the latter half of the 20th century saw monumental shifts away from this harrowing past with the rise of the Disability Rights Movement and landmark legal reforms, substantial barriers remain in addressing the injustices and ongoing challenges faced by individuals with IDD (Burns, 2009; Davis, 2015).

FINANCIAL INEQUITIES THAT LIMIT OPPORTUNITY

The consequences of this long history of discrimination manifest in various forms, including stark economic disparities that limit access to essential resources and opportunities. According to the National Disability Institute (2020), 26% of individuals with a disability live below the poverty line, compared to 11% of individuals without a disability. Structural barriers—including limited educational resources, discrimination in hiring, physically inaccessible workplaces, and inadequate social support—hinder financial stability (World Bank, 2023). This is further compounded by higher rates of unemployment, limited employment opportunities, and wage inequalities: Under Section 14(c) of the Fair Labor Standards Act, individuals with IDD can legally be paid subminimum wages, with median earnings as low as $3.50 per hour (Wage and Hour Division, 2024). These inequities make financial independence exceptionally difficult to attain. Additionally, individuals receiving Supplemental Security Income (SSI) face asset limits in which they risk losing crucial benefits, including Medicaid, if they save more than $2,000 (Musumeci & Orgera, 2021). This cycle of financial precarity impacts mental health, as financial instability contributes to chronic stress and limits access to resources—further deepening systemic disadvantages for individuals with disabilities (Houtrow et al., 2023).

LIMITATIONS IN HEALTHCARE

Healthcare access remains a major barrier for individuals with IDD, who often receive lower-quality medical and mental health care and face obstacles that impede comprehensive treatment (Krahn et al., 2015). An estimated 50% to 70% of individuals with IDD who require mental health services do not receive them, in part due to the lack of appropriate services covered by funded programs (Harris et al., 2018).

Medicaid, the primary funding source for IDD care, covers approximately 77% of essential services for individuals with IDD, including home- and community-based supports and general healthcare. However, it often provides only limited coverage for mental health services. These limitations include restrictions on specialized therapy, session frequency, and provider availability (Barth, 2021). Medicaid-funded programs tend to prioritize behavioral interventions over psychotherapy, reflecting outdated assumptions about the psychological needs of this population (Barth, 2021). While strictly behavioral interventions can be effective for managing specific concerns, neglecting emotional well-being leaves many individuals with IDD struggling with undiagnosed or untreated psychological issues (McNally et al., 2021).

Healthcare disparities extend beyond mental health to physical health. Individuals with IDD are more than twice as likely to experience chronic, preventable conditions—such as obesity, diabetes, heart disease, stroke, and other cardiovascular diseases—compared to those without disabilities (Dixon-Ibarra & Horner-Johnson, 2014). This elevated risk is often linked to systemic barriers, including inadequate access to routine and preventive care such as screenings, early interventions, and health education (Escudé, 2022; Gréaux et al., 2023). These structural shortcomings not only affect physical health but can also intensify mental health difficulties, creating a cycle in which one condition exacerbates the other (Division of Population Health, 2012).

LIMITED RESEARCH FUNDING

Beyond service access and coverage, another major challenge lies in the limited research infrastructure supporting IDD mental health care. Research on the mental health needs of individuals with IDD remains severely underfunded (Hassiotis et al., 2022). Government investment in this area is limited, partly due to systemic oversight and the minimization of IDD-related concerns within broader mental health policy agendas (Hassiotis et al., 2022). As a result, many initiatives depend on short-term grants from nonprofit organizations and private foundations (Hassiotis et al., 2022). Despite the substantial, well-documented needs of individuals with IDD, research specific to this population has historically received a disproportionately small fraction of overall mental health funding (National Institutes of Health, n.d.).

While nonprofit organizations play a vital role in supporting these efforts, their financial resources are far more limited than those of public institutions (Frumkin & Kim, 2001). This has made it difficult to initiate and sustain large-scale, long-term studies—limiting both the generalizability of findings and the ability to produce insights that are responsive to the varied needs within the IDD community (Frumkin & Kim, 2001). The scarcity of dedicated funding hinders scientific progress and restricts the development of effective, evidence-based interventions. These funding gaps contribute to the continued exclusion of individuals with IDD from both research and clinical care—reflecting and reinforcing broader patterns of systemic neglect.

LACK OF TRAINED PROVIDERS

Even when care is otherwise accessible, another major limitation is the shortage of trained professionals equipped to provide mental health treatment to individuals with IDD. Effective therapy for this population requires clinicians with specialized expertise in the psychological, biological, and sociocultural dimensions of IDD (American

Psychological Association [APA], 2022). However, many clinicians lack the necessary training and confidence to diagnose and treat mental health conditions in this community (Hinde & Mason, 2020). Although training opportunities are increasing, they remain insufficient to meet the growing demand (Lamar, 2020). Many states report a shortage of specialized providers, which causes long wait times: Some individuals face wait periods of three to six months before receiving mental health care (Lamar, 2020). These delays are particularly harmful to individuals with IDD who require timely support.

Existing clinicians often become overextended due to the shortage of trained professionals, the backlog of cases, and high caseloads. This overextension often dilutes the time and attention spent on each client. This, in turn, increases the likelihood of burnout and reduces the capacity to provide individualized care (Hinde & Mason, 2020). As a result, the quality of care suffers as clinicians struggle to meet the diverse needs of each client, which can contribute to worsening symptoms and diminished outcomes (Hinde & Mason, 2020). This issue highlights the critical need for both more specialized training and a greater number of qualified professionals to effectively address the unmet mental health needs of individuals with IDD.

The consequences of these systemic barriers are grave. Limited access to routine healthcare, higher prevalence of preventable physical conditions, elevated rates of mental health difficulties, and broader social determinants of health—such as economic instability and social exclusion—all culminate in an average 15- to 20-year reduction in life expectancy for individuals with IDD (White et al., 2023). A staggering 42% of deaths among individuals with IDD result from potentially preventable causes—nearly double the rate in the general population, 22% (Cooper et al., 2020). These disparities necessitate a multifaceted and systemic approach—one that addresses not only individual mental health needs but also the broader social, economic, and structural factors contributing to poorer health outcomes.

EXCLUSION FROM RESEARCH AND EVIDENCE-BASED PRACTICE

BARRIERS TO PARTICIPATION IN PSYCHOLOGICAL RESEARCH

Equitable care is not possible without a strong research foundation, yet the persistent exclusion of individuals with IDD from the research landscape has severely limited the understanding of their mental health needs and hindered the development of effective, evidence-based interventions (DeCormier Plosky et al., 2022). Individuals with IDD remain critically underrepresented in mental health research and clinical trials, resulting in a limited evidence base to guide psychological care (DeCormier Plosky et al., 2022; Friedman & Spassiani, 2024). Researchers have historically deemed controlled studies involving this population too difficult due to lingering misconceptions and various methodological challenges (Friedman & Spassiani, 2024). These challenges include participant recruitment, ethical concerns around ensuring informed consent, and the need for accessible accommodations, which can be costly (Friedman & Spassiani, 2024). Without appropriate infrastructure, researchers have often viewed such studies as too logistically challenging to pursue—inadvertently excluding this population even further.

However, recent efforts to rectify this historical exclusion have focused on increasing awareness of ethical research practices and actively addressing logistical barriers to participation. These efforts have led to the adoption of more inclusive methodologies, such as participatory research approaches (Sadler, 2023). These methods involve integrating individuals with IDD as active participants in the design and execution of studies, taking on collaborative roles such as co-researchers and advisors (Sadler, 2023). By showcasing the lived experiences of individuals with IDD, these approaches produce more accurate and contextually relevant findings, while helping counteract the historical exclusion of this community from research (Sadler, 2023).

DISPARITIES IN GLOBAL RESEARCH REPRESENTATION

While this progress is promising, there is a significant gap in research on how disability intersects with different racial, ethnic, and socioeconomic backgrounds, particularly in low- and middle-income countries (Magaña et al, 2022; Susanty et al., 2020). Cultural adaptations of psychosocial interventions are necessary to deliver effective support across diverse populations; however, such adaptations remain limited and underdeveloped (Susanty et al., 2020). Approximately 80% of people with disabilities globally live in developing countries, yet the vast majority of psychosocial interventions and research on IDD have been concentrated in high-income, Western countries, where the resources and frameworks for conducting such studies are more readily available (Susanty et al., 2020). This inequity places the vast majority of individuals with IDD at an even greater disadvantage, as most interventions designed in high-income countries fail to account for the cultural, socioeconomic, and contextual factors that shape their psychological needs.

Interventions must be designed to be both effective and accessible for individuals in resource-constrained settings, ultimately contributing to the reduction of global inequalities in disability care. True inclusivity cannot be achieved while much of the global IDD population remains especially overlooked. Only when these disparities—both between high- and low-income countries and across cultural groups—are addressed will meaningful equity in disability mental health care be within reach.

The exclusion of individuals with IDD from research is both a symptom and a driver of broader systemic inequities—rooted in inadequate funding, limited infrastructure, and ingrained biases within the research field. As a result, individuals with IDD continue to be left out of the very systems intended to support their well-being, perpetuating exclusion in both knowledge and care.

BARRIERS TO PSYCHOTHERAPY: MISCONCEPTIONS AND EMERGING PROGRESS

LEGACY OF EXCLUSION IN MENTAL HEALTH TREATMENT

Although participatory research approaches and more inclusive research have improved representation in mental health studies, misconceptions about the emotional experiences and therapeutic potential of individuals with IDD continue to limit their access to appropriate mental health care. Historically, disabilities were treated as illnesses requiring a cure rather than inherent parts of a person's experience (Linton, 1998). As psychology and Western psychotherapy emerged as formal disciplines in the late 19th and early 20th centuries, individuals with disabilities were systematically excluded due to prevailing discriminatory beliefs that viewed them as intellectually inferior (Linton, 1998). This "therapeutic disdain" (Bender, 1993) was rooted in assumptions that individuals with IDD lacked awareness of their mental health and were incapable of participating in their own psychological treatment.

These beliefs persisted into the 1990s and early 2000s, reinforcing the notion that psychotherapy was not a viable option for individuals with IDD. For decades prior, many professionals believed that individuals with IDD lacked the cognitive capacity to benefit from self-reflection or insight-based therapies (Bender, 1993). As a result, mental health treatment primarily followed the medical model, which focused on symptom management and modifying external factors, often without addressing deeper psychological needs (Olkin, 2022; Willner & Lindsay, 2016). Within this framework, concerns were predominantly addressed through pharmacological treatments, hospitalization, and strictly behavioral interventions (Olkin, 2022; Willner & Lindsay, 2016). These interventions were frequently administered by third parties—such as healthcare providers without mental health training or caregivers—often without the individual's consent (Willner & Lindsay, 2016).

Misconceptions about the cognitive capacity and self-efficacy of individuals with IDD led many professionals to assume they were incapable of making informed decisions about their own care (Bender, 1993). Consequently, treatment plans were often imposed rather than developed with their collaboration or consent, further stripping individuals of agency in their mental health treatment (Dunkley et al., 2018). Such methods distanced the individual from their own emotions and volition, reducing them to passive recipients of care and leaving mental health concerns inadequately addressed. When individuals with IDD are excluded from decisions about their care, it can lead to feelings of disempowerment and a reluctance to seek help in the future (Dunkley et al., 2018). This can contribute to medical trauma, worsen psychological distress, and deepen disparities in mental health support (Bradbury-Jones et al., 2020).

PROGRESS TOWARD INCLUSIVE AND EMPOWERING CARE

The long-standing belief that individuals with IDD cannot benefit from psychotherapy has begun to dissolve as research and advocacy efforts expand (Shepherd & Beail, 2017). In the late 1990s and early 2000s, emerging research began to demonstrate the effectiveness of adapted psychotherapeutic approaches, such as modified cognitive behavioral therapy—prompting a gradual shift in professional attitudes (Willner, 2005). Psychotherapy is now more widely recognized as an effective treatment for individuals with IDD (Porcelan et al., 2019; Shepherd & Beail, 2017). Informed mental health and disability professionals acknowledge that, with appropriate resources and support, individuals with IDD are wholly capable of growth, change, and recovery from mental illness through psychotherapy (Porcelan et al., 2019). This understanding has catalyzed positive change, prompting the integration of cognitive principles into behavioral therapy, creating a more comprehensive model that addresses potential behavioral challenges and the emotional experiences of individuals with IDD.

While many past misconceptions have been dispelled, remnants of these beliefs remain, and considerable progress is still needed to achieve truly equitable mental health care. Since psychotherapy for individuals with IDD is still a relatively new and evolving field, continued research is essential to refine and enhance treatment methods. Addressing research gaps and promoting integrated treatment approaches are key to strengthening the knowledge base needed to better support individuals with IDD. A crucial part of this effort involves amplifying the voices of individuals with IDD in both psychological research and clinical care, as inclusive mental health care cannot exist without their representation and participation.

MENTAL HEALTH EXPERIENCES AND TREATMENT

INCREASED RISK OF TRAUMA AND ADVERSE CHILDHOOD EXPERIENCES

The systemic inequities that limit access to inclusive care also contribute to the significantly higher rates of trauma, abuse, and mental health challenges experienced by individuals with IDD compared to the general population (Didden & Mevissen, 2022; Lunsky & Lake, 2019). Individuals with IDD are also more likely to experience multiple disabilities and comorbidities: Between 39% and 52% of people with IDD have a co-occurring psychiatric condition, such as anxiety or mood disorders (Healthy Minds Policy Initiative, 2024). Individuals with IDD are disproportionately exposed to adverse childhood experiences (ACES)—stressful or traumatic events experienced in childhood that can have lasting effects on an individual’s physical, emotional, and mental health. This further compounds their risk of psychological distress (Division of Violence Prevention, 2019; McNally et al., 2021).

Approximately 44% of people with IDD have experienced at least four ACEs, compared to just 13% of the general population (National Core Indicators, 2023). Some of the traumas individuals with IDD are more likely to experience include physical and emotional abuse and neglect at the hands of caregivers, as well as social challenges such as bullying, isolation, and exclusion (Didden & Mevissen, 2022; National Council on Disability, 2022). Individuals with IDD also experience higher rates of sexual abuse, coercion, and exploitation, as others may wrongly assume they lack decision-making capacity and exploit their trust, reliance on support, or limited access to resources (Beadle-Brown et al., 2010; Nixon et al., 2017). The cumulative impact of these experiences during crucial developmental years increases vulnerability to long-term mental health challenges, chronic health conditions, and persistent social isolation (National Core Indicators, 2023).

DIAGNOSTIC OVERSHADOWING

An additional barrier to effective mental health care for individuals with IDD is the tendency for providers to minimize or disregard their mental health challenges, or attribute them entirely to their disability. A pervasive issue known as diagnostic overshadowing occurs when symptoms are misattributed solely to a person's disability. This involves overemphasizing or focusing excessively on the disability while overlooking other important aspects of the individual's life, including life events, strengths and capabilities, and additional factors related to the client's presenting concerns (APA Task Force, 2022; Hallyburton, 2022). This bias results in individuals being perceived almost exclusively through the lens of their disability, often overshadowing their broader identity (APA Task Force, 2022).

While challenges associated with disabilities can contribute to mental distress, they are not the sole explanation for these individuals' difficulties. Disability may be an important and meaningful aspect of their identity, but it does not encompass the entirety of it. Unlike individuals without disabilities, who are typically viewed holistically by mental health professionals, individuals with IDD are frequently viewed through the restrictive framework of their condition (APA Task Force, 2022). Without proper training, many clinicians struggle to recognize how mental health conditions may present differently in individuals with IDD (Fletcher et al., 2016). Although clinicians generally mean well and are often motivated by a desire to help, the lack of sufficient training and awareness can unintentionally result in diagnostic overshadowing. The implications of this phenomenon are profound: Professionals often overlook or dismiss symptoms of anxiety, depression, PTSD, and other mental health disorders, leaving diagnosable and treatable mental health conditions unaddressed (Lunsky & Lake, 2019).

To effectively combat diagnostic overshadowing, treatment should aim to bridge the gap between the internal experiences and outward expressions of individuals with IDD. It is important for clinicians to have a foundational understanding that disabilities can profoundly affect mental health, while also recognizing that individuals often present with concerns unrelated to their disability. This awareness should inform the therapeutic process, wherein clinicians actively explore both disability-related and independent mental health challenges. This more nuanced perspective enhances diagnostic accuracy and fosters more compassionate, individualized care that addresses the full spectrum of challenges experienced by individuals with IDD.

IMPACT OF SOCIAL STIGMA

Social stigma and isolation may also harm the mental health of individuals with IDD. Although stigmatization has decreased in recent years due to growing awareness and advocacy efforts, residual stigma remains deeply ingrained in societal perceptions. Many individuals with disabilities unconsciously internalize these negative views, increasing their risk of psychological distress—particularly anxiety and depression—and contributing to social withdrawal and a decreased likelihood of seeking support (Dagnan & Waring, 2004).

In addition to stigma, factors such as low self-esteem, negative self-concept, unfavorable social comparisons, feelings of hopelessness, and limited social support have all been linked to heightened mental health difficulties among this population (Evans & Randle-Phillips, 2018). These psychosocial stressors, coupled with the ongoing lack of accessible mental health care, have been associated with increased suicide risk. Individuals with IDD are three times more likely to face suicide risks than the general population, and those on the autism spectrum are particularly vulnerable (Santomauro et al., 2024).

These disparities underscore the urgent need for accessible, trauma-informed mental health care that not only addresses the varied needs of individuals with IDD but also actively combats stigma and promotes psychological well-being. Without a nuanced understanding of how mental health conditions uniquely impact this population, clinical approaches risk overlooking the complex interplay between disability, trauma, stigma, and emotional well-being. To meaningfully improve care, it is vital to center the voices and lived experiences of individuals with IDD. Their perspectives offer invaluable insight into how mental health services can become more accessible, affirming, and responsive—ultimately contributing to a more inclusive and equitable mental health system.

RECOMMENDATIONS: THERAPEUTIC MODIFICATIONS FOR INCLUSIVE CARE

ADAPTING THERAPY FOR INDIVIDUALS WITH IDD

Traditional psychotherapeutic models often fail to address the unique cognitive, communicative, and social needs of individuals with IDD. Meaningful adaptations are integral to promoting engagement, enhancing comprehension, and creating a more empowering, supportive therapeutic experience. Therapy is most effective when tailored to the individual's developmental level, support needs, and cognitive and verbal abilities (Porcelan et al., 2019).

Clinicians should account for differences in how individuals with IDD communicate, express their emotions, process information, and use cognitive functions, such as emotional literacy, memory, and executive functioning (Porcelan et al., 2019). To support these differences, therapy can be modified in terms of time frame, session pace, and complexity of content. For example, therapists can adjust their speech, use visual aids to convey emotions or experiences, and alter the number of themes addressed in a single session to suit the individual's needs (Kneuer, 2024). Additionally, therapists should encourage multimodal communication as needed—using a variety of methods to accommodate different communication preferences and abilities—by incorporating assistive technology, gestures, or alternative methods (Communication Community, n.d.).

LANGUAGE CONSIDERATIONS

In addition to adapting therapeutic techniques, clinicians should also be intentional with their language and use terms that respect individual preferences to ensure inclusive therapy (Bui et al., 2018). Preferences for person-first language (PFL) and identity-first language (IFL) vary within the disability community (APA Task Force, 2022). Person-first language (e.g., "a person with IDD") prioritizes the individual and their personhood first, framing disability as one aspect of identity rather than a defining feature. Identity-first language (e.g., "an autistic person") places disability at the forefront, recognizing it as a core and inseparable aspect of identity. Many individuals with Down syndrome prefer PFL, whereas many autistic individuals advocate for IFL, though preferences are personal and not universal (National Down Syndrome Society, 2022; Taboas et al., 2022). Clinicians should ask clients about their language preferences to ensure that therapeutic conversations align with their sense of self. Sensitivity to language use fosters stronger relationships, validates identity, and challenges stigma (Bui et al., 2018).

While honoring personal preferences, clinicians should also be mindful of how broader language choices can unintentionally reinforce ableist assumptions. Using disability-friendly, inclusive language that is free from stereotypes and bias is necessary to promote equitable care. Language plays a powerful role in shaping public attitudes toward people with disabilities. Recognizing and working to counter implicit ableism is crucial to prevent harm to clients and avoid perpetuating societal stigma (Friedman, 2019). Terms like "heroic," "suffering from," or “wheelchair bound” reflect and reinforce limiting perceptions, while euphemisms such as “special needs” can diminish the reality of disability and contribute to discomfort and stigma (APA Task Force, 2022). It is imperative to focus on the whole person, and using respectful language—avoiding both overly idealized and stigmatizing terms—is an essential part of that commitment.

PROMOTING AUTONOMY AND DIGNITY IN THERAPEUTIC PRACTICE

Clinicians must also consider how their tone and behavior may affect a client’s therapeutic experience. One common concern in therapeutic settings is the risk of infantilizing clients with IDD. Infantilization occurs when adults with IDD are treated and spoken to as if they are younger than their actual age, often with an unintentionally patronizing tone (Robey et al., 2006). Assuming individuals with IDD lack agency and competency can undermine their autonomy and diminish their self-esteem (Schuengel et al., 2020).

Such assumptions can lead to learned helplessness—where an individual feels powerless to enact change, resulting in passivity and dependence (van der Molen et al., 2017). Infantilization may also contribute to internalized feelings of inferiority among clients with IDD (Robey et al., 2006). Clinicians should encourage independence, bolster self-confidence, and treat individuals as equals to eliminate harmful power dynamics and ensure dignity in therapeutic relationships. Clients have noted that the aspects of psychotherapy they most appreciate include feeling valued, validated, and treated like adults by their therapists (Pert et al., 2012). Feeling empowered and autonomous, along with engaging in meaningful conversations and observing changes taking place, significantly enhances their experience and outcomes (Pert et al., 2012).

IMPLEMENTING STRENGTHS-BASED CARE

Beyond avoiding infantilization and promoting autonomy, clinicians can support clients with IDD by employing a compassionate, strengths-based approach to therapy. Interventions that center personal strengths have been shown to promote positive mental health outcomes and help individuals with IDD experience a deeper sense of fulfillment and well-being (Flückiger et al., 2023). By recognizing and emphasizing clients’ strengths, clinicians can help bring about increased empowerment, resilience, and a sense of self-worth (Dunn & Dougherty, 2005). This approach encourages individuals with IDD to build on their existing capabilities, reinforcing their agency and capacity to navigate life’s complexities (APA Task Force, 2022).

Clinicians can strike a thoughtful balance—giving ample space to share and process difficult emotions while also highlighting clients’ inherent strengths. By remaining perceptive, offering validation, and allowing the client to guide the therapeutic process, clinicians can better attune to each person’s needs and provide life-enhancing care.

CENTERING THE CLIENT WHILE COLLABORATING WITH CAREGIVERS AND FAMILY

Effective therapy for individuals with IDD begins by centering the client as the primary participant, while involving caregivers as supportive partners when appropriate. Collaborating with family members and caregivers from residential or day programs can greatly enhance the therapeutic process, as their involvement helps individuals practice skills in natural, familiar settings (Rogers et al., 2024). In addition to reinforcing skills, family members often play a critical role in supporting emotional regulation and facilitating effective communication outside of sessions (Rogers et al., 2024). Strong, trusting relationships with caregivers and support systems promote emotional well-being and foster a greater sense of safety, consistency, and belonging (Hughes et al., 2023; Mestre et al., 2024).

While caregivers can be valuable supports, they should not become the primary focus of treatment. Less informed clinicians may engage almost exclusively with caregivers, unintentionally excluding the client (APA Task Force, 2022). However, therapy sessions should not just be about the client—they must actively involve and prioritize the client in their own treatment. For all clients, including nonspeaking individuals and those who use alternative communication methods, it is crucial that therapists directly address them and engage them in the conversation. Support members can assist as needed, but excluding clients from their treatment can be invalidating and disempowering (Pert et al., 2012). An especially vital adaptation in therapeutic practice with individuals with IDD is a deliberate shift toward actively involving them throughout the process—recognizing that they are the experts in their own experiences.

Collectively, these modifications help establish a therapeutic environment that honors dignity, promotes engagement, and empowers individuals with IDD as active participants in their care. When thoughtfully adapted to meet individual needs, psychotherapy can be a powerful and healing process (Porcelan et al., 2019). Although such practices are not yet standard in many therapeutic settings, implementing them consistently can help shift the field toward more responsive and person-centered models of care.

LOOKING AHEAD: FUTURE CONSIDERATIONS

To address the long-standing injustices faced by the IDD community, inclusion must be promoted at every level—with a strong focus on the mental health field. Individuals with IDD have experienced acute and enduring societal and institutional barriers that impact both access to and quality of care. Substantive progress requires increased research, education, advocacy, and awareness to promote a deeper understanding of their needs. Mental health professionals, social workers, and advocates must commit to ongoing learning and inclusive practices. At the heart of this work, advocacy efforts must center and elevate the voices of individuals with IDD—ensuring their needs and perspectives are heard

and actively shape the future of care.

At the macro level, systemic change is fundamental. Policy reform must directly address the pervasive inequities in mental health care for individuals with IDD. This includes advocating for Medicaid coverage that prioritizes inclusive mental health services and expanding funding for clinician training programs. Advocacy efforts should highlight both the critical importance and the rewarding nature of IDD mental health care. Raising awareness of the urgent need—and the profound impact—of this work can inspire more providers to enter the field and help build a more prepared and responsive workforce.

Progress also requires increased investment in research to better understand the needs of individuals with IDD, close gaps in care, and enhance the quality of evidence-based interventions available to this population. Policies must mandate inclusive practices across healthcare settings, from ensuring equitable access to enforcing antidiscrimination standards. Additionally, addressing global disparities in mental health care for individuals with IDD should remain a key priority to advance equitable treatment for those who have been historically underserved.

At the micro level, meaningful change begins in clinical practice. Clinicians must adapt care to the individual and adopt a person-centered approach that honors agency and autonomy. Therapists and social workers should cultivate therapeutic environments characterized by empathy, dignity, and mutual respect, where individuals with IDD remain central to their own treatment. When professionals see and support the whole person, they contribute to better mental health outcomes and improved quality of life. These efforts help lay the groundwork for a society in which individuals with IDD are truly valued, included, and equipped with the resources they need to thrive.

Looking ahead, the goal is for individuals with IDD to be able to readily access therapy when needed and to be recognized as people with a wide breadth of life experiences—not reduced to individuals defined solely by their disabilities. Achieving this vision requires moving away from substandard practices toward an unwavering commitment to consistently exceptional, equitable care. While there is substantial work to be done, impactful progress is already underway. Through sustained effort, the barriers that have long restricted access to care can be dismantled—and in doing so, there is potential for a more genuinely inclusive future for the IDD community.

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Mereces Todo Lo Bonito: Queer Latinx Mental Health Professionals and Gay Latino Identity Development

XAVIER SALAS

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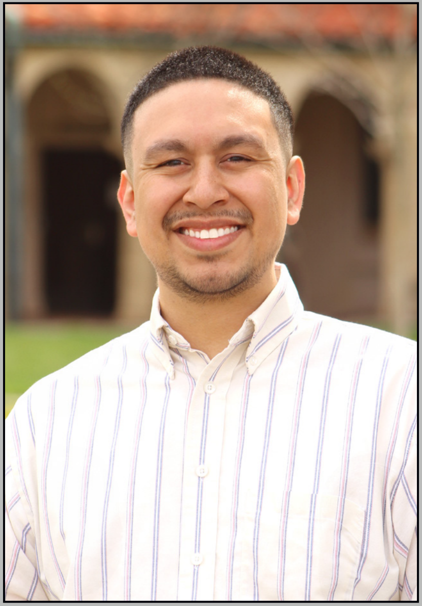

Xavier Salas is a graduate of Columbia University School of Social Work focusing on LGBTQ+ Latinx issues, Chicanx identity, and mental health disparities. His research explores the intersections of culture, sexuality, and mental health. He aspires to specialize in trauma-focused care and human sexuality, advocating for inclusive policies and culturally competent therapy for queer Latinx individuals.

INSPIRATION

As a Mexican-American gay man, I have navigated the complexities of identity—balancing my Latinx heritage with the need to live authentically. Throughout my journey, I realized the profound impact of representation in mental health, especially for LGBTQ+ Latinx individuals. Too often, we lack professionals who truly understand the intersectionality of our identities, leaving us to struggle with our sense of self in isolation. This paper is my call to action—to highlight the importance of recruiting and retaining queer Latinx mental health professionals who can guide others in navigating their paths to self-acceptance.

The need for this work has never been more urgent. With the current administration’s relentless opposition to DEI efforts and the increasing marginalization of LGBTQ+ rights, we are witnessing firsthand the dangers of invisibility. It is more crucial than ever to build a future where diverse voices are heard and valued.

As the poet Pablo Neruda once said, "Podrán cortar todas las flores, pero no podrán detener la primavera." ("They can cut all the flowers, but they cannot stop the spring.") This paper is my contribution to ensuring that our community’s resilience and potential continue to bloom, no matter the obstacles in our path.

ABSTRACT

This research explains the critical need to diversify queer Latinx mental health professionals to support the healthy formation of gay male Latinos' sexual identity. Gay male Latinos go through unique difficulties in their process of identity formation, shaped by cultural concepts such as familismo, machismo, and religion, and economic constraints that hinder access to helpful care. These obstacles fuel greater mental health risks, including depression, anxiety, and internalized homophobia. The underrepresentation of queer Latinx professionals in mental health, however, is not an isolated issue—it is a symptom of a broader breakdown in the system: Other groups of marginalized individuals are also often unable to access culturally competent care. Increased diversity in the mental health field is essential not only for gay Latino men but also for other LGBTQ+ and BIPOC individuals who face similar disparities.

Queer Latinx mental health professionals bring with them distinct lived experiences that enrich therapeutic relationships, deepen client outcomes, and strengthen research, policy, and clinical practice by interrupting prevailing Eurocentric models of therapy. These benefits are undermined by political efforts to dismantle diversity, equity, and inclusion (DEI) initiatives, further stigmatizing communities in need of affirming care. Despite these challenges, interventions such as pipeline programs, policy activism, and community organizing provide options for attaining and sustaining diversity in mental health. Committing to recruit and retain queer Latinx mental health professionals allows us to bring about systemwide change that benefits not just gay male Latinos but the mental health field as a whole. As the saying goes, "Mereces todo lo bonito"—you deserve everything beautiful—and that begins with access to care that understands, knows, and confirms identity.

"Our brown skin does not limit us but empowers us for greatness."
—Brian Saucedo

MERECES TODO LO BONITO: QUEER LATINX MENTAL HEALTH PROFESSIONALS AND GAY LATINO IDENTITY DEVELOPMENT

Many clients, particularly gay Latino men, have challenges finding the right mental health professional to meet their needs, as effective therapy requires both cultural competence and an understanding of sexual identity development. This research examines the unique challenges that gay male Latinos face during sexual identity development and the lack of queer Latinx mental health professionals who can provide identity-affirming, culturally competent care. Overall, this research seeks to answer the following three questions:

1. What are the specific issues for gay male Latinos in sexual identity formation?
2. How does a dearth of queer Latinx mental health professionals impact services for this population?
3. What are the potential implications of increasing the visibility of queer Latinx professionals in the mental health profession?

Sexual identity refers to one's lifelong sense of self as a sexual being within cultural categories (Levy, 2009). Cultural and socioeconomic factors shape sexual identity development for Latino gay men, influenced by family, religion, and traditional norms such as machismo, caballerismo, and familismo. Machismo is defined as "a set of values, attitudes, and beliefs about masculinity, or what it is to be a man" (Nuñez et al., 2016, p. 3) and caballerismo is "comprised of chivalry, familial ties, and is associated with emotional connectedness" (Rivera et al., 2021, p. 3). In alignment with caballerismo, familismo is where the "higher emphasis is placed on the family unit in terms of respect, support, obligation, and reference" (Valdivieso-Mora et al., 2016, p. 1).

The cultural and socioeconomic factors that shape sexual identity development for gay Latino men are unique and require culturally competent care practices. The scarcity of queer Latinx mental health professionals limits access to empathetic and culturally informed care. Overburdened mental health systems can lead to incomplete sexual identity development and internalized homophobia. This underrepresentation is problematic, especially given the high levels of mental health challenges within the LGBTQ+ community. As a result, culturally relevant support becomes vital.

To fully grasp the impact of this underrepresentation, it is crucial to examine theoretical models that address sexual identity development. These theoretical models help to describe individuals transitioning through identities in sociocultural contexts and provide an underlying structure that we can apply to analyze the facilitators and inhibitors of integration into one's identity. From the use of these frameworks, we can better appreciate the intersection and effects of cultural values, family, and external societal pressures upon the lives of gay Latino men.

Theoretical models, like the Developmental Model of the Closet, examine the role of concealing minority sexual orientations and its effect on identity development (Cass, 1984). Cass's (1984) six-stage model delineates the movement from identity confusion to identity synthesis, where a homosexual identity becomes integrated into the broader self-concept. Queerness disrupts traditional sexual identities with fluidity and inclusivity (Heasley & Crane, 2003). This upheaval defies strict social norms, provoking resistance from conservative institutions that preserve binary understandings of gender and sexuality (Wade & Ferree, 2015). In considering the critique of the gender binary, it becomes clear how it falls short of an artificially established ideology. Nevertheless, this critique also facilitates an expanded system that legitimates multiple identities and experiences, gradually expanding the sphere for self-expression and acceptance among queer and mainstream communities (Butler, 1990).

This research aims to add to the literature regarding gay male Latinos' difficulties in sexual identity formation, while highlighting the important role queer Latinx mental health professionals can have in the process. Gay male Latinos face unique challenges based on cultural, religious, and economic considerations that contribute to high rates of mental health stressors. Increasing the number of queer Latinx mental health professionals promotes gay male Latinos' mental well-being through tighter therapeutic relationships, role modeling, and intersectional, identity-congruent care. Furthermore, this research highlights the importance of cultural competence in mental health and demands greater representation of queer Latinx professionals, ensuring gay Latinos receive the affirming care they deserve.

THE UNIQUE CHALLENGES FACED BY GAY LATINO MEN IN SEXUAL IDENTITY DEVELOPMENT

CULTURAL FACTORS

Gay male Latinos face unique challenges with sexual identity development due to traditional Latinx gender norms like machismo and caballerismo. As Rosenberg et al. (2024) states, people identifying with these norms are more likely to self-identify as exclusively heterosexual rather than gay, bisexual, or queer. Sexual identity development may involve efforts to align with community and family expectations. Gay Latino men may avoid openly identifying as GBQ (gay, bisexual, queer) to conform to machismo's emphasis on hypermasculinity, prioritizing acceptance within their cultural environment. Moreover, emotional responsibility in the form of caballerismo may lead individuals to conceal their GBQ identity to uphold family values that conflict with nonheteronormative orientations.

Machismo and caballerismo are institutionally embedded in Latinx family structures, religious ideology, and cultural imperatives, which collectively constitute a complex environment for the construction of sexual identity. Machismo emphasizes strength, superiority, and heterosexual masculinity, and is often promoted by fathers and father figures who want their sons to meet these standards. Conversely, caballerismo, which calls for responsibility, honor, and respect, creates a sense of obligation to maintain family unity by not engaging in any form of activity that may cause perceived shame. Cultural norms, such as machismo, familismo, and heterosexism, provide the context for the process of coming out, and may result in feelings of rejection and the use of coping mechanisms such as alcohol and other drugs (Gerena, 2021a). This triad of gender roles, familial duty, and societal expectations may lead to deeply internalized homophobia, complicating or inhibiting the integration of identity (Meyer, 2003).

Additional complexities that emerge in the development of individual identity include family and religious institutions. Family, central to Latino culture, often lacks support for LGBTQ+ identities, particularly when influenced by spiritual institutions like the Catholic Church. Religious beliefs, especially within Catholic and Evangelical communities, often promote heteronormativity as a moral and spiritual duty, intensifying the intrapsychic conflict experienced by gay Latino men. Garcia (2014) states that this lack of support may present challenges for gay Latino men in finding a balance between their sexual identity and their cultural and religious traditions.

Culturally competent care addresses such a set of complexities, reducing health disparities and improving patient satisfaction. Collaboration with bilingual and bicultural professionals helps avoid issues such as misdiagnosis and less inclusive or responsive services. Patients who receive culturally sensitive care have shown higher satisfaction rates, with better long-term outcomes (Moyce et al., 2022; Robles et al., 2020).

For this reason, mental health professionals working with Latino gay men should be aware of the cultural factors affecting this population. Culturally sensitive care may help promote the healthy development of sexual identity for this population and decrease the impact of traditional norms. By integrating cultural sensitivity into the therapeutic relationship, mental health professionals can establish trust, validate lived experiences, and address the particular stressors of Latino gay men, such as familismo, religious context, and expectations of masculinity. This not only enhances treatment participation in mental health, but also enables individuals to navigate their identities more assertively and resiliently.

SOCIOECONOMIC FACTORS

Socioeconomic factors strongly influence the mental health and identity development of Latino gay men. Poverty, immigration status, and education affect individuals' access to mental health services and shape their identities. As such, challenges can arise when an individual tries reconciling gay and Latino identities within rigid familial and cultural expectations that are encased in strong patriarchal and gender roles and often accompanied by identity confusion, isolation, and internalized homophobia (Zea et al., 2003). Negotiation strategies for managing socioeconomic factors within these intersectional identities are common, alongside feelings of exclusion and isolation.

While cultural expectations shape self-identity and social acceptance, financial and structural barriers limit access to affirming mental health care, compounding the challenges faced by Latino gay men (Meyer, 2003). Economic barriers further exacerbate mental health disparities among Latino gay men, including a lack of insurance; limited geographic access to affirming providers, particularly in rural areas; and complicating factors such as transportation and immigration status. These barriers contribute to the underuse of mental health services by Latinos, with Latino gay men suffering higher psychiatric distress due to intersectional oppressions (Gerena, 2021a). The mental health system has prevented Latinx people from gaining adequate access to resources in a wide-ranging scope. Disparities tied to race and socioeconomic status worsen the problem, particularly within rural areas where mental health resources are scarce (McGregor et al., 2019; Moyce et al., 2022).

For some Latino gay men from immigrant families, balancing sexual identity with acceptance from their family involves “moral management” strategies, meaning they subtly challenge their parents about negative views while focusing on educational and career successes (Ocampo, 2013). These approaches are generally aligned with the aforementioned traditional Latinx gender constructs of machismo and caballerismo, which serve as both obstacles and resources in negotiating cultural and familial expectations. Machismo's emphasis on masculinity and toughness may lead some Latino gay men to take on hypermasculine habits, or to repress sexual identity in the interest of maintaining familial respect. Conversely, caballerismo's emphasis on duty, fidelity, and emotional connection allows these men to re-create their sexual identity on terms that highlight factors including being good sons and providers, and that their successes in school and/or career are part of their family duty. These values enable them to court parental approval and gradually work on the conversations that challenge strict gender and sexual expectations.

The intersection of racial and socioeconomic challenges, including discrimination and marginalization, along with overlapping identities in race, ethnicity, and sexual orientation, underscore the need for culturally competent or adapted mental health services that reflect the lived experiences of this population. Despite the negative effects of these challenges, resiliencies and support networks play an important role in helping participants make informed and positive decisions in their identity development within the Latino gay male community (Harper et al., 2016).

Issues such as the intersectionality of multiple marginalized identities place Latino gay men in peculiarly challenging positions that impact their mental health outcomes. These intersecting identities often exacerbate feelings of exclusion and isolation due to the discrimination perpetuated by mainstream society, but most notably from within their own ethnic and LGBTQ+ communities. This intersectionality leads to different mental health challenges that demand a deeper understanding of their experiences. A thorough examination of the deeper layers of identity may yield a more specific picture of how Latino gay men navigate the dynamics of their mental health, family dynamics, and cultural expectations; it also points to the need for tailored mental health interventions.

Latino gay men often face what scholars describe as "double minority stress," the intersectional effect of racial and sexual minority identities that exacerbates dangers to mental health (Salas et al., 2023). They frequently traverse a cultural terrain where homophobia is present within Latinx communities and where they also face racism in LGBTQ+ spaces, resulting in a loss of their sense of belonging (Velez et al., 2019). Within their families, acceptance can be conditional, with some relatives able to tolerate their identity as long as it is not ostentatious, thus maintaining their sense of invisibility (Morales-Chicas & Cokley, 2021). Other Latino gay men feel that their lived experiences of being Latino are frequently reduced to a caricature in predominantly white LGBTQ+ spaces, where they are seen as objects of racial fetishization or tokenization, leaving them feeling out of place (Han & Ayala, 2018). These stressors lead to elevated levels of depression, anxiety, and substance use among Latino gay men—rates significantly higher than in their white LGBTQ+ counterparts (Díaz et al., 2022). These combined factors contribute to the limited ability to obtain culturally competent services for their mental health needs, magnifying an already inequitable gap (Zea et al., 2003). An intersectional lens filtering in the cultural, family, and systemic contexts of gay Latino males' experiences will be critical to dealing with these challenges.

MENTAL HEALTH IMPLICATIONS

Gay Latino men suffer from potentially serious health and psychological problems because of discrimination at the intersection of racism, cultural norms, and family rejection (Díaz et al., 2001). These hardships often manifest as substance dependence, risky sexual behaviors, and psychiatric distress (Meyer, 2003). Racism within LGBTQ+ communities exacerbates low self-esteem, leading to higher levels of depression and anxiety compared to their white peers (Santos & VanDaalen, 2016). Racialized stereotypes perpetuate body dissatisfaction, anabolic steroid misuse, and eating disorders. Disrespectful treatment by and mistrust of the medical system further increase health disparities and decrease access to care (Le et al., 2024). Societal and familial pressures—in the form of the fear of ostracism or internalized shame—faced by gay Latino men increase their degree of emotional distress and raise the risk of depression and suicidal ideation (Tajón, 2009). These challenges are best addressed through a comprehensive approach in which intersectional experiences are considered and culturally competent mental health care is promoted.

The intersection of ethnic and sexual minority statuses means gay Latino men bear a heavier burden of stigma and discrimination from both mainstream society and the Latino community, often resulting in a higher prevalence of psychiatric distress. Cultural stigma also contributes to the underuse of mental health services, which can worsen untreated conditions and threaten long-term well-being (Gerena, 2021b).

Cultural norms enforcing heterosexual conformity, coupled with discrimination and stigma against LGBTQ+ individuals, increase psychiatric distress and the prevalence of psychiatric disorders (Yarber & Sayad, 2018). Family rejection, particularly from fathers, seriously impacts mental health, increasing anxiety, depression, suicidal ideation; substance use as a coping mechanism; and difficulty forming long-term healthy relationships due to internalized homonegativity.

THE ROLE OF QUEER LATINX MENTAL HEALTH PROFESSIONALS IN SEXUAL IDENTITY DEVELOPMENT

THE IMPORTANCE OF AFFIRMATIVE THERAPY

Affirmative therapy is an essential component in the treatment of members of the LGBTQ+ community, particularly gay Latino males. It contributes to positive identity development and decreases stigma. It is a form of psychotherapy aimed at confirming and advocating on issues affecting minorities in sexual and gender identity (Hinrichs & Donaldson, 2017). This framework helps to navigate the intersections of ethnic, cultural, and sexual identities to address mental health. Coming out is especially challenging for gay Latino men due to cultural and family factors such as machismo, caballerismo, and familismo. All these cultural pressures can contribute to significant fear of rejection and opposition to nonconformity with traditional gender role expectations.

All this means that therapists must build a solid working alliance with their clients by promoting trust, practicing cultural competence, and confirming the client's intersecting identities. A robust therapeutic alliance here involves the creation of a safe, nonjudgmental environment where the client is heard and validated, and the use of culturally responsive interventions that respect the client's values and experiences (Johnson, 2012). This builds rapport and encourages open discussion about identity, family, and mental health concerns.

Research indicates that understanding a client's coming out narrative strengthens the therapeutic relationship—the sense of trust, collaboration, and emotional connection between a client and therapist—and therapy satisfaction, which refers to the client's perception of how well therapy meets their needs and promotes personal growth (Bachelor, 1995; Bordin, 1979). In this regard, a minority stress-focused cognitive behavioral therapy (CBT) treatment tool called the ESTEEM intervention decreased anxiety and substance use for Latino gay and bisexual men, underscoring the importance of culturally tailored treatments (Keefe et al., 2023). By addressing minority stress and anchoring cultural identity, this intervention likely established trust, validation, and rapport—essential elements that strengthen the therapeutic alliance. Similarly, culturally adapted CBT in the case of a depressed gay Latino adolescent improved depressive symptoms and family dynamics by integrating values from culture and self-hood (Duarté-Vélez et al., 2010). This culturally responsive intervention not only addressed clinical concerns but also created a safe space for identity exploration, solidifying the client-therapist alliance and resulting in greater therapy satisfaction.

While the definition and validation of affirmative therapy are still elusive, there is empirical support for its efficacy in addressing the needs of LGBTQ+ individuals from racial and ethnic minorities. Studies have shown that affirmative therapy techniques—such as fostering positive identity development, validating cultural values, and addressing experiences of discrimination—lead to improved mental health outcomes, including reduced depression, anxiety, and internalized homophobia (Crisp & McCave, 2007). Therefore, future research should focus on refining and validating affirmative methods to determine their continued efficacy and cultural competence among racial and ethnic minorities (Johnson, 2012).

THE LIMITATIONS OF CURRENT MENTAL HEALTH SERVICES

Gay Latino males face disparities in access to mental health services due to a lack of cultural competency from therapists who are not Latinx. Barriers include the limited availability of culturally and linguistically appropriate services and institutional mistrust. Integrated care remains limited due to the lack of standard measures and empirical research (Bhui et al., 2007; McGregor et al., 2019).

These challenges stem largely from cultural misalignment, language barriers, and resource limitations. Many mental health assessments fail to account for the unique experiences of gay Latino men. Besides the lack of access to Spanish-language services and bilingual providers, financial constraints serve as additional barriers to obtaining high-quality mental health care (Aguilar-Gaxiola et al., 2012; Cerezo et al., 2020; Moyce et al., 2022). Gay Latino males' mistrust of mental health care is rooted in discrimination, compounded by providers' inadequate training in cultural humility and intersectionality (Dawes et al., 2023). Barriers related to the cost of care and a lack of appropriate LGBTQ+ cultural competency are also associated with limitations in access to services for this demographic group (Aguilar-Gaxiola et al., 2012; Fish et al., 2022).

Immigration further exacerbates the social isolation and barriers to health services faced by Latinx people, requiring culturally competent approaches in social work (Furman et al., 2009). For the majority of Latinx immigrants, poor language skills, deportation fear, and unawareness of available services are some of the factors that lead them to feel excluded and deny them access to vital mental health services. Undocumented individuals also tend to avoid visiting healthcare providers due to suspicion or legal concerns.

Solutions may involve enhancing provider cultural competence through training in immigration-related stressors, acculturation problems, and intersectional sexual and cultural identities. Increased access to services may involve the creation of bilingual mental health services, recruitment of diverse providers, and culturally competent outreach among immigrant communities. Policy-level advocacy to reduce disparities must work on healthcare coverage for undocumented people, funding for community-based organizations that serve immigrant and LGBTQ+ communities, and protecting vulnerable populations from healthcare discrimination.

THE NEED FOR AND BENEFITS OF QUEER LATINX MENTAL HEALTH PROFESSIONALS

Queer Latinx mental health professionals play an important role in the development of trust and understanding among gay Latino men. Their shared cultural and sexual identity builds stronger therapeutic alliances, leading to culturally relevant care (Gerena, 2021b; Gerena & Rodriguez, 2023). Gay Latino men often face a tension between familismo and their sexual identity. This tension occurs when the desire to preserve traditional family roles collides with the expression of sexual orientation without restraint, leading to emotional tension and fear of rejection. Social workers must be culturally sensitive, assess family support, and promote open communication to decrease stigma and improve mental health. This is particularly pertinent in light of the reality that machismo as a cultural phenomenon attached to conventional masculine dominance and pride tends to reinforce stringent gender roles, which accumulate internalized homophobia and social isolation (Gerena, 2021b).

Through providing safe spaces, inclusive language, and respect for client identities, queer Latinx professionals normalize discussions of sexual orientation and trauma while ensuring confidentiality (Gerena & Rodriguez, 2023). The acceptance of gay Latino men by their fathers is particularly significant, making family dynamics an important area for professionals to master, in addition to cultural competence (Gerena, 2021a). This acceptance is significant because fathers may express traditional patriarchal values in Latino households, where masculinity and gender are valued. For gay Latino men, acceptance by their fathers can affirm their identity, reduce internalized homophobia, and make them feel more valuable as people. Good father-son relationships have been linked with improved mental health status, including lower depression and anxiety rates (Morales et al., 2012). Fathers who openly declare acceptance of their sons can also affect broader family acceptance, a ripple effect that strengthens family bonds and reduces stigma.

ENHANCING CULTURAL COMPETENCY

Cultural competency among health professionals is essential for enhancing the quality of care in diverse populations, including gay Latino males. Queer Latinx professionals offer insight into cultural nuances, using their own experiences to foster empathy and challenge stereotypes, thereby making care more culturally competent (Rosenberg et al., 2024). Awareness of these challenges helps clinicians provide safe environments for gay Latino men to explore their personal experiences without shame (Rosenberg et al., 2024). Lived experiences of queer Latinx professionals enhance rapport-building and strengthen patient-provider relationships, reducing health disparities.

Provider training should include knowledge of belief systems and culturally sensitive care planning that fosters improved collaboration with clients and families (Bhui et al., 2007). Increasing workforce diversity in terms of bilingual and bicultural professionals is critical. Pipeline programs are needed to address the shortage of providers familiar with the needs of diverse communities (Aguilar-Gaxiola et al., 2012). Language access and tracking inequities are additional strategies that promote health equity (Flórez et al., 2021).

The significance of culturally competent care is widely acknowledged. Providing a specific example of a successful culturally adapted mental health intervention can illustrate its impact in practice. For instance, the chief emphasis in narrative therapy for gay Latino men is to develop the skills necessary to help the client reframe his experiences of cultural conflict and familial rejection, by building strength and resilience. Similarly, traditional healing practices, such as *curanderismo* (a holistic healing practice), could be included, or community leaders, such as *promotores* (community mental health workers), could be brought into mainstream mental health care to help bridge the gap between mainstream services and cultural beliefs. This could make interventions more acceptable and accessible to Latino clients (Cutshall, 2024; Johnson et al., 2013). These culturally adapted therapeutic approaches, incorporated with affirmative therapy, allow a deeper understanding of how mental health care can be adapted to meet the needs of gay Latino men, showing in practice what culturally competent care looks like and how it can improve mental health outcomes.

Queer Latinx professionals are integral to improving cultural competency, therapeutic relationships, and culturally relevant care. In addition to institutionalizing cultural competence education for all providers, increasing the availability of such professionals would lead to better health outcomes and greater equity for gay Latino men and other underserved groups.

PROMOTING POSITIVE ROLE MODELS

Gay Latino males and other marginalized communities depend on positive role models for self-acceptance and growth. Individuals relate better to those who share their cultural and sexual identity, which fosters a sense of belonging and raises self-esteem (Zea et al., 2003). Queer Latinx mental health professionals can serve as powerful role models by demonstrating how to integrate sexual identity with cultural expectations while overcoming internalized homophobia.

One important element in the therapeutic relationship is managing transference and countertransference. The feelings a client may hold toward their role models can be transferred onto the therapist. While this positive attitude can be helpful, it must be carefully managed to maintain balance in the therapeutic relationship. The therapist should recognize countertransference and use supervision and self-reflection to manage these dynamics.

IMPROVING MENTAL HEALTH OUTCOMES

Representation in mental health settings fosters trust between service recipients and providers. Greater representation among professionals—especially those who have similar backgrounds to or share a language with their clients—creates an atmosphere of greater inclusiveness and better outcomes for Latino patients (Flórez et al., 2021). While the evidence for effectiveness continues to evolve, cultural competency training has been associated with positive staff attitudes and clinician satisfaction. However, further research is needed to assess its impact on patient outcomes (Bhui et al., 2007).

Quantifiable statistics regarding the number of queer Latinx mental health providers, compared with the higher rates of mental health issues in LGBTQ+ Latinx populations, might create demand for more practitioners within this area. Although demand for culturally competent care is growing across LGBTQ+ communities, very few practicing mental health professionals identify as LGBTQ+ or Latinx. According to the American Psychological Association (2022a), less than 5% of the psychology workforce is composed of Latinx individuals; still fewer are LGBT. These low numbers, arguably, have contributed to disparities in mental health outcomes, with LGBTQ+ Latinx individuals having higher rates of major depressive disorder, generalized anxiety, and suicidal ideation than their white counterparts (National Center for HIV, Viral Hepatitis, STD, and TB Prevention, 2021). Increasing the number of queer Latinx practitioners may help bridge these disparities and improve overall mental health outcomes.

BROADER IMPACTS OF INCREASED QUEER LATINX MENTAL HEALTH PROFESSIONALS

An increased presence of queer Latinx mental health professionals extends beyond individualized care to influence research, policy, and clinical practice in a meaningful manner. Their unique standpoints enhance an understanding of the intersectionality of culture, sexuality, and mental health, creating more representative and inclusive research.

Scholarship from queer Latinx scholars tends to encapsulate the multifaceted experiences of gay Latino men, addressing gaps in the literature and combating dominant discourses that overlook their specific mental health issues (Salgado et al., 2022). By producing culturally relevant research, these researchers are helping create evidence-based interventions that are tailored to the lived experiences of their communities, ultimately improving mental health outcomes on a larger scale.

In terms of policy, queer Latinx mental health professionals have an important part to play in shaping legislative agendas to dismantle structural impediments to mental health care. Through experience and clinical awareness, they can highlight the unique issues gay Latino men face, while encouraging policymakers to place culturally attuned care and workforce diversity at the forefront. Their work played a crucial role in the enactment of bills such as the Mental Health Workforce and Language Access Act of 2023, which allocates funds to recruit bilingual and bicultural mental health professionals and to increase culturally appropriate services (Rodriguez & Santiago, 2023). Additionally, their leadership positions in professional organizations—such as the National Latinx Psychological Association and the APA's Division 44 (Society for the Psychology of Sexual Orientation and Gender Diversity)—expand queer Latinx voices in state and national policymaking. In becoming directly engaged with these causes, queer Latinx professionals drive systemic change toward greater inclusivity and accessibility of mental healthcare.

This policy work has already shown positive effects. For example, in its first year, the Mental Health Workforce and Language Access Act has assisted more than 200 new bilingual mental health professionals employed in federally qualified health centers, increasing service availability for Latinx communities (Rodriguez & Santiago, 2024). In another example, California and New York made a direct investment in workforce diversity initiatives and reported a 15% rate of growth in the number of Latinx-identified mental health professionals in public health settings, contributing to improved patient satisfaction and engagement in therapy (Sanchez et al., 2024). Furthermore, organizations such as the National Latinx Psychological Association stepped up mentorship efforts, resulting in a 20% boost in Latinx applicants to graduate mental health training programs (American Psychological Association [APA], 2024). These preliminary results reflect the actual returns on policy investment—bridging gaps and creating a more representative mental health workforce.

Growth in the number of queer Latinx mental health professionals leads to a broader cultural shift in mental health organizations. Their presence disrupts the traditional Eurocentric models of therapy through the introduction of models that emphasize collectivism over individualistic values, intersectionality, and culturally affirming approaches. When queer Latinx mental health professionals are included as educators and mentors in training curricula, they equip future practitioners to work with diverse populations, reducing the stigma that keeps gay Latino men from seeking care (Gonzalez et al., 2021). Their leadership within health systems also fosters organizational change that promotes equity, including by implementing inclusive intake assessments and developing trauma-informed, LGBTQ+-affirmative treatment plans.

Through their influence on practice, policy, and research, queer Latinx mental health professionals play a radical role in reshaping mental health care to improve therapeutic outcomes at the individual level. They also instigate change at the systemic level that improves outcomes among broader LGBTQ+ Latinx communities.

POTENTIAL CRITICISMS

Cultural competence training alone cannot address the mental health needs of gay Latino men. Lived experience provides a higher level of insight that cannot be replaced with training. Queer Latinx mental health professionals possess a unique perspective that facilitates increased trust, reduces fears of cultural misunderstandings, and enhances therapeutic rapport (Morales et al., 2021). Evidence-based literature states that clients from marginalized communities are more willing to disclose personal problems to therapists from the same cultural background, leading to better treatment acceptance and outcomes (Santos & Valdez, 2020).

Critics argue that prioritizing representation in mental health treatment can enable racial or ethnic matching in ways that minimize client choice or put up unnecessary barriers to care. The goal is not exclusion; rather, it is to ensure that LGBTQ+ Latinx clients can access providers who understand their unique issues. The APA (2022a) emphasizes that representative diversity for mental health professions is a matter not of preference but of equity, given it directly influences disparities in access and quality of care. Moreover, when mental health professionals have meaningful cultural similarities with clients, they are better able to address the intersectional experience of discrimination, rejection by the family, and internalized stigma (Guzmán et al., 2019).

Rather than suggesting that gay Latino men can only be treated by queer Latinx mental health professionals, the emphasis should be placed on getting more such professionals into practice to ensure equal access to culturally competent care. By integrating recruitment and retention strategies for these professionals, mental health centers can move beyond superficial cultural competence gestures and toward a systemic approach that meets the needs of gay Latino men.

STRATEGIES FOR INCREASING THE NUMBER OF QUEER LATINX MENTAL HEALTH PROFESSIONALS

EDUCATION AND TRAINING

Delivering culturally competent care to gay Latino males (or any other LGBTQ+ individuals) requires an expansion of recruitment and training programs for queer Latinx mental health professionals. These programs should prioritize the development of queer Latinx professionals in a way that allows them to deliver culturally competent and trauma-sensitive care with an understanding of intersectional identities in service delivery to LGBTQ+ individuals.

The inclusion of more queer Latinx professionals creates avenues for systems of inclusivity and equity within the profession that may inspire future generations and provide the profession with increasingly diverse perspectives. Success in these programs will depend on an inclusive organizational culture, external pressures like continuing education requirements, and strong leadership (Fish et al., 2022). Furthermore, mentors are imperative for supporting queer Latinx professionals in their career paths by offering advice and a sense of community. These initiatives are important in helping the mental health system become more inclusive and improving outcomes for LGBTQ+ Latinx clients.

POLICY RECOMMENDATIONS

Recent legislation, including the Mental Health Workforce and Language Access Act of 2023 and the CARE for Mental Health Professionals Act, introduced in 2023, provides critical opportunities to advance diversity in the mental health workforce. The Mental Health Workforce and Language Access Act aims to improve language access in mental health care by authorizing grants to recruit professionals who speak languages other than English and promote culturally competent care. The CARE Act, if enacted, will strengthen the mental health workforce through practices across state lines and by including in the workforce essential but often marginalized groups, such as queer Latinx professionals, who are necessary to provide culturally sensitive care.

These acts also offer financial resources to support the recruitment and retention of queer Latinx students in mental health professions, creating more inclusive work environments. For example, professionals who are queer and Latinx can join institutions like the National Association of Social Workers (NASW) or the APA, either individually or in groups, to advocate for policy changes. They may also be able to secure grants to promote diversity within the mental health workforce overall and specifically within their profession.

In this vein, organizations and authorities can make a significant impact by implementing concrete initiatives focused on attracting and retaining queer Latinx professionals. Pipeline programs such as Mental and Behavioral Health Education and Training and the Health Careers Opportunity Program, both funded by the U.S. Health Resources and Services Administration, have successfully recruited underrepresented groups into health careers through financial aid, culturally sensitive training, and mentorship (Nivet et al., 2016). Meanwhile, more far-reaching enforcement of laws offering incentives to hire bilingual and bicultural mental health therapists could lead to gains like those seen in New York and California. Active hiring and retention focus on expanding mental health care system services, similar to international initiatives like Canada’s Promoting Health Equity: Mental Health of Black Canadians Fund (Public Health Agency of Canada, 2023). These examples indicate the need for collaboration between educational institutions, government agencies, and professional organizations to facilitate a diverse workforce.

COUNTERING ANTI-DEI EFFORTS

Despite recent anti–diversity, equity, and inclusion (DEI) efforts, such as the U.S. administration’s rescissions of federal funding, there remains potential—and a necessity—to continue with policies that enable the recruitment and retention of queer Latinx mental health professionals. Some state and federal organizations and nonprofits can still independently implement internal policies to promote workplace diversity (Williams et al., 2023). The NASW and the APA can enhance scholarship and mentorship programs aimed at underrepresented groups without intervention from the government. Foundations such as the Robert Wood Johnson Foundation and KFF remain committed to healthy equity programs that facilitate hiring and retaining diverse mental health practitioners (García & Hardy, 2024).

Public agencies may face legal and political difficulties in embracing explicit DEI efforts, but they can prioritize inclusive recruitment in other ways. For instance, language-access policies remain legally permitted under Title VI of the Civil Rights Act of 1964, and clinics and hospitals can rationalize the hiring of bilingual and bicultural providers as a requirement for effective patient care (Sanchez et al., 2022). Similarly, some states with strong labor protections, like California and New York, have persisted in promoting the hiring of diverse mental health professionals even in the wake of shifting federal policies (Rodriguez & Nguyen, 2024). Other health institutions have also embraced DEI principles within cultural competency and workplace development, giving programs new titles to suit evolving legal mandates while retaining their impact.

For job seekers pursuing employment in mental health programs amid anti-DEI efforts, personal narratives and anecdotes remain powerful weapons. Most organizations continue to allow personal statements in resumes, where job seekers can articulate how their own experiences and unique identities serve the field. This allows queer Latinx job seekers to highlight the strengths of their backgrounds and activism without explicitly using DEI terminology (Perez et al., 2023). Lastly, professional networks within affinity groups such as the National Latino Behavioral Health Association or the LGBTQ+ Health Equity Initiative (American Public Health Association) can establish systems of support independent of formal DEI efforts so that mentorship and community-building are sustained no matter the policy shifts.

As DEI policy is increasingly curtailed, policymakers, advocacy organizations, and mental health institutions must come together in pursuit of flexible solutions for serving underrepresented professionals. With access to private funding, legal defense of language access policies, and narrative capacities in hiring and admission processes, stakeholders can continue to incentivize a diversified mental health workforce. These efforts not only circumvent anti-DEI policies but also affirm the determination and priority of representation in mental health care.

COMMUNITY ENGAGEMENT AND SUPPORT

Community engagement and support resources help heal and validate the experiences of gay Latino men, particularly in fostering positive sexual identity development. These resources offer encouragement, belonging, and access to vital support as individuals navigate their sexual and cultural identities. Through activists, local LGBTQ+ organizations provide safe spaces, counseling, peer support, and educational workshops, all specifically geared toward the needs of gay male Latinos. By addressing stigma, these resources help create an environment where individuals can thrive and reach their full potential. This is further supported by local programs, including pride movements, cultural festivals, and affirming church services, that provide LGBTQ+ individuals with opportunities for connection and mutual support. These spaces also enable discussions on salient issues affecting gay Latino males.

Family support is also crucial. When families are accepting, it can have a significantly positive impact on a person’s mental health. Educating family members on LGBTQ+ issues and calling for free, open conversations will cultivate understanding and close these gaps—specifically, the lack of culturally informed understanding about sexual identity, mental health stigma, and misconceptions rooted in traditional values. Collaborations among mental health workers, community organizations, and local advocates are necessary to develop effective support systems: These partnerships enable the creation of culturally relevant programs and services that address the diverse needs of gay Latino men, helping them build confidence and resilience in their identities.

Community organizations serve an immensely important function in the mental health of gay Latino men through a myriad of services: peer mentoring, advocacy, and legal support. In this light, peer mentoring programs offer them the opportunity to interact with others who may share similar experiences and provide advice to alleviate loneliness. Advocacy efforts led by community organizations help reduce stigma and promote systemic changes to guarantee LGBTQ+ people’s rights and access to care, These organizations may also provide legal support, particularly in cases involving discrimination or immigration, which may be harmful to mental health (Meyer, 2003). Successful collaborations between mental health providers and community organizations have shown that culturally relevant care works. For example, joint efforts between LGBTQ+ community centers and healthcare providers have established various culturally adapted programs and workshops for counseling, where issues like internalized homophobia and identity development can be evaluated in a nonjudgmental setting (Crisp & McCave, 2007). This helps build a continuous network of support where the mental, emotional, and legal needs of gay male Latinos are addressed.

Case studies of LGBTQ+-affirming community interventions offer proof of the positive impact of these programs for gay male Latino mental and health outcomes. For instance, O'Donnell, Sánchez, and Grant (2021) explored the role of mentoring in Latinx adolescents, and they demonstrated that mentoring can build trust and improve psychological well-being, such as lowering anxiety and depression. The contribution of their work was that it found positive mentoring relationships to be best in fostering self-esteem and emotional resilience among Latinx youth, including sexuality minority youth. Another study, Familias con Orgullo, had a family center intervention focus to improve communication and eradicate depressive symptoms among Latinx sexual minority youth (Estrada et al., 2024). The intervention, by the way of family counseling and education, helped families become more accepting of their LGBTQ+ children and reduce mental health problems such as depression. These studies emphasize the importance culturally appropriate interventions to enhance mental health and reduce internalized homophobia, loneliness, and conflict in interpersonal relationships among gay Latino men.

CONCLUSION

Psychological well-being issues in gay Latino men are products of intersecting economic, cultural, and structural barriers that render sexual identity complex to form. Cultural values of familismo, machismo, and caballerismo, combined with religious conservatism, result in internalized homophobia, family rejection, and financial inequalities. There is also a limit to gay Latino men's ability to seek affirmative services, typically because of language barriers, lack of enough culturally competent providers, and fears of discrimination in healthcare centers (Crisp & McCave, 2007). As such, the population tends to have disproportionately high rates of depression, anxiety, and suicidal ideation. Yet despite these issues, the current mental health system remains considerably unresponsive to them.

Queer Latinx mental health professionals are crucial to closing these gaps. Due to their identity, they can build credibility, provide culturally affirming treatment, and validate the sexual identities of gay Latino men in ways that traditional practitioners cannot. They can provide affirmative therapy without fear of rejection. Furthermore, their policy campaigning and research help supplement institutional initiatives toward culturally sensitive and adaptive mental health interventions addressing Latinx LGBTQ+ issues.

However, such progress is under immediate threat by the current presidential administration's reversal of DEI policies. Diversification of mental health personnel is being undone through funding policies that limit culturally competent training and discourage hiring queer Latinx mental health professionals. The trend places affirming care out of reach and exacerbates the existing disparities in mental health care, particularly among already underresourced, marginalized communities. Without active resistance, these political measures will create further significant barriers to care for gay Latino men.

More urgently than ever, schools, policymakers, and community-based organizations must move to protect and expand programs that support queer Latinx mental health professionals. That involves maintaining pipeline initiatives, advocating for funding protections, and creating community-based interventions that provide direct support to LGBTQ+ Latinx individuals. Representation in mental health care is not a privilege; it is a necessity. Investing in representation ensures that the next generations of gay Latino men receive the culturally affirming care they will need.

This work is not just about statistics, policy changes, or workforce development—it is about real people. It is about a young Latino boy sitting in church, praying for his socially unacceptable feelings to disappear. It is about a teenager who rehearses his coming-out speech a hundred times but never finds the courage to say it aloud. It is about the man who has spent years hiding, only to realize he has been hiding from himself. These individuals deserve to see mental health professionals who understand and affirm them, and a world that embraces them. This paper is a call to action, a plea to ensure that no gay Latino man ever feels alone in this journey.

At last, *mereces todo lo bonito*—you deserve everything beautiful. Gay Latino men deserve mental health care that understands them, honors their struggles, and supports them toward healing. A fortification of queer Latinx mental health professionals' visibility is not just a move toward equity—it is a prerequisite for justice. The fight for representation in mental health persists, to ensure that every single one of those individuals has access to practitioners who fully understand and care for them.

"There are millions of us, and we're strong and we're loved. You don't have to sacrifice being Latino or being LGBT to be part of both communities."—Ruben Gonzales

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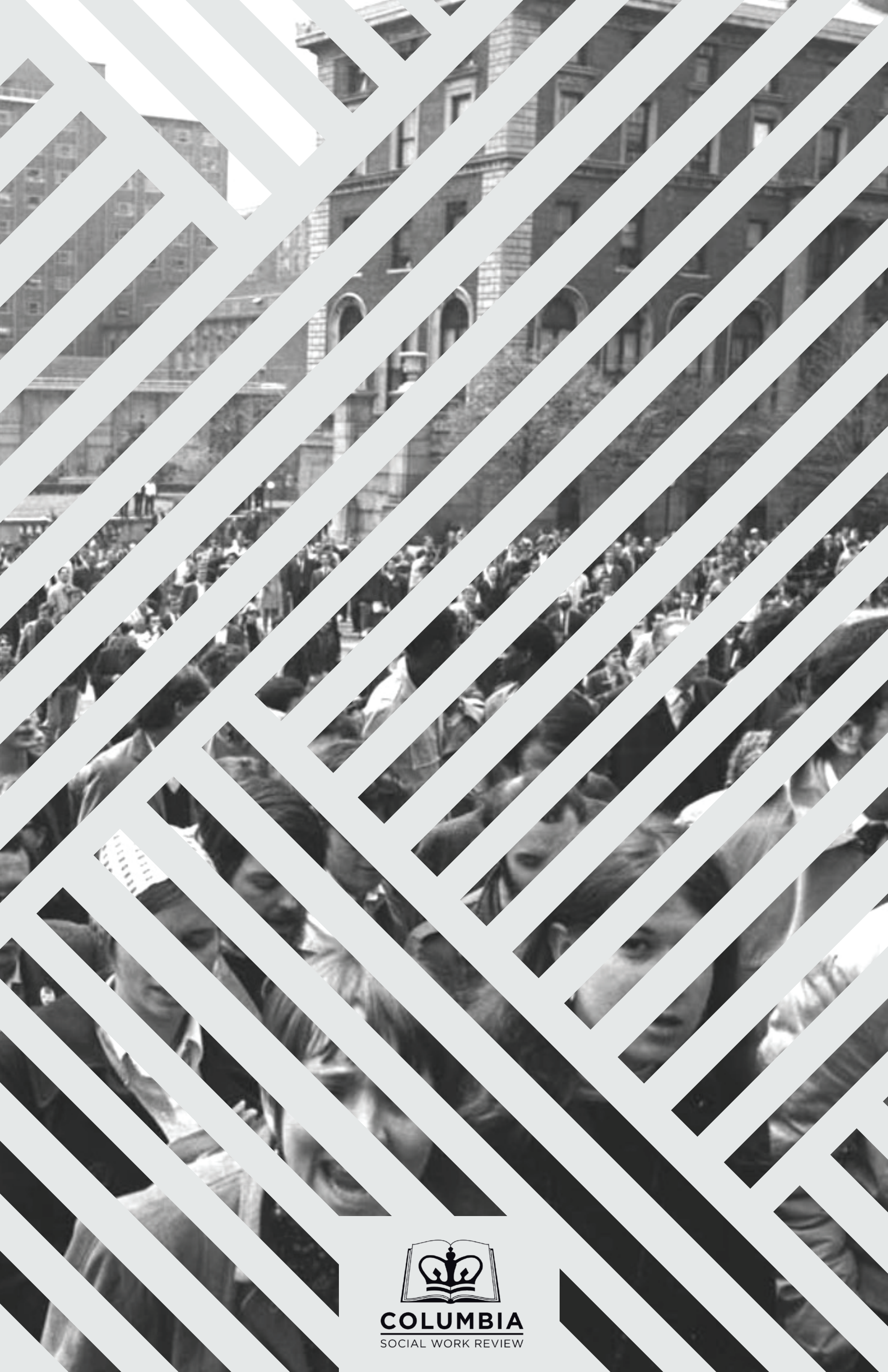

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