MAPPING
THE ROAD TO EQUITY

THE ANNUAL STATE OF LGBTQ COMMUNITIES

2018

#Out4MentalHealth

MAPPING THE ROAD TO EQUITY:

The Annual State of LGBTQ Communities

2018

www.Out4MentalHealth.org

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Executive Summary

Introduction

    #Out4MentalHealth seeks to create a mental health equity agenda to reduce mental health disparities by revealing the daily challenges LGBTQ Californians face. *Mapping the Road to Equity: The Annual State of LGBTQ Communities, 2018* lifts up LGBTQ Californians' voices to inform the work of community advocates, service providers, and policymakers. Town Halls and Round Tables, interviews with county staff and statewide key informants, a literature review, and other methods inform the findings detailed below. Community input, #Out4MentalHealth research, and involvement in statewide advocacy inform the included recommendations. This following summary of key findings reflects the full Report, which starts on page 17.

Law Enforcement and Criminal Justice

    LGBTQ Californians identified differential treatment and violence at the hands of law enforcement. The literature review affirms these concerns and adds a systematic analysis of the "school-to-prison pipeline," which funnels LGBTQ youth, especially queer and trans youth of color, into jails and prison. LGBTQ advocates reported mixed results in training police departments to be more culturally competent. #Out4MentalHealth's recommendations include:

1. **Eliminate laws criminalizing people for being homeless, engaging in sex work, or other status offenses.**
2. **Increase the use of crisis intervention teams consisting of mental health professionals and peers.**

3. Implement rigorous training for state and local law enforcement personnel.

Housing, Homelessness, and Gentrification

The housing crisis affects LGBTQ Californians in unique ways. Family rejection, especially early and late in life, contributes to disproportionate housing insecurity. Effects of gentrification push LGBTQ people in need of services away from LGBTQ-specific organization hubs in cities. LGBTQ people who become homeless face rejection and risk of violence when living on the streets and when trying to access services. Family rejection, the school-to-prison pipeline, job and housing discrimination, increased criminalization of homelessness, and continued criminalization of sex work and status offenses all add to disproportionate risk of homelessness for LGBTQ Californians.

#Out4MentalHealth's recommendations include:

1. **Ensure policies allow LGBTQ-safe access within sex-segregated and family shelters.**
2. **Increase funding for dedicated services for homeless and runaway youth programs and ban high-barrier shelters that reduce access for LGBTQ youth.**
3. **Address the lack of affordable housing - particularly in areas where LGBTQ services are located.**

A House Divided

Learned and internalized racism, sexism, cissexism, monosexism, xenophobia, and ageism can make it difficult to consolidate power and work toward justice that serves all LGBTQ people. Multiply marginalized LGBTQ people often feel excluded or that they have to choose between their LGBTQ or racial, ethnic, disability, or gender allegiances. Concerted ongoing efforts in advocacy, education and community building are needed to support the pursuit towards true justice for and the well-being of all LGBTQ people.

Schools and Families

California laws protect the rights of LGBTQ youth to attain education in a safe environment. Yet, uneven enforcement of these policies means that LGBTQ youth continue to face harassment from peers and staff, and parents advocating on their children's behalf often encounter complex and bureaucratic systems that are resistant to change. School-based harassment and barriers to educational attainment can increase risk of depression and suicidality.

Parents express love for their children based on their learned values. Values that do not support LGBTQ experiences, culture, and rights may lead parents to show love through acts of fear and rejection. Family rejection is associated with homelessness, substance use, and suicidality risk, whereas family support can buffer the effects of heterosexism, such as harassment and bullying in schools. To support family well-being and the health of LGBTQ youth, parents need and deserve support in parenting their LGBTQ children.

#Out4MentalHealth's recommendations include:

1. **Enforce compliance with AB 1266, which requires students to have equal access to sex-segregated facilities in accordance with their current gender identity.**
2. **Engage LGBTQ stakeholders in the Local Control Accountability Plan process and dedicate Local Funding Formula resources for LGBTQ-inclusive programming and curriculum in schools.**
3. **Provide education and training for parents about how to be supportive of their LGBTQ children.**

Health Care Access

Accessing health care remains a serious issue for many LGBTQ people. LGBTQ people living in rural parts of the state, and transgender Californians overall, face particularly high barriers in accessing culturally affirming care. #Out4MentalHealth's recommendations include:

1. **Expand Medi-Cal to cover all income-eligible Californians, regardless of immigration status.**
2. **Fund programs to help transgender people access covered transition-related care, such as health system navigators or community liaisons.**
3. **Increase Covered California subsidies for low- and middle-income Californians, and expand measures to reign in high health care costs.**

Rejection and Affirmation by Providers

Providers often reject their LGBTQ clients, intentionally or unintentionally. Refusing to provide services, violating confidentiality, and dishonoring the validity of LGBTQ clients' identites or relationships are some examples of provider rejection. On the positive side, there are providers who put an effort into creating LGBTQ-affirming spaces and practices. Examples of affirming practices include: using correct names and pronouns, acknowledging family, and having LGBTQ materials and symbols in the providers' office and lobby

Sexual Orientation & Gender Identity (SOGI) Data Collection

Various state and county agencies are required to collect SOGI demographic data and report on specific categories of sexual orientation and gender identity. #Out4MentalHealth conducted interviews and compared assorted sources of data to learn how and what data is being collected, as well as what barriers may hinder compliance with the regulations.

#Out4MentalHealth's recommendations include:

1. **Standardize questions and SOGI data measures across all state and county programs required to ask demographic questions under AB 959, AB 677, and the MHSOAC's PEI & INN Regulations.**

2. **Revise demographic data collection procedures such that counties are responsible for collecting and reporting disaggregated data, and state departments are responsible for analyzing that data and making it available to researchers, advocates, and other stakeholders.**

3. **Provide training to counties on standard procedures to collect and report SOGI data across all programs, including best practices that protect client population privacy in data collection and reporting.**

The Political is Personal

The last decade ushered in a huge expansion of protections and rights for LGBTQ people at the federal and state level, including marriage equality, increased access to health care through the Patient Protection and Affordable Care Act, nondiscrimination protections in health care and education, and a commitment to address LGBTQ disparities. In the past two years, changes at the federal level have led to some erosion of existing protections and additional threats to others. Meanwhile, California continues to pass legislation protecting LGBTQ residents, reducing health and mental health disparities.

Introduction

#Out4MentalHealth is a California statewide LGBTQ mental health initiative of the California LGBTQ Health and Human Services Network and NorCal Mental Health America, funded by the MHSOAC using Mental Health Services Act (MHSA) dollars. #Out4MentalHealth creates and advocates for an LGBTQ mental health equity policy agenda through the inclusion of LGBTQ Californians' voices, novel research, public outreach and communications, and the provision of free community and provider training.

Each year, #Out4MentalHealth will produce an Annual State of LGBTQ Communities Report to provide insight into project findings and highlight issues that are relevant to the health and well-being of LGBTQ Californians. We hope community advocates use the information in this Report to support their local efforts, providers learn how to improve their practice for effective and inclusive services to LGBTQ clients, and legislators hear the voices of their LGBTQ constituents calling for continued changes in public policy and priorities throughout this document.

In 2018, #Out4MentalHealth reached communities across California. Many of you reading this document may have met #Out4MentalHealth staff at Town Halls, Round Tables, Key Informant and County Interviews, community events like Pride, conferences, advocacy events, and policy meetings. All of these activities inform the following Report.

The LGBTQ Acronym

The acronym LGBTQ (Lesbian, Gay, Bisexual, Transgender, Queer/Questioning) is used in this Report because it is recognizable, it is consistent with the language used in recent California policy (some of which funds this work), and it provides for brevity in this Report. Although some professional and governmental entities (e.g., National Institute of Health) are using the term "sexual and gender minorities" (SGM), this is not a term that is necessarily familiar to or in usage by the communities the term represents. Our usage of LGBTQ in this Report, however,

> comes with the caveat that the LGBTQ acronym does *not* represent all individuals or populations whose sexual orientation, gender identity or gender expression is seen as outside society's expected norms. The myriad of self-described identities, attractions and expression by individuals from all races, ethnicities, cultures, genders, ages, and background cannot begin to be covered by a simple acronym developed predominantly in a white, Western, comparatively affluent context (Mikalson, Pardon, & Green, 2012, p. 19-20).

There are many individuals, cultures, and communities who identify as sexual orientation and/or gender identities which fall outside the LGBTQ acronym; they too face health disparities, lack of targeted research, and do, anecdotally, struggle with barriers to health access in California. The acronym does not take into account #Out4MentalHealth's constant recognition that no person is ever just their sexual orientation or gender identity, as they are also a person living at the intersections of racial, ethnic, class, national, religious, ability, and additional identities. Although the LGBTQ acronym is used in this Report, #Out4MentalHealth writes with the entirety of our diverse communities in mind and a commitment to raising up the voices of those least heard.

Looking Back:

The 2018 Annual State of LGBTQ Communities Report is designed with another report in mind: Mikalson, Pardo, and Green's 2012 First, Do No Harm: Reducing Disparities for Lesbian, Gay, Bisexual, Transgender, Queer and Questioning Populations in California, of the California Reducing Disparities Project, Phase 1. First, Do No Harm provided groundbreaking research, an important update on LGBTQ mental health in California, and acted as the reference for both the #Out4MentalHealth Project and the California Reducing Disparities Project, Phase 2. Today, First, Do No Harm remains an important resource to reflect on histories and current realities of LGBTQ mental health in California and to learn about LGBTQ- community-based interventions for mental health. To read the First, Do No Harm Report, visit **www.norcalmha.org/lgbtq-educing-disparities-project.**

The #Out4MentalHealth Logo

The #Out4MentalHealth Project Team and the #Out4MentalHealth Workgroup worked together to create a logo for the project which would convey the many perspectives of our diverse LGBTQ communities. For 2017 Pride Month, the Philadelphia Office of LGBT Affairs' *More Color, More Pride* campaign created a new official pride flag with the addition of black and brown stripes to symbolize the inclusion of people of color (Paynter, 2017).

#Out4MentalHealth has included in our logo both the rainbow and the black and brown stripes to reflect #Out4MentalHealth's foundation and commitment to viewing LGBTQ mental health through an *intersectionality* lens (Crenshaw, 1989)—that is, with a recognition of how racism, classism, heterosexism, cissexism, sexism, and other systems interact with each other to create individual experience and population health disparities. #Out4MentalHealth therefore works from the belief that the liberation of LGBTQ people from heterosexist and cissexist systems must involve fighting racism, classism, sexism, and all other intersecting systems of oppression, as all of these systems are intertwined together.

The State of LGBTQ Communities in California

Mapping the Road to Equity: The Annual State of LGBTQ Communities, 2018 provides critical insight into the experiences of LGBTQ Californians. Each major theme includes background information and a literature review. The words and experiences of #Out4MentalHealth Town Hall and Round Table attendees are included throughout the literature reviews to impress upon the reader the salience and impact of these issues in the everyday lives of LGBTQ Californians. The themes explored in this Report are

explored specifically because LGBTQ Californians spoke of these issues on a consistent basis at most or all #Out4MentalHealth events.

The County[1] SOGI (Sexual Orientation and Gender Identity) Data Collection and The Political is Personal sections are included in this Report because of their implications in providing statewide perspective to LGBTQ mental health. The County SOGI Data Collection section discusses best and current data collection practices by county and state agencies to inform continued advocacy efforts for improvements in SOGI demographic data collection, which will hopefully lead to improved services for LGBTQ populations. The Political is Personal section educates stakeholders on recent, current, and future political activities that have far-reaching implications for LGBTQ Californians' health and well-being.

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[1] The term "county" in this Report is generally used to refer to the Behavioral/Mental Health Departments and Authorities in counties across California as well as local non-county Mental Health Authorities such as the City of Berkeley, Tri-City Mental Health Authority, and Sutter-Yuba Behavioral Health.

LAW ENFORCEMENT
AND CRIMINAL JUSTICE

Police Brutality

Police brutality gained national attention in the past five years following a series of incidents where law enforcement officers killed Black people, as in the examples of Michael Brown (Ferguson, MO), Freddie Gray (Baltimore, MD), Tamir Rice (Cleveland, OH), Rekia Boyd (Chicago, IL), and Eric Garner (Staten Island, NY). More recently, civil protests in the names of those lost to police brutality, including Stephon Clark (Sacramento, CA) and Desmond Phillips (Chico, CA), have occurred in various California cities. Trans and nonbinary people, in particular, are at higher risk of experiencing police antagonism compared to the general population in the United States (Grant, Mottet, Tannis, Harrison, & Herman, 2011; James et al., 2016). Although rarely featured in local and state mainstream media channels, accounts of physical violence and even death by police brutality—especially targeting trans or nonbinary people of color—are common in LGBTQ communities, negatively impacting their sense of well-being and fostering an anticipation of police violence.

Youth at Risk

The *school-to-prison pipeline* is a term often used to describe the systems that funnel youth of color and LGBTQ youth[2] out of comprehensive school setting(s) into juvenile and adult prisons. The mechanisms of the school-to-prison pipeline include inadequate school funding and supervision, excessive student discipline, and an overreliance on police and school resource officers (SROs) to respond to student behavior. In addition, there are the larger socioeconomic impacts of racism, such as

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[2] This Report uses "youth" to refer to people under the age of 25 unless a different age range is specified.

housing discrimination, incarceration, and the long-lasting effects of Jim Crow policies, internment, forced migration, and enslavement. As evidenced below, additional risk factors in educational and (in)justice systems push LGBTQ youth of color into this pipeline.

LGBTQ youth face family rejection, instability and poverty, zero-tolerance policies in schools, disproportionate targeting and discipline of LGBTQ students, and an increase in police presence in schools (Center for American Progress [CAP] and Movement Advancement Project, 2016).[3] LGBTQ youth of color, in particular, may be disciplined in schools by staff and by police specifically for their gender identity or expression (Burdge, Licona, & Hyemingway, 2014). In surveys of juvenile detention centers and correction facilities across the United States, 20% of all incarcerated youth identified as LGBTQ or gender nonconforming and, of the incarcerated youth identifying as girls, nearly 40% identified as being LGBTQ (CAP et al., 2016).[4]

LGBTQ youth thrown out of their family homes (Grant et al., 2011; James et al., 2016) are at a higher risk of run-ins with the police (CAP et al., 2016) while facing difficult and dangerous decisions for survival, such as where to sleep and how to find food. Youth left to fend for themselves may try to meet their needs by selling drugs or engaging in sex work, activities that could lead to incarceration (Dank et al., 2015a; Dank et al., 2015b; James et al. 2016). LGBTQ youth staying on the streets or skipping classes may risk arrest for runaway and truancy, which are status offenses that can land them in juvenile probation settings, such as halls and camps (Jafarian & Anathakrishnan, 2017). Lacking access to safe coping mechanisms for feelings of rejection, isolation, and internalized lack of self-worth, some LGBTQ youth may also turn to substance use, increasing the risk of law enforcement interaction even further.

Nonheterosexual adolescents suffer disproportionate punishments by schools

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[3] See "LGBTQ Youth and the School to Prison Pipeline" Fact Sheet in Appendix D

[4] See "LGBTQ Youth and the School to Prison Pipeline" Fact Sheet in Appendix D

and the criminal justice system, which implicates not only schools, police, and the courts, but also other youth-serving health and welfare systems that often fail to meet the needs of nonheterosexual adolescents. (Himmelstein & Brückner, 2011, p. 55).

The Status Offense Reform Center:

For more information on status offenses and how they criminalize children who need support, visit the website of the Status Offense Reform Center of the Vera Institute of Justice at **www.vera.org/projects/status-offense-reform-center**.

LGBTQ youth are also disproportionately represented in the child welfare system at approximately 20%, with 13.4% being LGBQ and 5.6% transgender (Wilson, Cooper, Kastanis, & Nezhad, 2014; Wilson & Kastanis, 2015), due to a range of factors including the increased likelihood of being removed from homes (Irvine & Canfield, 2016), family rejection, and abuse contingent on the child's gender expression, gender identity, and/or sexual orientation. LGBTQ youth in foster care are moved between placements more often than their heterosexual or cisgender peers and are more likely to be placed in a group home (Wilson et al., 2014; Wilson & Kastanis, 2015). Family rejection, multiple spells in foster care, and multiple placements increase the risk of incarceration (Cutuli et al., 2016; Jonson-Reid & Barth, 2000).

Foster Youth Help Line:

If you are a foster youth or you know a foster youth in need of support, the California Ombudsman for Foster Care Help Line exists to hear from you. **Call 1-877-846-1602** to learn about the rights of foster youth and to get support.

All of the factors stated above—family rejection, lack of access to care, substance use, excessive school discipline, re-housing, and police targeting—contribute to the school-to-prison pipeline for LGBTQ youth. LGBTQ youth of color, who constitute 85% of LGBTQ youth in juvenile facilities, face exceptional risk of being shuffled into this system (Irvine & Canfield, 2016).

Distrust of Police

LGBTQ participants spoke about community relationships with their local police departments at almost every #Out4MentalHealth event. Considering #Out4MentalHealth staff did not ask specifically about local relationships with law enforcement and criminal justice systems, this issue is clearly at the forefront for LGBTQ communities in California. Participants often referenced instances in their communities where local law enforcement officers targeted or mistreated vulnerable community members (trans and nonbinary people, youth, people of color, people living with disabilities, people experiencing homelessness, and sex workers). Many participants expressed fear and distrust of law enforcement and their respective departments, as well as an unwillingness to reach out to them in an emergency. This distrust is reflected in the findings of the 2015 U.S. Transgender Survey, where 57% of

respondents reported feeling uncomfortable calling the police for help (Herman et al., 2016). Owen, Burke, Few-Demo and Natwick (2017) also found that LGBTQ people were less likely to trust that police would treat LGBTQ people and people of color fairly. Even well-intentioned law enforcement may not consider the unique needs or appropriate treatment of LGBTQ people.

The 2015 U.S. Transgender Survey:

In 2015, The National Center for Transgender Equality conducted the largest survey of transgender people in the United States. This major effort provided important information for communities, providers, and policymakers about trans experiences. Read the Report at **www.ustranssurvey.org**.

"If there was a violent crime happening, one of the last places I would call would be the police. And that's a problem."

"The police asked me, 'Why are you being so vulgar?'
By which he meant to call me a faggot."

"People I know who are LGBTQ and homeless or LGBTQ people of color don't want to call the police."

"There's so many resources, but such fear and distrust of [local police department]."

Policies Targeting Sex Workers

Together, the school-to-prison pipeline (Burdge et al., 2014) and housing/employment discrimination contribute to high numbers of trans people[5], gender nonconforming people, and LGBTQ people of color engaging in sex work and survival sex. In the 2015 U.S. Transgender Survey, 19% of respondents had exchanged sex for money, food, or a place to sleep (James et al., 2016). While a complete discussion of sex work is beyond the scope of this year's Report, comments from attendees at #Out4MentalHealth events expressed the need to support sex worker rights and their access to safe means of doing their work. The continued criminalization of sex work in California places LGBTQ sex workers at increased risk of incarceration and economic discrimination.

The Sex Worker Outreach Project (SWOP):

With chapter organizations in Los Angeles and Sacramento, SWOP is a national network advocating for the rights, safety, and well-being of people who exchange sex for money or things of value. Learn more and get involved at **www.new.swopusa.org.**

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[5] Trans, transgender, nonbinary, and genderqueer people define their identities in many ways. Many people, including #Out4MentalHealth staff, use "trans" as an umbrella term for gender-diverse communities.

Participants in the Santa Rosa, Fresno, and San Fernando Valley Town Halls specifically spoke about the Federal SESTA-FOSTA (Stop Enabling Sex Traffickers Act and Fight Online Sex Trafficking Act). While supporters of the SESTA-FOSTA claim its purpose is to combat sex trafficking, in reality the Act removes the opportunity for sex workers to have discussions about safety, develop safe networks, and screen potential clients online, and use other safeguards to protect themselves and each other—such a removal increases the risks associated with sex work.

"The fact they took ads off Craigslist and Backpage puts our communities at risk, especially trans women and people who don't have documentation. This is making sex work more dangerous by pushing people back out onto the streets."

"Sex workers are being forced back into street-based sex work. It increases risk of violence, criminalization, [and] police surveillance."

"We got trans women who've escaped here from their home countries, and there's only so much we can do for them. Since they don't have papers, they get into sex work."

Community Efforts to Engage in Police Reform

Many participants spoke of their efforts to train local police departments how to show respect to LGBTQ people and build healthier relationships with LGBTQ communities. Some of these efforts have been more successful than others: several activists cited police departments' lack of willingness to engage with communities, whereas law enforcement has been receptive to LGBTQ training in other communities. Recent research by Israel et al. (2017) on LGBTQ trainings with law enforcement identified some level of resistance, (i.e., vocal disagreement or criticism) as well as receptiveness (i.e., active engagement and displays of empathy for marginalized groups). Future trainers of law enforcement may look to such research in planning their curriculum in order to anticipate resistance and receptive responses.

"[Our local] police department fired 45 members for not being supportive of LGBTQ."

"What the police say when you're in their house is horrendous. The county has shut out LGBTQ people, people with disabilities, people of color [from] trying to train the police."

"The police department is unwilling to learn how to respond to homelessness, and the city council isn't listening."

Notably, Governor Jerry Brown signed legislation in September 2018 requiring that peace officers in California receive training on LGBTQ culture, history, and effective ways to respond to cases of domestic violence and hate crimes affecting LGBTQ people (Peace Officer Training Act, 2018). This legislation requires consultation with LGBTQ

members of law enforcement and expert community members to develop and implement the trainings.

"Police don't know how to track or record gender or sexuality-based violence."

"Police cooperation with the LGBTQ community is for show."

"[Our local] police department is more accepting of LGBTQ people and can have positive interactions because they've been trained using curriculum developed by trans people and [trans] organizations."

HOUSING, HOMELESSNESS, AND GENTRIFICATION
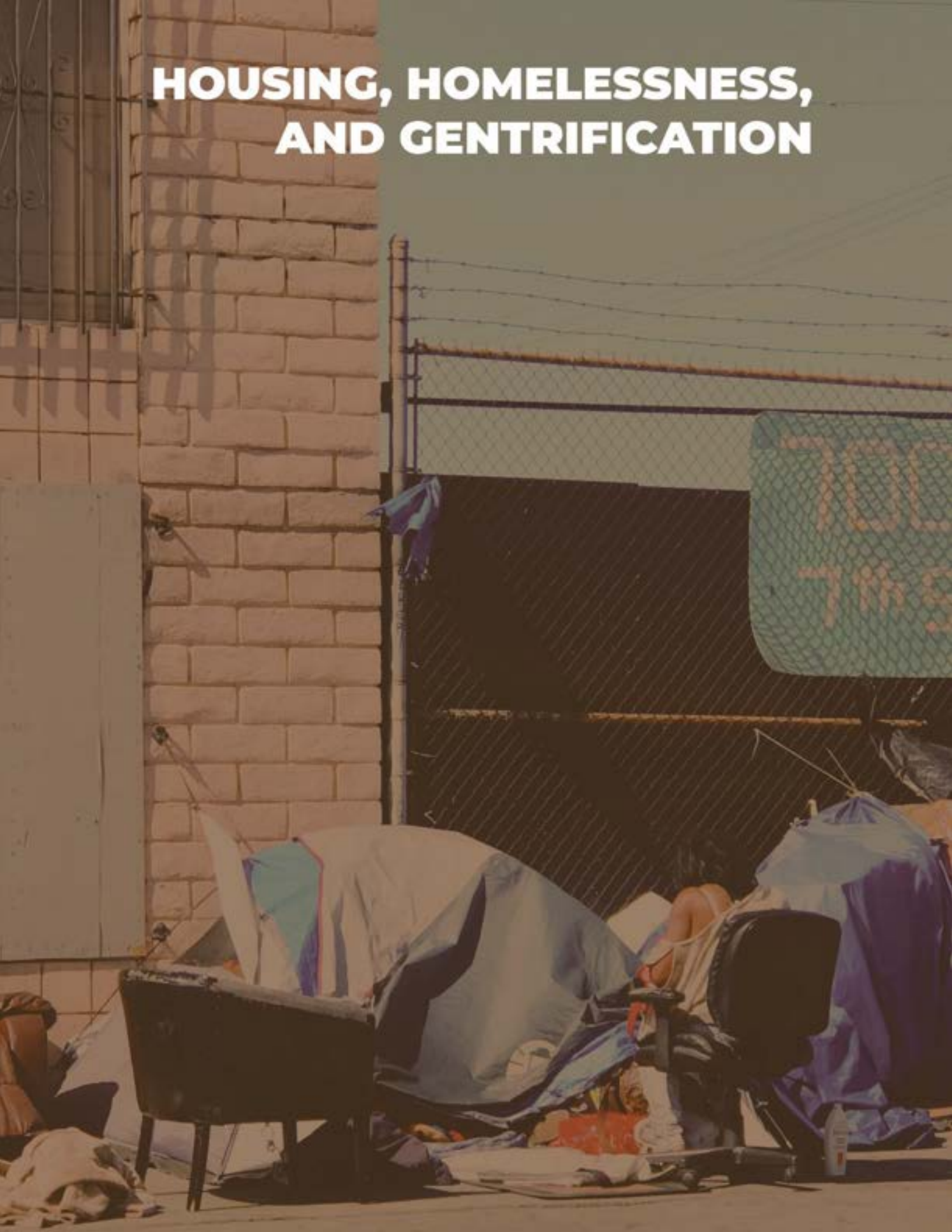
Gentrification and Rising Housing Costs

Many LGBTQ people have historically congregated in urban centers, which served as safer enclaves for those living outside of society's accepted relationship and gender expression norms. Over time, LGBTQ community- and population-oriented services, such as LGBTQ Community Centers and HIV clinics, were established and located in these community hubs, such as West Hollywood, San Francisco's Castro neighborhood, San Diego's Hillcrest area, and Sacramento's Lavender Heights. As acceptance of LGBTQ people has increased over the generations, many LGBTQ individuals integrated into straight and cisgender neighborhoods. Concurrently, traditionally LGBTQ urban hubs have been gentrified and made economically inaccessible to the majority of LGBTQ individuals (Hoy-Ellis, Ator, Kerr, & Milford, 2016).

As LGBTQ people become progressively far-flung from the communities they have built over decades, there is an elevated risk of social isolation, particularly for LGBTQ older adults. Isolation can lead to loneliness, depression (Hoy-Ellis et al., 2016) and risk of suicidality, as well as poor physical health. Both LGBTQ youth and older adults face compounded effects of rising costs for basic living needs, gentrification of LGBTQ community spaces, and their already heightened risk of isolation due to family rejection and discrimination across their lifespan.

Lack of Affordable Housing

Lack of affordable housing was brought up as a barrier by participants at every #Out4MentalHealth Town Hall and Round Table. Many LGBTQ people indicated finding and retaining housing in proximity to their families, support systems, and communities is no longer financially viable. Participants noted how skyrocketing housing costs and

gentrification, issues that impact the economic security of Californian communities at-large, affect them specifically as LGBTQ people. Impoverished and working-class LGBTQ people in need of affirming services may have to travel longer distances to access LGBTQ service organizations, which are often located in historically LGBTQ hubs. While LGBTQ community centers and organizations do their best to serve those in need, Town Hall and Round Table participants across the state voiced difficulties around the distances they needed to travel for services and community-affirming resources.

"Housing and transportation difficulties can create isolation. It can feel like your life has shrunk."

"I want to stay sober with the people I got clean with. There's a lack of affordable [HUD] VASH [Veterans Affairs Supportive Housing] and Housing and Urban Development won't budge on the VASH value"

"In some neighborhoods like [where I live], there may not be LGBTQ-welcoming spaces like schools, libraries."

"You have to wait years on a waitlist and go through a complex process to get into [older adult] housing."

"Porque te rechazan en viviendas, porque no te aceptan en algunos lugares"
("Because they reject you in housing, because they don't accept you in some places")

Anti-Homeless Policies

LGBTQ people experiencing housing insecurity and homelessness may face legal struggles, further pushing them into poverty, as cities and neighborhoods have implemented anti-homeless laws. It has been documented in empirical literature that California cities were found to have more anti-homeless laws on average compared to cities in other states (Fisher, Miller, Walter, & Selbin, 2015). Fisher, Miller, Walter, and Selbin at UC Berkeley's Law Policy Advocacy Clinic (2015) analyzed all municipal codes in 58 of California's cities and found that in *every single municipality*, local ordinances were used to cite, arrest, and place homeless people in jail for harmless daytime activities such as "standing, sitting, or resting at public places" (p. 2); the authors also discovered the ordinances banned homeless people from "sleeping, camping, or lodging in public places" (p. 10) in *all cities except one*. The City of San Francisco's 2017 Point in Time Count found that 30% of homeless people in the city identified as LGBTQ, twice the percentage (15%) of LGBTQ residents in the city (City and County of San Francisco & Applied Survey Research, 2017), indicating that LGBTQ people are overrepresented in the homeless population and therefore may carry a greater burden of these anti-homeless policies.

"Police are targeting people experiencing homelessness.
There's a no-camping ordinance.
There's a $250 fine for collecting recycling or 4 months in jail."

LGBTQ Runaway & Homeless Youth

Data suggests upwards of 40% of runaway and homeless youth (RHY) identify as LGBTQ (Durso & Gates, 2012), with the greatest concentrations as high as 45% in densely urban areas like Hollywood and San Francisco (Rabinovitz, Desai, Schneir, & Clark, 2010). Many LGBTQ youth experience homelessness due to family rejection when they come out or when they are outed to their families. A national sample of providers from LGBTQ RHY-serving organizations reported approximately 68% of LGBTQ youth they serve have experienced family rejection and trans RHY face greater mental and physical health challenges than other homeless youth (Durso & Gates, 2012).

A Homeless Youth Resource:

If you are a runaway or homeless youth or if you know one, call the National Runaway Safe line at **1-800-RUNAWAY or text 66008** to get connected with resources.

LGBTQ youth experience homelessness differently than both their straight and cisgender peers; for example, a study of RHY in Hollywood found LGBTQ RHY face higher risk than non-LGBTQ peers of being robbed, harassed by police, physically assaulted, and raped while on the streets (Rabinovitz et al., 2010). LGBTQ RHY may choose to stay on the street rather than experience discrimination from social services and shelters, where shelter is often gender-segregated, and staff and residents may harbor and act upon anti-LGBTQ attitudes (Macio & Ferguson, 2016). Most shelters do not offer LGBTQ-specific programs such as support groups, legal counsel, and mental

and physical health services, despite the overrepresentation of LGBTQ youth among RHY and the need for culturally specific services (Macio & Ferguson, 2016; Prock & Kennedy, 2017). While youth in general hesitate to go to adult shelters due to risk of violence, this hesitation may be further augmented in LGBTQ youth for fear of bias-motivated violence.

[LGBTQ Service Provider] "When we try to refer trans women to a shelter, they end up leaving the shelter because they are being misgendered [and] harassed."

"At shelters, you can't be trans."

"People who lose housing face discrimination. Homeless services are sex-segregated, so systems don't let us be who we are."

"LGBTQ people experiencing homelessness are isolated if they're not receiving services."

Furthermore, homeless youth—especially those who choose to face the risks of the streets rather than expose themselves to the aforementioned risks of shelters—may face more interaction with law enforcement. Homeless youth are faced with police stops and arrests simply for being a runaway or for violating local policies that target homelessness (i.e., no-camping ordinances, restrictions to park access, or public indecency laws). Such policies disproportionately affect all people experiencing homelessness who may not have regular access to a safe place to sleep or public restrooms.

LGBTQ youth may face rejection from friends, school staff, religious or spiritual communities, and neighbors, as well as families and caregivers. Lacking the options of

safe and affirming family, friends, and youth shelter, LGBTQ youth may begin shoplifting and trading things of value—personal belongings, favors, sex, or drugs—to get food or a place to stay. These survival tactics place LGBTQ youth at risk of exploitation by human traffickers, and of police arrest with subsequent entry into the criminal justice system (CAP, et al., 2016; Polaris Project, 2016).

"There are groups trying to address LGBTQ homelessness,
but many LGBTQ homeless are isolated.
They become homeless and don't know what to do.
Many are college kids. Mental health and family rejection are driving homelessness."

LGBTQ Older Adult Homelessness

LGBTQ older adults who experience homelessness or housing insecurity are facing the accumulation of a lifetime of discrimination. Some LGBTQ older adults come out of the closet later in life and may have lived with long-term stress associated with being closeted. Throughout most of their lives, LGBTQ older adults did not have the right to marry, lost loved ones in the HIV/AIDS epidemic, faced employment and housing discrimination without legal protections or recourse, and experienced family and community rejection, among other barriers. These historical and current forms of oppression result in low economic security, limited or reduced familial resources, and higher risk of chronic physical and mental health challenges for LGBTQ older adults.

"Living day to day when you feel isolated is challenging"

Older adults must juggle their own desires for continued independence, their health, their family members' and caretakers' wishes and needs, and their finances for long-term housing. LGBTQ older adults, especially those of color, who enter assisted living facilities may additionally fear and/or experience the biases of their caretakers and other residents.

A HOUSE DIVIDED

MINORITY STRESS & CONFLICTS IN ALLEGIANCES

Multiple Marginalization

Town Hall and Round Table participants often expressed they do not feel welcomed by other parts of LGBTQ communities and identified how many community spaces have historically perpetuated systems of oppression, such as racism, sexism, ableism, ageism, monosexualism, and cisgenderism. For example, predominantly white mainstream LGBTQ spaces are often criticized for being unwelcoming and exclusive. Gay men can overtly and covertly behave in sexist and sometimes misogynistic ways toward lesbian, bisexual, and trans women. Cisgender lesbians have often excluded trans women. Bisexual individuals are frequently viewed with suspicion by lesbians and gay men, especially if they are in a mixed-gender relationship. Mirroring society in general, many LGBTQ spaces and events do not take into consideration the needs of individuals who require different forms of physical access than their able-bodied counterparts.

Being LGBTQ generally means you share a common experience with other LGBTQ people in our hetero- and cis-normative society. The concept of *minority stress* is used to describe the unique stressors experienced by LGB people which are above and beyond daily stressors (Brooks, 1981; Díaz, Ayala, Bein, Henne, & Marin, 2001; Meyer, 2003; Morales, 1989). In recent years, the model of minority stress has expanded to include discussion of cissexism, sexism, and racism to speak to the unique stressors of multiply marginalized LGBTQ people (Cyrus, 2017; Moradi et al., 2010; Parra & Hastings, 2018). These stressors are community-specific, chronic, socially-based, and anticipated; in other words, these stressors are unique to people's identities or statuses, experienced on an ongoing basis throughout people's lives, and are learned and expected to recur in the future. Minority stressors include experiences of discrimination (such as denial of services), group stigma, and internalized oppression. The effects of these additional and chronic stressors carry implications for people's

psychological well-being (Hatchel, Espelage, & Huang 2017; Hatzenbuehler, 2009; Meyer, 2003; Parra, Benibgui, Helm, & Hastings, 2016; Sandil, Robinson, Brewster, Wong, & Geiger, 2015).   Furthermore, research indicates that the interaction of multiple marginalizations increases the odds of developing mental health challenges. Bostwich, Boyd, Hughes, and West (2014) found discrimination for sexual orientation alone or racial discrimination alone did not predict a mental health challenge, but those reporting both sexual orientation and racial discrimination were significantly more likely to have faced a mental health challenge in the past year.

Made to Choose

Those living at the intersections of multiply marginalized identities, such as queer and trans people of color (QTPOC), may experience a specific sort of minority stressor called "conflicts in allegiances." Conflicts in allegiances, as generally described in the literature, is when a person perceives an incompatibility between their identities due to racism within LGBTQ spaces and heterosexism within their racial or ethnic communities (Santos & VanDaalen, 2016; Sarno, Mohr, Jackson, & Fassinger, 2015), though the concept may be applied to tensions between other identities. QTPOC, as well as other people with multiply marginalized identities, may feel they need to choose between communities and their choice of one community is a betrayal of the other; high levels of this conflict has been connected with higher risk of depression symptoms (Santos & VanDaalen, 2016). These conflicts do not indicate a higher level of heterosexism in racial or ethnic communities than among white people. To the contrary, and despite long-standing stereotypes of communities of color being more heterosexist than white people, research indicates that perceived heterosexist stigma, internalized homophobia, and degree of outness are not concentrated issues in communities of color, and communities of color and white people share more

commonalities in these struggles than differences (Meyer, 2010; Moradi et al., 2010). The conflicts in allegiances should therefore not be understood to mean QTPOC experience any greater exposure to heterosexism in communities of color. Rather, heterosexism may carry different weight for QTPOC when it comes from their own community, which they rely on for social support in dealing with the effects of racism.

"If you're a person of color, you don't have bars to go to,
and WeHo [West Hollywood] isn't so welcoming."

*"A lot of the community here is Latino and the reality is there's a lot of **machismo.***
People don't want to talk about it. Machismo exists in every culture—
how you have to act when you're a boy, a man...
Have a husband or a wife and then you can leave your family's house.
I love to be a man, I just love other men."

Some research on conflicts in allegiances with LGB people of color indicates a correlation between higher commitment to LGB identity and lower levels of depression (Chen & Tryon, 2012; Santos & VanDaalen, 2016). Other research supporting a resilience perspective has proposed that LGBTQ people of color may benefit from a kind of inoculation against internalized homophobia and heterosexist stigma, in the form of social supports or a "sense of mastery" and ability to handle discrimination (Meyer, 2010; Moradi et al., 2010).

"There's not many resources for QTPOC.

It's an extra challenge to be in a white county."

¿Cuáles crees que son los retos más grandes que QTPOC enfrentan en SFV y LA?

: "La comunidad"

: "Discriminación, por el género y raza"

: "Enfrentarse como gay a la sociedad"

(What are the greatest challenges facing QTPOC in San Fernando Valley & LA?

: "The community."

: "Discrimination, for race and gender."

: "Facing/Confronting society as a gay person.")

"Lack of racial diversity makes it difficult for me to know if I can be out.

I'm about the only person of color in the room,

do I also want to be the only queer person in the room?"

Trans-negativity

There is no true movement for sexual and gender justice without trans and nonbinary people. However, the T in LGBTQ has often been silenced or has been included in the acronym only for the semblance of inclusion. The T in LGBTQ is often included without funding and programming tied specifically to work on gender. The effect of cissexism within LGBQ communities carries historical and current implications for trans and nonbinary health. For example, some argue that the shifting priorities of lesbian and gay struggles for equality since the 1960s have only recently been inclusive of the needs and experiences of trans and nonbinary people. Likewise, leadership and staffing of LGBTQ advocacy organizations and nonprofits does not always reflect the gender diversity of LGBTQ communities. Gay bars and social environments have traditionally been designed exclusively for cisgender gay men and lesbian women. Trans and nonbinary people have ample reason to not feel included, and this sense of not being welcome constitutes its own form of stress.

"Gay boys don't know about trans communities."

"Even in LGBTQ spaces, nonbinary isn't talked about."

Bi-negativity

Bisexual/pansexual/sexually fluid (bi/pan/fluid) people also experience a specific form of oppression, which may be referred to as *monosexism*—the idea that attraction to a single gender (i.e., being strictly straight, gay, or lesbian) is more legitimate and trustworthy than being attracted to two or more genders. Bi/pan/fluid people face

social stigma based on erroneous assumptions, such as negative views of sex and/or that bi/pan/fluid people are attracted to all people, cannot be trusted in relationships, or do not fully understand themselves or their attractions (Israel & Mohr, 2004). As with trans people, LGBTQ-designated and generic community-based services typically do not offer bi/pan/fluid-specific services, and bars and common spaces often cater specifically to monosexual people. Just as LGBTQ people are raised with internalized homophobia, transphobia, and sexism as members of this society (DiPlacido, 1998; Green, 2004; Meyer, 2003; Otis, Rostosky, Riggle, & Hamrin, 2006), they also learn to distrust bi/pan/fluid people and to act upon monosexist stereotypes. Bi/pan/fluid people facing discrimination related to their sexual orientation may not feel welcome in gay and lesbian communities, effectively reducing access to community resources that would otherwise buffer the toxic effects of these stressors. Recent research indicates bisexual individuals have lower social well-being, or a low sense of fitting within their social environment, compared to gay men and lesbians, which is largely mediated by community connectedness and sexual identity salience (Kertzner, Meyer, Frost, & Stirratt, 2009).

"People build walls, but not everybody is one thing or another."

*"I've been out here since '74. Gay men
have been dismissive of bi and trans communities.
People don't give the time of day to understand each other."*

Intergenerational Divisions

LGBTQ older adults spoke to their sense of isolation from younger LGBTQ generations. Some spoke to changing neighborhoods, others spoke of ageist ideas of value and beauty, and still others feared their stories and lives would be forgotten. Given that LGBTQ people typically grow up in heterosexual and cisgender families and communities, LGBTQ communities rely upon intergenerational ties, education systems, and community resources to learn about LGBTQ history and the important work of older generations.

"Gay bars have vanished. When you're older, if you don't have a perfect face or body, you're a ghost, you're invisible."

"[We need a] strong presence of older [LGBTQ] people who are willing to mentor and help people step up and take a leadership role."

"If that invisibility isn't broken, our story dies with us."

"Because of the age gap, I, at 19, am not friends with older people who know what services exist."

"In the LGBTQ community, every letter is separate."

Sharing Stories:

Diverse Elders is a coalition of five national organizations, including SAGE (Services and Advocacy for Gay, Lesbian, Bisexual, and Transgender Elders), where older adults share their stories. Visit DiverseElders.org to learn about LGBTQ living and recent history, connect with older adults, and share your own stories.

Strength in Community

All LGBTQ people deserve the same sense of community, love, affirmation, and access to support. Town Hall participants expressed a desire for community support, a sense of belonging, healthy and out role models who look like them, and to live in communities with a common understanding of and commitment to each other. Many participants spoke of LGBTQ community centers providing life-saving supports. Having access to social support systems from communities and families is a key factor in promoting a sense of belongingness and potentially reducing the risk of suicide (Hill, Rooney, Mooney, & Kaplow, 2017). Research indicates (LGB) peer support could be a buffering factor for LGB young adults who perceive their families' attitudes toward LGB as negative or who have experienced family victimization (Parra, Bell, Benibgui, Helm, & Hastings, 2017). For youth ages 18-21, LGB peer support, in particular, is identified as being informed and affirming as compared to support from heterosexual friends and family (Doty, Willoughby, Lindahl, & Malik, 2010).   Where the stress of potential or actual community rejection may have consequences to a person's health and well-being, community-based supports are important resources in buffering the negative effects of these social prejudices (Doty et al., 2010; Hill et al., 2017; Parra et al., 2017; Kwon, 2013).

"Coming to [the local LGBTQ center] saved my life."

"[The local LGBTQ center] fosters community connections and makes it easier to build friendship and find support."

"I joined an LGBT bowling group. We can be ourselves out in public. I was nervous it would be gays and lesbians and I wouldn't feel welcome, but it was open arms."

"Being at the [local LGBTQ center] gave me a place where I feel accepted. [As someone in a hetero-appearing relationship] I can be honest with myself and I can connect with bi people who share my experience."

"The [LGBTQ] Community is visible in [local area] and that makes it easier for individuals to be visible themselves."

SCHOOLS

Beyond Sticks and Stones

While there may be differences by age and grade, most youth spend numerous hours attending school. School climate, interactions with staff, and peer relationships can all have an impact on the mental health and well-being of LGBTQ students (Kosciw, Greytak, Giga, Villenas, & Danischewski, 2016)—much more so than on their heterosexual counterparts (Denny et al., 2016). Research shows LGBTQ students (and those perceived to be) are exposed to varying degrees of victimization in school, including verbal, physical, and sexual harassment (Kosciw et al., 2016). Higher levels of victimization have been shown to increase the likelihood of depression, suicide attempt(s) (Hatchel et al. 2017), missing school, lower grade point averages, not pursuing college or other post-secondary education, and having lower self-esteem (Kosciw et al., 2016). LGBTQ students who see the victimization of their peers based on their identity or expression may come to anticipate or fear being victimized themselves (D'Augelli, Pilkington, & Hershberger, 2002). Victimization can occur from other students, staff, or both (Dragowski, McCabe, & Rubinson, 2016), as well as from discriminatory school policies (Kosciw et al., 2016), indicating that simply having anti-bullying policies is not enough to protect LGBTQ students from harm.

Challenges Advocating on Behalf of LGBTQ Students

Parents attended several of the Town Halls and provided insight into their experiences advocating for themselves and on behalf of their children in schools. Some of these parents identified as LGBTQ themselves and others were straight and cisgender parents advocating for the well-being of their LGBTQ children. Collectively, these parents identified struggles with school bureaucracies and some instances of overt hostility from school administrators in regard to anti-bullying programs and LGBTQ-supportive initiatives. There was a recurrent theme among parents where schools gave in to the pressure of anti-LGBTQ parental advocacy; in other words, other parents would complain about LGBTQ-inclusive school curriculum or the implementation of a climate survey and the school would subsequently shut down the new initiative.

"As a bi parent, I face discrimination with schools. My daughter has faced stigma from staff and principal."

"There's no bi-sensitive trainings for K-12 staff. I worked in schools and had to threaten lawsuits for derogatory language and hiring discrimination."

"LGBT questions were removed from climate surveys at [School District] because a parent complained."

"I've been with PFLAG for 15+ years. It's impossible to get into schools despite our outreach."

You have the right to be protected in school:

"Under state law, public schools and non-religious private schools that receive state funding have a legal duty to protect students from discrimination and harassment on the basis of actual and perceived sexual orientation or gender identity, or on the basis of association with a person with one or more of these actual or perceived characteristics" (California Safe Schools Coalition, 2016).

Bathroom Access

Access to bathrooms and locker rooms in schools is a protected right in California. Furthermore, California adopted the Equal Restroom Access Act (2016) two years ago, requiring public and private facilities mark single-stall restrooms as all-gender. Many schools across the state have made swift changes to ensure their staff understand the rights of students and to modify restrooms as soon as possible.

A Student Right:

A pupil shall be permitted to participate in sex-segregated school programs and activities, including athletic teams and competitions, and use facilities consistent with his or her gender identity, irrespective of the gender listed on the pupil's records (Cal. Ed Code § 221.5, 2015).

However, some schools have not made these required changes. During #Out4MentalHealth Town Halls and Round Tables, community members shared their

recent experiences of schools not honoring their students' rights under the law. Even when schools are in compliance with the letter of the law, they may not be following the "equal access" spirit of the policy. For example, one high school student shared that their school provides a facility for them to change before and after gym, and yet the facility is on the opposite side of campus away from where everyone else changes and far from where class starts. Whether or not it was intentional on the school's part, the student was divided out from their peers, their gender identity was amplified by having to go across campus, and the additional walking distance meant they were more likely to be marked tardy for class.

"As a high school student, there's a lot of issues with bathrooms. There's only one gender-neutral bathroom on campus, you have to get permission to use the restroom because it is a staff bathroom. It makes going to the bathroom a big deal."

Inclusive Climate & Visibility

An LGBTQ-inclusive school environment benefits all students, especially LGBTQ students who may be facing rejection by their families, religious or spiritual communities, or other off-campus environments. Research indicates peer victimization does not fully account for LGBTQ students' higher risk factors for negative mental health outcomes. This suggests anti-bullying programs alone do not address these disparities, but rather schools need to address their environment as a whole in order to reduce suicide-related risks (Robinson & Espelage, 2012). Research also indicates (LGB) peer support could be a buffering factor for LGB young adults who perceive their families' attitudes toward LGB as negative or who have experienced family victimization (Parra et al., 2017). An inclusive school climate encourages positive peer support.

Additionally, openly LGBTQ staff who are engaged in school activities, active LGBTQ organizations such as Gender and Sexuality Alliances (GSAs), and LGBTQ-inclusive policies, curriculum, and building structures (i.e., trans youth being able to conveniently access restrooms in accordance with their gender identity) are just a few examples of what constitutes a supportive and inclusive school environment in California.

"Local GSAs and student clubs help youth be who they are."

"We're the first county to have a high school prom king and queen who are trans."

"More 'out' staff in schools creates affirming school environments."

"We've had supportive agencies like schools that make it easier [to do] LGBTQ-affirming work here."

Sadly, many schools and districts—and the people working and studying within them—are not LGBTQ-inclusive, presenting serious hindrances to the intellectual, mental, socioemotional, and physical well-being of LGBTQ and gender nonconforming youth, as well as youth who are perceived to be LGBTQ or gender nonconforming. The testimonials of Town Hall and Round Table participants highlight the role of secondary schools in the development of healthy adolescents and adults, with the potential of making significant contributions to society. Schools are more than just a learning environment—they are a second home where peers, including LGBTQ youth, can interact with each other, form lasting friendships, find and look up to positive role models, grow together, and discover acceptance for who they are.

"[We need] more visibility for LGBTQ people in schools. Schools aren't buying LGBTQ-inclusive text books, so teachers have to decide to incorporate LGBTQ info. There's no training or support for LGBTQ inclusion."

"High schools may include tokenized info about LGBTQ people, [like] high rates of STDs/HIV."

The FAIR Education Act gives you the right to an inclusive and affirming education:

§ 51204.5. Instruction in social sciences shall include the early history of California and a study of the role and contributions of both men and women, Native Americans, African Americans, Mexican Americans, Asian Americans, Pacific Islanders, European Americans, lesbian, gay, bisexual, and transgender Americans, persons with disabilities, and members of other ethnic and cultural groups, to the economic, political, and social development of California and the United States of America, with particular emphasis on portraying the role of these groups in contemporary society.

§ 51500. A teacher shall not give instruction and a school district shall not sponsor any activity that promotes a discriminatory bias on the basis of race or ethnicity, gender, religion, disability, nationality, or sexual orientation, or because of a characteristic listed in Section 220.

§ 51501. The state board and any governing board shall not adopt any textbooks or other instructional materials for use in the public schools that contain any matter reflecting adversely upon persons on the basis of race or ethnicity, gender, religion, disability, nationality, or sexual orientation, or because of a characteristic listed in Section 220 (FAIR Education Act, 2011).

FAMILIES

The Harm of Rejection

Family support, particularly from parents,[6] is crucial to the mental health and well-being of LGBTQ youth and young adults. Research indicates LGBTQ youth who grow up in highly accepting families have greater self-esteem and better health as young adults than those who grow up with low to moderate acceptance (Ryan, Russell, Huebner, Diaz, & Sanchez, 2010). In contrast, parental rejection can have devastating consequences, including elevated rates of suicide attempts, depression, and likelihood of [illegal] substance use (Ryan, Huebner, Diaz, & Sanchez, 2009), as well as higher levels of distress and risk for other negative mental health outcomes (McConnell, Birkett, & Mustanski, 2016). Additionally, parental rejection is associated with lower frequency of condom use and higher incidence of positive HIV status (Wilson, Iverson, Garofalo, & Belzer, 2012).

LGBTQ youth placed in the child welfare system also experience negative consequences when faced with rejection from their resource parents.[7] In a study by McCormick, Schmidt, and Terrazas (2015), LGBTQ foster youth expressed feelings of shame, loneliness, and confusion regarding rejection from their resource parents. As a result, they were also much more reticent to discuss personal issues with their resource parents or other adults and professionals in their lives (McCormick et al., 2015).

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[6] In this section, the term parents refers to anyone acting in a parental role, including legal guardians, caregivers, and resource parents.

[7] In 2016, California passed the Resource Family Approval Act, vastly restructuring the Child Welfare System. Formerly known as Foster Parents and Foster Homes, Resource Parents and Resource Homes, which include kinship homes, are required to undergo a standardized approval process and continuing education.

The Rights of LGBTQ Foster Youth:

In California, current and prospective resource parents are required to receive 12 hours of annual resource parent courses that includes training on:

1. The rights of foster youth to be free of discrimination on the basis of actual or perceived sexual orientation, gender identity, sex, and HIV status;
2. The cultural needs of LGBT children, cultural competency, and sensitivity; and
3. Child and adolescent development of sexual orientation, gender identity, and expression (Resource Family Approval Act, 2016).

The majority of LGBTQ individuals are born to and/or are raised by heterosexual and cisgender parents, who are typically not connected to LGBTQ communities. Parents may therefore hear, believe, and repeat anti-LGBTQ messages, and their support systems may not be LGBTQ-affirming. Therefore, parents often go through their own journeys when they realize they have an LGBTQ child, including feelings of shame, anger, blame, guilt, sadness, grief, and fear for their child's safety (Brill & Kenney, 2016; Brill & Pepper, 2008; Herdt & Koff, 2000). These experiences are understandable given how a child coming out can shift parents' expectations, and such feelings can present challenges to being a caring and affirming parent. Many parents would benefit from positive support resources that allow them to process their feelings without their children present, thus honoring their own journey without negatively affecting their LGBTQ child.

Support for parents of LGBTQ children—places to start:

1. PFLAG: **www.pflag.org** (find a chapter near you)
2. Family Acceptance Project: **familyproject.sfsu.edu**
3. Gender Spectrum: **www.genderspectrum.org**

Most parents are not taught how to best respond to their child coming out as LGBTQ or other non-heterosexual or non-cisgender identities, feelings, or expressions. Even when coming from a place of love, parents can send messages their children perceive as mildly to severely rejecting. For instance, parents who believe being LGBTQ is a negative outcome may be concerned that others have influenced their child and, in turn, may feel blocking access to LGBTQ friends or resources is a reasonable measure to keep their child "safe." However, research shows this action is "just as harmful as physically beating a gay or transgender child" (Ryan, 2009, p. 8). Other examples of harmful rejecting behaviors include: blaming the child's behavior as the cause of bullying; excluding the child from family events; asking the child to keep their identity secret; telling the child they will be punished by God for being LGBTQ; and pressuring the child to behave, act, or dress in a gender conforming manner (Brill & Pepper, 2008; Ryan, 2009). As stated above, even though parents may act from a place of love, these and other rejecting behaviors can create devastating outcomes for their children as they grow into adulthood.

"I belong to a conservative white family; there's a lack of awareness of what LGBTQ people face.... There's a belief that LGBTQ people and communities are all about sex."

*"In response to my [bi]sexuality, my dad said he would understand if I were gay.
He said he doesn't want me to be the 'hookup kid.'
Mom said, 'I understand the concept, but I don't get it.'"*

Children may respond to these rejecting behaviors by developing a negative LGBTQ identity, which may lead to internalizing problems such as developing depression or a sense of inadequacy (Willoughby, Doty, & Malik, 2010). For example, a child told there is something wrong with them may learn to think negatively of their own identity and believe their sexual orientation or gender identity should be kept a secret; this in turn may lead to anxiety or shame. Town Hall and Round Table participants repeated a common refrain that they had the sense their identities were a shame on the family.

*"When you come out to family, it's different, with machismo in the family.
They don't mind someone else's kids, it's when it's in the family."*

*"There's fear of 'what will the neighbors say?' They call us faggots, **maricon**."*

*"Family will accept anyone else who comes out,
but it's different when it's your own family."*

The Hope of Affirmation

Studies indicate parental acceptance of LGBTQ children is a key factor in mitigating risk for depression, suicide, drug use, psychological distress, and other negative outcomes (Ryan, 2009; Snapp, Watson, Russell, & Ryan, 2015; Wilson, Chen, Arayasirikul, Raymond, & McFarland, 2016). Research also indicates parental acceptance is associated with positive outcomes for LGBTQ youth and young adults (Ryan et al., 2010; Snapp et al., 2015), and may be the most influential type of positive social support (Snapp et al., 2015). While childrearing education is provided to parents by pediatricians, schools, religious institutions, media, friends, and family, they are rarely given information on how to parent an LGBTQ child with acceptance and affirmation. Educating parents regarding the benefits of acceptance and the consequences of rejection may be one of the most important interventions for improving the health and well-being of LGBTQ youth and young adults (McCormick et al., 2015; Ryan et al., 2010).

HEALTH CARE
ACCESS

Finding and Getting to Care

Accessing health care remains a serious issue for many LGBTQ community members, especially for queer, trans, and questioning people in need of health care (Macapagal, Bhatia, & Green, 2016). Research focusing on how state-level political orientation influences geographic difference in health care access cited California as having the second-lowest likelihood for trans people experiencing care refusal in comparison to other states (White Hughto, Murchison, Clark, Pachankis, & Reisner, 2016). While this may be true at a statewide level, the testimonials of Town Hall participants speak to their difficulties accessing health care in varying local political environments within California.

A sizable proportion of therapists are not adequately trained or even willing to serve trans clients, and several trans people spoke of their difficulties in finding therapists who could provide the much-needed quality support. In addition to inaccessibility of gender affirming mental health care, clinics providing competent medical care, such as hormone replacement therapy (HRT) or gender confirmation surgeries, are not readily accessible to many trans Californians. Trans people residing in areas outside of major cities, such as San Francisco and Los Angeles, will often travel long distances and at great cost to receive the care they need. At #Out4MentalHealth events in rural and semi-urban areas of California, attendees spoke of organizing fundraisers or carpooling multiple patients to save money. The cost in travel, co-pay, and medical fees for mental and medical health care remains prohibitive for many trans and nonbinary people.

"You have to go over the mountain to get HRT [Hormone Replacement Therapy]."

"We have to refer trans youth to Planned Parenthood [in a different city because our local one] doesn't have a doctor in the area [who can provide trans services]. Kaiser and Planned Parenthood are the few places to offer transgender services."

Trans Youth Access to Confidential Health Care

People up to age 26 who are on their parents' insurance face specific barriers to accessing the mental and physical health care they need. One of the most consistently cited barriers for youth who attended #Out4MentalHealth Town Halls and Round Tables is maintaining privacy from parents who may disapprove of, limit access to, or not authorize the medical and mental health care they are seeking or receiving, despite the fact youth have a protected right to access health care. While transportation is a barrier for trans patients in general, it is especially salient for youth who may not have a car, a job or any savings, or who cannot take time off from family and school without it being noticed, questioned, and sanctioned by parents.

Youth Rights to Confidential Health Care:

If you are a youth on your parent(s)' insurance and you want to access health care privately, visit MyHealthMyInfo.com to find answers to your questions and to fill out a Confidential Communication Request Form.

Youth of any age in California have a right to confidentially receive birth control, emergency contraceptives, abortion services, and prenatal services. Youth ages 12 and older are also entitled to confidential HIV/STI testing, diagnosis, and treatment.

Youth have the right to access all those services without parental knowledge and consent.
Trans youth in foster care have a right to access gender-affirming mental health services and health care under AB 2119, passed in law as of September 2018 (ACLU California & ACCESS Women's Health Justice, 2018).

"As a trans male, it's hard to find resources. I don't know where to start to seek support. There should be more people who know the ins and outs, so I don't have to rely on Google. And I can't access services without fear of my family finding things out or knowing where I'm going for care."

"I have no idea where to start and I know I'm not the only one. I can't find resources if I'm interested in transitioning. If I'm still on my parents' insurance, how can I get help without alerting them? I can't get to San Francisco; I can't get to LA on a moments' notice."

"For LGBTQ youth under age 18 who aren't out to parents, it's hard to get care without parents finding out. It would be great for youth to access private care without having to come out to parents."

"Transportation is a barrier for youth trying to access services that their parents can't know they get."

REJECTION
BY PROVIDERS

Forms of Rejection

In 2011, the LGBTQ California Reducing Disparities Project Community Survey asked LGBTQ community members whether they had faced rejection from various providers (Mikalson et al., 2012). Following publication of these findings, many providers asked, "Well, how do you know the providers were being rejecting?" and "Are you sure that they [LGBTQ clients/patients] weren't misinterpreting or overreacting?"

Some providers engage in practices which may not be extreme or overtly rejecting, but nonetheless cause harm. In a paraphrase of psychologist Dorothy Riddle's 1996 development of the Riddle Scale, Hunter (2005) described the perspectives which can inform the harmful practices of providers, with specific regard to sexual orientation:

- *Pity*: Practitioners view heterosexuality as preferable to any other sexual orientation. Persons who cannot change their lesbian, gay, or bisexual orientation or seem to be born that way should be pitied.
- *Tolerance*: Practitioners tolerate same-sex or bisexual orientations as just a phase of adolescent development that eventually will be outgrown. These practitioners treat those who do not outgrow this "phase" or are "immature" in their development with the protectiveness and indulgence one might apply to a child.
- *Acceptance*: Practitioners say they accept LGB persons. Thinking that they have to accept them, however, implies that these clients have a "problem."
- *Liberal*: Practitioners are friendly with LGB persons but have not thought beyond this to how they are still biased. They display heterosexist bias, for example, when they take for granted the privilege associated with heterosexual status (p. 137-138).

In light of these provider perspectives and the doubts expressed by providers following the publication of *First, Do No Harm* Report, #Out4MentalHealth asked Town Hall and Round Table participants to describe how their providers have been rejecting and/or affirming to them specifically as LGBTQ people. The following narrative accounts and quotations by Town Hall and Round Table participants provides insight into how providers reject and discriminate against LGBTQ clients, intentionally or unintentionally.

My Provider Refused to Test Me for HIV or Provide PrEP

HIV testing is a commonplace preventative health practice that should be accessible to all regardless of identified risk, and is available in many private medical offices and community health clinics. Pre-Exposure Prophylaxis (PrEP) is a pill taken daily for HIV prevention, and is prescribed to patients who have tested negative for HIV and commit to being tested for HIV, sexually transmitted infections (STIs), and liver and kidney functionality every three months prior to and during active use of the prescription (Centers for Disease Control [CDC], 2018). The prescription is available on some, but not all, insurance plans; as it is under patent, it has become costly and unattainable without insurance coverage (Luthra & Gorman, 2018).

Learn More About PrEP:

Visit **pleaseprepme.org** to find information about PrEP, a directory of providers throughout the country who are known to prescribe PrEP, and resources for providers who would like more information to be able to prescribe it themselves.

Some patients stated their providers outright refused to test for HIV with excuses that it was not medically necessary or the test was not available, while others requesting access to PrEP under the brand of Truvada discovered their providers did not know what PrEP is or refused to provide PrEP treatment.

[When asking for PrEP] "They were morally opposed to the concept [and said] you shouldn't be having unprotected sex. [My doctor told me to] tough it out."

HIV disproportionately affects men who have sex with men (whether they do or do not identify as gay, bisexual, or queer) and transgender women, predominantly those of color. The HIV infection rate is also highly concentrated among sex workers and intravenous drug users, many of whom identify as members of LGBTQ communities. Apart from the epidemiology of HIV, there is a long history of HIV-related stigma that may prevent people from seeking testing and treatment, and their providers' individual decisions to deny care contributes to that stigma. The refusal of preventive and responsive care is in defiance of state, national, and international commitments to ending the HIV epidemic through increased testing of at-risk populations, expanded use of treatment as prevention, and continuity of care for people living with HIV (California Department of Public Health [CDPH], 2016; White House, 2015; UNAIDS, 2016).

"[My provider asked me] 'Why do you need an HIV test?' I got to see their notes for the referral and they said 'high risk due to homosexual activity.'"

"Cuándo te rechazan] Porque seas gay, o tengas enfermedad."

("When they reject you] because you are gay, or sick")

"Doctors judge and ask: 'why are you sleeping with so and so?'"

My Provider Treats Trans People as Curiosities

Many trans and nonbinary people commented their providers ask superfluous questions and examine their bodies out of curiosity rather than necessity. Community members said they were made to feel like an object rather than a person receiving care. People forgo mental and medical care for many reasons. The stress of needing care and being treated as an object or curiosity is enough to discourage anyone from accessing care in the future. Trans and nonbinary people, especially those living in rural areas, may have extremely few options of providers who they can trust to treat them with dignity.

"If I have a cough, I should not have to take my pants off."

"My provider didn't address my issues, [they] focused on my being trans.
I felt like a curiosity."

My Provider Lacks Balance

Providers who are aware their client identifies as being LGBTQ either focus too much or too little on their patient's sexual orientation or gender identity, especially in the identification of risk factors for health outcomes. Respondents stated they want their provider to have an awareness of LGBTQ-specific needs, recognize their identities, and ask about their experiences in a nonjudgmental manner. In the same vein, the respondents also stressed they do not want their providers to overemphasize their identities or assume their needs fall within biased assumptions (i.e., "all gay men have HIV," or "all trans women are sex workers").

"Providers are either fully focused on you being trans or they completely ignore it. There's no balance."

"After I talk about being trans, health providers don't take me seriously about other health needs."

[En tu experiencia, ¿cómo es que un proveedor te hace sentir aceptado?]
"Que no le importe, mi género y raza y también el idioma"
(What makes a provider feel affirming?
"When they don't care about my gender, race, or language.")

Well-intended attempts to create a welcoming environment for new LGBTQ patients with the claim of being able to serve them (despite a lack of reputable training or experience with LGBTQ patients), or the expression of excitement at finally having an LGBTQ patient can backfire and harm patients.

"I've had experiences where doctors say 'Oh, you're gay?
You're my first, you're like a unicorn.' I need my provider not to go overboard."

"Clinics will say: 'We're gay or trans-friendly,'
but I call up and they say: 'Oh, you'll be my first trans patient!'"

My Provider Doesn't Respect My Relationships

Providers working from a *heterocentric* perspective, which assumes heterosexuality to be the "default" sexual orientation and places greater value on heterosexual relationships and norms, may intentionally and unintentionally cause harm to their clients. Providers relying upon stereotypes of LGBTQ relationships may base their work on the false assumption that LGBTQ relationships are all about sex. Such assumptions can lead to misunderstandings in the provision of health services, as well as harm to the client.

[My doctor said,] "Here's info about contraception
if you ever get in a 'real' relationship."

"My gynecologist asked me: 'Do you have a boyfriend?' and I said: 'No.'
So then [my doctor asked]: 'Are you sexually active?' I asked: 'How?'
And they specified: 'Penetrative.'
And I asked: 'Penetrative with WHAT?'
They were annoyed when I corrected them."

Still other providers are dismissive of their clients' partners. Community members at Town Halls and Round Tables mentioned providers refusing to mirror the

language they use (i.e., partner, girlfriend, boyfriend, wife, husband) or acting rudely to partners when accompanied to receive care.

"It's a decision on their part not to use the language I use, like saying 'friend' when I say partner. [It's] a passive-aggressive way to say 'I don't agree with that.' It shuts down my willingness to seek care and be open."

"I've experienced providers being dismissive of significant others. A couple times in my past, people have responded negatively when I'm with my partner as she seeks care."

Patients Have the Right to a Support Person of Their Choosing:

According to the California Hospital Association, patients in California who are in no condition to make decisions for themselves have the right to choose a support person or visitor while hospitalized. Hospitals may not discriminate based on your relationship with the person by blood, marriage, or domestic partnership, or on the basis of gender identity or sexual orientation (California Hospital Association, 2017). Read more about your rights as a hospital patient at **www.calhospital.org/patient-rights.**

My Provider Abandoned Me

Where some well-intended providers make claims of their ability to work with LGBTQ clients despite their lack of training, other providers will simply end or discontinue care with excuses of lacking expertise or lacking knowledge of in-network or out-of-network providers for patient referrals.

"I had a doctor tell me when I was in mid-transition,
'I'm overwhelmed, I haven't been trained, and I don't know how to treat you.'
I felt lost, like I'm never going to be able to get treatment."

"They say 'I don't have experience with that' and then you don't get a referral.
Providers are often not solutions-oriented,
they don't take the extra step to get me care."

"I had to train my therapist's assistant to write the letter so I could get surgery."

My Provider Requires Me to Take a Pregnancy Test

Depending on the system they work in and the services they provide, medical providers are often instructed by their hospital or medical group to test pubertal / premenopausal patients with uteri for pregnancy. This is to ensure a fetus is not accidentally harmed by a medical test or procedure. Unfortunately, the majority of medical staff do not understand this practice can feel very rejecting to patients who identify as lesbian, state they are in same-sex relationships, and/or report not being exposed to sperm.

Many LGBTQ people have experienced rejection throughout their life by having their identities, relationships, and behaviors dismissed or belittled. Therefore, when a female patient states she is lesbian, in a same-sex relationship, etc. as a means to communicate they cannot be pregnant, the provider's insistence the test is still required is often perceived as either dismissive or distrusting. This feeling of rejection is compounded when the patient is then faced with having to pay for a test they believe is unnecessary.

While it is true in general that female patients may be unknowingly pregnant, providers need to understand the rejection they may be transmitting when communicating about pregnancy tests. Patients should be allowed to sign a waiver stating they are not pregnant and understand the risks of abstaining from the procedure. If providers are not comfortable with forgoing a pregnancy test, they should incur the cost of the test and not require the patient to take on the expense. At the very least, providers need to be aware why an LGBTQ patient with a uterus may be quite offended by the insistence of a pregnancy test and communicate with them in a way that will ease that rejection.

"My provider was making me pay for a pregnancy test. 'I'm not paying for that.' I've got my gold star—I'm the out-est lesbian in town!"

"[I've been] forced to take a pregnancy test. [My provider] wouldn't believe that there's no way I could be pregnant."

My Provider Doesn't Believe I'm Bi / Pan / Fluid

Providers may rely upon bi-negative attitudes in their practice, such as false assumptions that bi/pan/fluid identities are transitional or imply a lack of self-knowledge, or that bi/pan/fluid people are untrustworthy, hypersexual, or confused. One major effect of bi-invisibility is that many of these negative attitudes remain unchallenged, to the extent that providers think these assumptions are the basis for accurate guidance in their practice.

"The second you say bisexual [to a provider], there's this shame, there's an assumption that you're dirty. You see their facial expression and then there's the interrogation."

"A psychiatrist asked me, 'What do you think makes you bisexual?' I made sure to find a new psychiatrist."

"I hugged a lesbian friend and a provider made a disparaging comment - 'Oh, you're lesbian again.'"

"My mental health provider said, 'I think you're this, not this,' as if I don't know my own identity."

My Provider Misgenders Me

A person's pronouns can be just as meaningful and important as their name. It can be painful and disorienting to be referred to with the wrong pronoun—and this pain can be especially pronounced if a person has had to fight hard to be recognized as the gender they know themselves to be.

"They deliberately used the wrong pronouns. It makes me feel like I'm not welcome, like less of a human being."

"Pronouns, they don't get it. Even if I tell them, they still say 'she.'"

Many Town Hall and Round Table participants shared their stories of providers and office staff deliberately using the wrong pronouns. On two separate occasions at the Town Halls, parents identified instances when office staff loudly asked about or called attention to the gender identities of their young children who were seeking care.

"I have a trans 11 year old and for the most part things are good, but one provider couldn't wrap their head around it and intentionally messed up pronouns. They weren't even trying."

Being outed as trans or nonbinary in the waiting room, whether intentionally or unintentionally, appears to be a commonplace experience. Office staff and providers regularly call people by "sir / ma'am" to the front desk or call them by the name listed

on legal documents (i.e. insurance card, ID, etc.) to start their appointment. Trans and nonbinary people may face emotional or physical risk when outed in public places, so this action can present serious distress and potential consequences to patient safety. Furthermore, a person's transgender status may be a purpose of care in that office and therefore may be protected information under the Health Information Portability and Accountability Act (HIPAA). The best practice is to not harm the client/patient by revealing their gender identity to the public.

"Doctors take my name as optional.
I shouldn't have to legally change my name to have it respected."

"[I kept being misgendered] even after correcting them
three times in multiple departments. I got a look like,
'Why does this matter to you?'"

"Providers misgender me and don't use my name,
even despite having my pronouns on a name tag."

My Provider Violates My Privacy

Providers have a responsibility to maintain the privacy of their patients' medical information, which may include trans status. HIPAA sets requirements for the correct sharing and storage of health information in the United States. As trans people often (though not always) receive services specifically regarding their trans status, as in transition-related services, their trans status may be protected health information. To reveal such information may therefore be in violation of federal law.

"A clinic staff said out loud to the lobby, 'Mr. ___, I see you had a hysterectomy.'"

Despite these protections, many attendees at #Out4MentalHealth events shared stories of their information being made public, specifically in the waiting room or lobby of a provider's office. In one story, the receptionist raised their voice such that other patients in the lobby could hear. Another person chose not to respond when their provider called them by the name assigned to them at birth, despite giving the provider their chosen name in advance. As mentioned in the previous subsection, parents also shared their experiences of receptionists outing their child in the lobby, compromising the parents' and child's privacy.

"[I want providers to] respect my child's name,
without me having to explain it at length in front of everyone."

Trans patients outed in the waiting room may fear for their safety and may choose to leave and forgo the treatment they were seeking. They may understandably not return to an environment they have discovered to be hostile. Given other barriers trans people face to accessing care, it is important providers and their staff create an environment that welcomes and retains trans people in care.

AFFIRMATION
BY PROVIDERS

Forms for Affirmation

Participants in the Town Halls and Round Tables also spoke of their providers' affirming practices. Some providers make simple one-time changes, like editing an intake form, that make a big difference for LGBTQ patients. Other providers put in greater effort to learn about LGBTQ communities and to consistently interact with their patients in gender affirming and more LGBTQ-competent ways. #Out4MentalHealth hopes providers read the following examples, which came directly from LGBTQ clients/patients in California, and implement some of these ideas in their own practice.

My Provider Treats Me as A Whole Person

LGBTQ people want to be seen by their provider for the entirety of their person, and LGBTQ people seek care for as many reasons as (and maybe more than) straight and cisgender people. Sometimes LGBTQ people seek care for reasons not related to their sexual orientation or gender identity, such as the loss of a family member, recovery from an accident, or unemployment. Providers should not assume an LGBTQ person's identities and experiences have nothing to do with their reason for seeking care (for example, they may have just lost a family member who defended them when they came out of the closet in a hostile family environment), but they should equally not assume that all care sought by LGBTQ people is directly related to their LGBTQ status.

"I just started with a new therapist, she supported me in coming out to a group,
in seeking new experiences as bi, and supported me through my divorce."

Sometimes LGBTQ people seek therapy specifically related to their experiences as LGBTQ people—for example, gender affirming therapy or hormone replacement therapy. Other examples of LGBTQ-specific forms of care include coming out support, dealing with family rejection, or support with integrating LGBTQ and religious identities.

"I had a provider who was good about talking about my faith and my sexuality, and allowed me to explore the connections by asking questions from a faith perspective that didn't make assumptions. My provider was affirming."

Sometimes LGBTQ people seek care that takes their sexual orientation or gender identity into account. It would be an oversight, for example, if a couples' therapist working with a same-sex couple ignored the fact that sexual orientation may play a role in the structure and style of the relationship. Likewise, a patient claiming they have increased risk of HIV / STIs because of their sexual behaviors should be provided with appropriate testing and treatment.

My Provider Uses My Correct Name and Pronouns

Where many people attending the Town Halls told stories of being misgendered, some spoke of provider offices where their pronouns were acknowledged, kept on file, and then used appropriately. Using the correct name and pronouns generally requires provider offices to have two separate data fields in their systems: legal identification used for insurance purposes and the name and pronoun used by the client. Many providers have taken the initiative to make this simple shift because they know it increases the likelihood their trans and nonbinary patients will feel welcome and seek and remain in care. Furthermore, using a patient's correct name and pronouns is, as mentioned previously, often a matter of patient safety and privacy.

"I was with a doctor recently who assumed I was straight.
I corrected him and he recognized it and it was fine and we moved on.
It wasn't a big deal. If they're honest, genuine, and willing to explore that's good."

"Planned Parenthood staff didn't act weird about trans stuff.
They provided privacy and they were knowledgeable. They made it easy."

"I appreciate it when people with privilege or power, like providers or businesses,
say 'I don't know about pronouns or other topics, and I'm willing to learn.'"

Electronic Health Records As a Tool:

The Electronic Health Records (EHR) Working Group of the World Professional Association for Transgender Health recommends several practices that hospital and clinic systems can implement to improve EHRs and better serve trans and gender nonconforming patients. A strong EHR will allow the following:

1. Collection of preferred name, gender identity, and pronoun preference with other demographic information;
2. A means to keep an organ (or anatomical) inventory to document patients' medical transition history and current anatomy;
3. Simple updates to a patient's name, gender, and pronoun selections as they progress in their transition; and
4. Prompt providers with a patient's preferred name and pronouns (Deutsch, et al. 2013)

My Provider Acknowledges My Family

Families form an important foundation of any person's well-being, and so providers should be ready and able to affirm a person's relationship with their family. When LGBTQ people speak of their families—whether the family they grew up with or the family they have created—providers should remember many LGBTQ people have to work harder than heterosexual and cisgender people to maintain or create their families. Familial bonds may be all the more important in supporting youth as they come out and develop a sense of identity. LGBTQ adults may have to advocate for their right to foster or adopt children and may face discrimination as same-sex parents in medical settings and schools. Trans and nonbinary adults who want to carry a pregnancy may delay or forgo medical transition and risk associated gender dysphoria. LGBTQ older adults may have lost their partner and/or chosen family in the HIV/AIDS

epidemic. Adults who come out later in life may be rejected by their family-of-origin, spouses, and children. Finally, many LGBTQ people build families that do not mirror the heteronormative nuclear family but are nonetheless just as important sources of health and well-being. Providers should be ready to navigate the complexity of LGBTQ people's relationships with family, affirm the value of LGBTQ-headed families, and increase their understanding of how families can strengthen LGBTQ health.

> *"My doctor, who I've had for 15 years, always asks about my partners.*
> *My doctor was willing to read the 'Ethical Slut' and learn more about my life."*

> *"I have a trans kid, it's great when I don't have to explain it to the office at length."*

In the following quote, a provider honored the passing of a person's spouse and recognized the grief experienced by their patient.

> *"I came to an appointment without my spouse and my provider said*
> *'You're not in a condition to receive care considering your recent loss.'"*

My Provider Engages in Conversation with Me

People want to trust and build connection with their providers, whether they are receiving mental, physical, dental, or other forms of care. Many people spoke of their appreciation for providers who engaged them in conversation. Some people appreciated their provider's willingness to candidly discuss sensitive topics like sex,

identity, and religion. Other people appreciated providers who took their time, who showed they cared about them, and who clearly saw their patients as human beings seeking and deserving of well-being.

"Asking me about my spouse, and when they actually try to get to know me.
[When they ask things like,] 'How long have you been together?'"

"My provider said they'd heard of pansexuality but asked me what it means to me."

"When specialists show empathy and ask what is going on in my life,
they try to get to know me."

My Provider's Intake Forms Let Me Authentically Identify Myself

Asking SOGI questions, and providing options that reflect LGBTQ identities and experience, can be an important practice for a provider's office. LGBTQ people are more likely to feel welcomed if they see their identities listed on the form.

"[It's affirming] when forms ask 'What is your sex
assigned at birth' or ask for pronouns."

"I was surprised to see a good set of options on my clinics intake forms."

"I like being able to describe my identities on intake forms."

This practice signals to incoming clients the provider's office considers LGBTQ health and well-being and provides LGBTQ-competent or -specialized services. Furthermore, intake forms with LGBTQ options make it easier for patients to come out to their providers. When options reflective of LGBTQ identities are not available on intake forms, LGBTQ people may feel the burden fall on them to come out to their provider.

> *"The way they list gender on their forms, and then I have to explain that I'm not on the form. Its invalidating, and it tells me they didn't even think about it and I'll have to educate and do emotional labor."*

As with any other information on an intake form, the provider can use the information to ask individualized and respectful questions that can inform the provision of care. Finally, asking this information can help a provider to evaluate whether they are effectively reaching out and providing services to LGBTQ communities.

> *"We need better intake forms, and also for providers to actually check the forms so they know ahead of time."*

My Provider's Office Displays LGBTQ Materials and Symbols

Placing LGBTQ-related materials in the lobby is a simple action that can signal to LGBTQ clients a provider is LGBTQ-affirming. There are many ways an office can accomplish this. Some offices post rainbow stickers or Safe Zone signs in their front windows or at the receptionist's desk. Waiting rooms and other public spaces can include posters and images of LGBTQ people and/or families. Bookshelves can include

resources on LGBTQ health, and pamphlet holders can include pamphlets from local LGBTQ organizations. Some providers alter their name tags or badges to include a rainbow badge or to list their pronouns. Finally, community members in rural and conservative areas mentioned it is especially meaningful when providers publicly advertise their services as LGBTQ-affirming.

[What do providers do that feels affirming?]

"Having LGBTQ imagery and literature around."

"Having LGBTQ literature out and visible in the provider office."

SEXUAL ORIENTATION & GENDER IDENTITY
(SOGI) DATA COLLECTION

If We're Not Counted, We Do Not Count

Research informs policy and practice, so it is important research include questions on sexual orientation and gender identity (SOGI).[8] Population-level research can inform communities, providers, and politicians of the levels of access, community outreach, health disparities, and health needs of marginalized communities, including LGBTQ communities. In recent years, major gains have been accomplished with the inclusion of SO and/or GI questions in the California Health Interview Survey, the U.S. Department of Health and Human Services' (HHS) National Health Interview Survey, the Health Resource and Services Administration's Health Center Patient Survey, the National Health and Nutrition Examination Survey, and the Department of Justice's National Crime and Victimization Survey (Cahill & Makadon, 2017; Gates, 2017; Jans et al., 2014).

Unfortunately, SOGI questions continue to be left out of many critical population-level surveys; in recent years, SOGI questions have been removed from the National Survey of Older Americans Act Participants, the Annual Program Performance Report for the Centers for Independent Living, and the U.S. Census Bureau's American Community Survey, which is one of the largest surveys and most important public sources of data on residents across the nation. The Trump administration has been openly opposed to the collection of SOGI data and, in some cases, ceased releasing important SOGI data that were already collected (Durso, 2017; Cahill & Makadon, 2017). Most recently, a Centers for Disease Control and Prevention (CDC) official announced plans to remove SOGI questions from an optional module of the Behavioral Risk Factor

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[8] Surveys ask about sexual orientation and gender identity in many ways. While some may ask respondents about their identities (gay, lesbian, bisexual, straight, etc.; male, female, transgender, genderqueer, etc.), others may ask about attraction, behaviors, or marital status.

Surveillance System (BRFSS)—which is a major survey that collects data on health behaviors, service use, and opportunities for health promotion, and is currently used in over 30 states (The Williams Institute, 2018).

An Ongoing Threat to LGBTQ Health:

"The CDC's announcement appears to be part of an alarming trend within the federal government aimed at limiting our knowledge about LGBT people, despite the fact that these data are vital to policy making and designing evidence-based interventions to improve health and well-being" - Adam Romero, Williams Institute Director of Federal Policy (The Williams Institute, 2018).

Though SOGI questions will no longer be included as an option in the BRFSS starting in 2019, the BRFSS is an example of the variation in implementation of SOGI questions in major surveillance systems. SOGI question implementation can vary by whether the questions are asked over the phone, in person, or on paper; the number of questions asked; the focus of the questions on identity, behavior, or attraction; the phrasing and sequence of questions; the number and wording of response options offered; and the method of data analysis. As Baker and Hughes (2016) noted, some states implementing the BRFSS optional module used their own sexual orientation and/or gender identity questions, while others adopted the BRFSS proposed SOGI questions, and still others did not use the optional module. Given how variations in data collection presents barriers to data analysis, #Out4MentalHealth recommends broad and cohesive implementation of the same questions and methods so researchers can make more informed and conclusive claims about the health outcomes, needs, and experiences of LGBTQ populations.

Multiple research institutions recommend a two-part (gender identity and sex assigned at birth) question to accurately survey for gender identity (Deutsch et al., 2013;

The GenIUSS Group, 2014; Sausa, Sevelius, Keatley, Iñiguez, & Reyes, 2009). Research

from the Fenway Institute with the Centers for American Progress (2013) found the

majority of patients understand the two-part question and are willing to answer the

questions. This recommendation was used to help inform the development of SOGI

demographic data collection for the Prevention and Early Intervention (PEI) and

Innovation (INN) programs under California's MHSA (Poshi Walker, personal

communication, June 15, 2018). With input from LGBTQ advocates, the MHSOAC added

requirements for SOGI demographic data collection to the PEI and INN Regulations in

2015.

Decline to State:

While the MHSOAC did take input from LGBTQ advocates, not all recommendations are reflected in the categories listed in this section. In addition, advocates questioned the inclusion of a "Decline to State" option, noting their experience that staff members uncomfortable with asking SOGI questions have been known to simply check "Decline to State," if they are the ones capturing the information. Advocates pointed out to Commissioners that all demographic information is voluntary, and therefore a "Decline to State" option is unnecessary, as the client can just skip the question. The MHSOAC addressed these concerns by stating in the Regulations that counties only need to report "the number of respondents who decline to answer the question," and that "Decline to State" was not a category. However, when counties asked for clarification regarding the category "Number of respondents who declined to answer the question," MHSOAC staff directed counties in a 2016 technical assistance document to include a "Decline to State" category. This was done without the public comment process used to develop the original Regulations or feedback from advocates (MHSOAC Regulations Subcommittee Meeting, March 23, 2016; MHSOAC, 2018; Poshi Walker, personal communication, September 28, 2018).

The Regulations require county mental and behavioral health departments to collect and report the following SOGI categories to the MHSOAC from their PEI and INN programs. The MHSOAC does not regulate how the data is gathered; counties differ in their use of phrasing, questionnaire format (written or verbal), hardcopy or electronic health records, and addition of non-regulation categories. As evident from the results of research conducted by #Out4MentalHealth (discussed in the next section) the variations in implementation of the Regulations, method of collection, phrasing of questions, categories, and reporting provide room for error and present complications for population-level analysis.

Figure 1

Reporting Categories for PEI & INN Programs

Sexual Orientation:
- Heterosexual
- Gay or lesbian
- Bisexual
- Queer
- Questioning or unsure of sexual orientation
- Another sexual orientation
- Number of respondents who declined to answer the question

Sex Assigned at Birth:
- Male
- Female
- Number of respondents who declined to answer the question

Current gender identity:
- Male
- Female
- Transgender
- Genderqueer
- Questioning or unsure of gender identity
- Another gender identity
- Number of respondents who declined to answer the question

Figure 2

How #Out4MentalHealth recommends asking SOGI questions for PEI & INN programs: #Out4MentalHealth recommends demographic questions be answered privately by the respondent, when possible, using either paper or tablet. Recommended phrasing and categories based on the regulations are as follows:

Do you think of yourself as:
- Heterosexual or straight
- Gay or Lesbian
- Bisexual
- Queer
- Questioning or unsure of sexual orientation
- Another sexual orientation [please specify:] _____

What is your current gender identity?
- Male
- Female
- Transgender
- Genderqueer
- Questioning or unsure of gender identity
- Another gender identity [please specify:] _____

What sex were you assigned at birth?
- Male
- Female

Ideally, researchers and advocates could make claims about LGBTQ mental and physical health with greater certainty if they could access large datasets with standardized questions and methods, such as the U.S. Census. As previously stated, the current administration is moving researchers further from this goal with the removal of SOGI questions from the U.S. Census, BRFSS, and other major surveys. This makes the SOGI data we collect in California even more important in order to document the LGBTQ population size; identify LGBTQ health disparities and whether they differ by region; justify funding LGBTQ-specific services; and help inform additional research to increase the health and well-being of LGBTQ Californians. Unfortunately, the lack of requirements to collect SOGI data in all programs; the lack of staff training on how to ask SOGI questions using standard methods; differentiation in the phrasing of questions and categories offered; the notation of responses to these questions; and the reporting and analysis of survey results all present serious barriers to the development of reliable and meaningful data on LGBTQ population health. These barriers leave policy makers and community organizers wanting for information that could support their efforts to close health disparities and improve the lives of LGBTQ people.

SOGI Data Collection Efforts

#Out4MentalHealth used several methods to learn about the ongoing implementation of California's policies on SOGI demographic data collection, particularly under MHSA. These methods included the following:
- Project staff conducted a key informant interview with Jennifer Susskind, a professional in MHSA data collection with extensive experience working with counties.
- Project staff reached out to staff members at the Departments of Aging, Health Care Services, Public Health, and Social Services to get an update on

their implementation of the Lesbian, Gay, Bisexual, and Transgender Disparities Reduction Act (AB 959), which requires the collection of SOGI data in those agencies' programs by July 2018.

- MHSOAC staff provided #Out4MentalHealth with data on which counties had reported SOGI data by the July 2018 reporting deadline, which allowed for comparisons with the county interview data collected by #Out4MentalHealth.

- Finally, the most extensive part of #Out4MentalHealth's research involved interviewing personnel in 36 counties across California to ask them about their knowledge and implementation of the PEI and INN Regulations regarding SOGI data collection. Those interviews and the comparison with the MHSOAC-provided data sought to assess for (1) county fidelity to the regulation categories, (2) county readiness and capacity to gather this data, and (3) barriers to implementation of SOGI data collection.

Key informant interview results

#Out4MentalHealth conducted a key informant interview with Jennifer Susskind, a subject-matter expert on demographic data collection and reporting within MHSA programs. A number of barriers to SOGI demographic data collection have been noted throughout this section and, as the interview highlights, the greatest of them are systemic factors with an impact on all demographic data collection, not just SOGI data.

Susskind asserts that the most frequently stated barriers to county demographic data collection are (1) the extent and burden of demographic information asked of counties and (2) the lack of consistent training on evidence-based research methods to integrate these questions and report their results. The latter issue poses a serious dilemma as it has to account not only for the scale of statewide trainings and the need for detailed protocols to guide the trainings, but also the inclusion of both county

providers and contractors who collect data. Susskind noted both barriers affect the accuracy of demographic data collection in general, including for racial and ethnic status, which presents an important opportunity for broad interdisciplinary coalition work in racial, ethnic, sexual, and gender justice.

There are some serious concerns with how staff collect, or choose not to collect, data. LGBTQ people are spread across geographic regions, cultures, races, ethnicities, and socioeconomic classes in the U.S. population, and yet Susskind noted some agencies report 100% of their program participants are heterosexual, possibly suggesting staff may not have asked questions about sexual orientation. Datasets with entirely heterosexual samples are a clear indicator of the effects of heteronormativity, where the program is either (1) assuming all their clients are heterosexual and therefore not asking the question, (2) are not creating a safe space for their clients to identify as other than heterosexual, or (3) are known to be unwelcoming to LGBTQ people, such that LGBTQ do not access the service. Susskind also stated the "Decline to State" option is "at least some of the time interpreted as 'Decline to Ask.'" This barrier creates an undercount of LGBTQ people, which can subsequently affect funding decisions.

Susskind also mentioned that, in rural and in more conservative counties, many residents oppose government intrusion and surveillance. This opposition may present a cultural barrier to data collection in general, and to demographic data collection in particular.

Furthermore, Susskind noted the expectation among program participants that their demographic information will remain anonymous and yet, in order to track access and link data, program staff must maintain records of individual participant demographics throughout the referral and linkage process. Many counties are shifting to Electronic Health Records (EHR) to collect their demographic data, which typically reduces the work involved in data collection. However, this means anonymity cannot be maintained in demographic data collection. Not maintaining anonymity presents an

issue particularly in small counties where residents, staff members, and state agencies are especially cautious of protecting client privacy, as violations of privacy can place clients at risk of physical and emotional harm.

Regarding solutions, Susskind called for "consistent training, clear guidelines, and data collection systems that are uniform across the state." Susskind went on to add, "I may be in a minority because counties like the autonomous nature of how they are doing it now, but if you're going to do data collection correctly then you have to do it consistently."

AB 959 implementation updates

California has made a significant commitment to improving the availability and quality of SOGI data. In 2015, Governor Brown signed AB 959 into law, a bill by Assemblymember David Chiu that requires four departments within the California Health and Human Services Agency (CHHS) to collect SOGI data by July 1, 2018: the Department of Health Care Services, the Department of Aging, the Department of Social Services, and the Department of Public Health. LGBTQ advocates worked with CHHS to provide recommendations for the implementation of SOGI data collection with the goal of securing high quality, consistent data collection across all four departments that could be easily analyzed and compared.

#Out4MentalHealth contacted each department required to collect SOGI data to request an update on their AB 959 implementation. Three of the four departments responded, and their updates are described below.

The Department of Health Care Services (DHCS) collects SOGI data through Medi-Cal's online Single Stream Application, and the hardcopy version is currently under review. Some DHCS programs are not using the Single Stream Application. Implementation occurred on or before July 1, 2018 for Every Woman Counts (EWC) and Improving Access, Counseling, and Treatment for Californians with Prostate Cancer

(IMPACT). The Breast and Cervical Cancer Treatment Program (BCCTP) and the Family Planning, Access, Care and Treatment (FPACT) program plan to implement SOGI data collection in early 2019.

DHCS personnel shared SOGI questions and answer categories for each question, shown below in Figure 3, which currently appears in the online Single Stream Application. The first question is displayed on the application by default, and the rest of the questions are optional and appear separately after the application has been submitted.

Figure 3

<div style="border:1px solid">

Department of Health Care Services

SOGI Data Collection Questions

The following question is included on the online Single Stream application:

What is your sex?

- Female
- Male
- Transgender: male to female
- Transgender: female to male

The optional questions below appear in a separate form after the application has been submitted:

What is your gender? (check the box that best describes your current gender identity)

</div>

- Female

- Male

- Transgender: male to female

- Transgender: female to male

- Non-Binary (neither male nor female)

- Another gender identity

What sex was listed on your original birth certificate?

- Female

- Male

Do you think of yourself as:

- Straight or heterosexual

- Gay or lesbian

- Bisexual

- Queer

- Another sexual orientation

- Unknown

The Department of Aging began collecting SOGI data prior to the July 1 deadline and plans to provide reports online in the second quarter of 2019. All Area Agencies on Aging assessments, including those by contractors, now include SOGI questions.

The Department of Social Services (DSS) implemented SOGI data collection prior to the July 1 deadline, including the Department of Social Services' Child Welfare side. As of a phone conversation on July 13, 2018, the DSS was working to update the

demographic information questions for CalWORKS forms. DSS reports will be made available annually or quarterly, depending on the reporting cycle and availability of data.

DSS staff shared answer categories for each question, shown in Figure 4, though the phrasing of the questions was not provided.   #Out4MentalHealth staff inquired further about the "Unable to Determine" category for the sexual orientation question, and DSS staff offered to look more into its intended definition (a response was not provided in time for the publishing of this Report).

Figure 4

Department of Social Services

SOGI Answer Categories

Below are the options program participants can select when answering SOGI questions.

Sexual Orientation:

- Asexual
- Bisexual
- Gay
- Lesbian
- Pansexual
- Heterosexual
- Decline to State
- Unable to determine
- Not listed

Sex Assigned at Birth:

- Female
- Male
- Intersex

Gender Identity:

- Female
- Genderqueer / Gender Nonbinary
- Male
- Transgender female
- Transgender male
- Not listed
- Unsure
- Decline to state
- Did not ask

Not only do the SOGI questions and answer categories shown in the DHCS and DSS demographic information forms differ between the two departments, they also differ from the format of the SOGI questions suggested in the MHSOAC's Regulations for PEI and INN programs. As much as the requirement that the four departments collect and report SOGI data is a major step forward, the departments' capacity in statewide data analysis would be strengthened if they used a standardized method in demographic data collection.

County SOGI data reported to the MHSOAC

There are 59 mental/behavioral health departments in California implementing hundreds of PEI and INN programs. The MHSOAC passed SOGI data collection regulations for the PEI and INN programs in 2015, provided some guidance on implementation of those regulations the following year, and expected the counties to provide their first data reports by July 2018. The expectation that SOGI questions be added to demographic forms in hundreds of programs across 59 counties represented a major undertaking, given consideration of the sheer number of programs, existing time constraints for staff, and the availability of resources. This shift in regulations required editing of county demographic forms across multiple program and county contractors, training of county and contractor staff, and the construction or alteration of data reporting systems to allow for standardized reporting. Therefore, #Out4MentalHealth anticipated significant variation in the SOGI data provided by counties across the state and requested access to this data from the MHSOAC after the July 1, 2018 deadline.

The MHSOAC generously supplied #Out4MentalHealth with access to an aggregated county-reported SOGI dataset from PEI programs in September 2018, two months after the first reporting deadline. SOGI data from INN programs were not included in the dataset. The MHSOAC shared this data despite the fact that they were

still in the process of data analysis, as they recognized the importance of including the information in this Report. The following program-specific data analysis hence remains incomplete and includes a breakdown of SOGI data by program for a total of 341 PEI programs across only 24 of the 59 counties. However, the data from MHSOAC did include information from all 59 counties on whether they reported no SOGI data or some sexual orientation and/or gender identity data.

In this discussion of the provided MHSOAC dataset, counties reporting *any data at all* that integrated some or all of the MHSOAC Regulation categories on sexual orientation and/or gender identity are included in one of the three groups (sexual orientation only, gender identity only, or both SOGI). Within the SOGI-reporting counties where program-specific data is available, most counties had some percentage of programs that were not able to report. As the dataset does not disclose whether or not specific categories were included in the counties' reports, the level of accuracy and thoroughness of these reports cannot be addressed at this time.

Overall, 27 of 59 counties (46%) submitted no SOGI data for their PEI programs. Thirty-two counties (54%) submitted some form of SOGI data; 23 counties (39%) had some data for both SOGI, five counties (8%) recorded data on sexual orientation only, and three counties (5%) had data on gender identity only. One remaining county reported data on sexual orientation only, but all responses were marked as "Decline to State." Of the 23 counties that submitted some data on both SOGI, the MHSOAC provided PEI program-specific reporting data on eight of those counties, representing a combined 161 individual PEI programs. Of those 161 PEI programs, 70% (*n* = 112) presented data for sexual orientation and/or gender identity. While program-specific data is not available at this time for the other 15 counties that reported on both SOGI, it is reasonable to assume there was reporting variation among programs within those counties, as well.

Within any one county, individual programs might ask questions on sexual orientation only, gender identity only, both SOGI questions, or no SOGI questions.

Looking at only the 24 counties where PEI program-specific data was available, 12 reported sexual orientation and/or gender identity data. At least one type of data on sexual orientation and/or gender identity was reported for 58% of the 12 counties' 203 PEI programs (n = 118), which means that out of all 341 PEI programs across the 24 Counties, only 35% reported on at least one type of data.

Comparison of the MHSOAC and #Out4MentalHealth data

The data from the MHSOAC differed markedly from the information gathered in #Out4MentalHealth interviews with county personnel. Data for 21 of the 36 counties who were interviewed and who subsequently submitted data to the MHSOAC diverged from the data collection methods they described in their interviews with #Out4MentalHealth. As a case in point, 16 of those 21 counties stated in their interviews they ask questions for either sexual orientation or gender identity or both, but then did not report any data at all to the MHSOAC.

#Out4MentalHealth assessed for what SOGI questions were being asked and for county adherence to the Regulations, but did not inquire about what the counties intended to report. Nonetheless, it may be reasonable to anticipate a correlation between what a county asks and what information they then report. One issue with the analysis is the current lack of program-specific information across all counties, which prevents further depth and accuracy in the comparison of MHSOAC and #Out4MentalHealth data. For example, one county reported to #Out4MentalHealth they do not ask any SOGI questions, but then delivered sexual orientation data to the MHSOAC. That county is included among other counties that submitted sexual orientation data in Figure 5, even though their data was reported from only one of their PEI programs. Similar discrepancies in the data may account for the variation between MHSOAC and #Out4MentalHealth data.

Figure 5
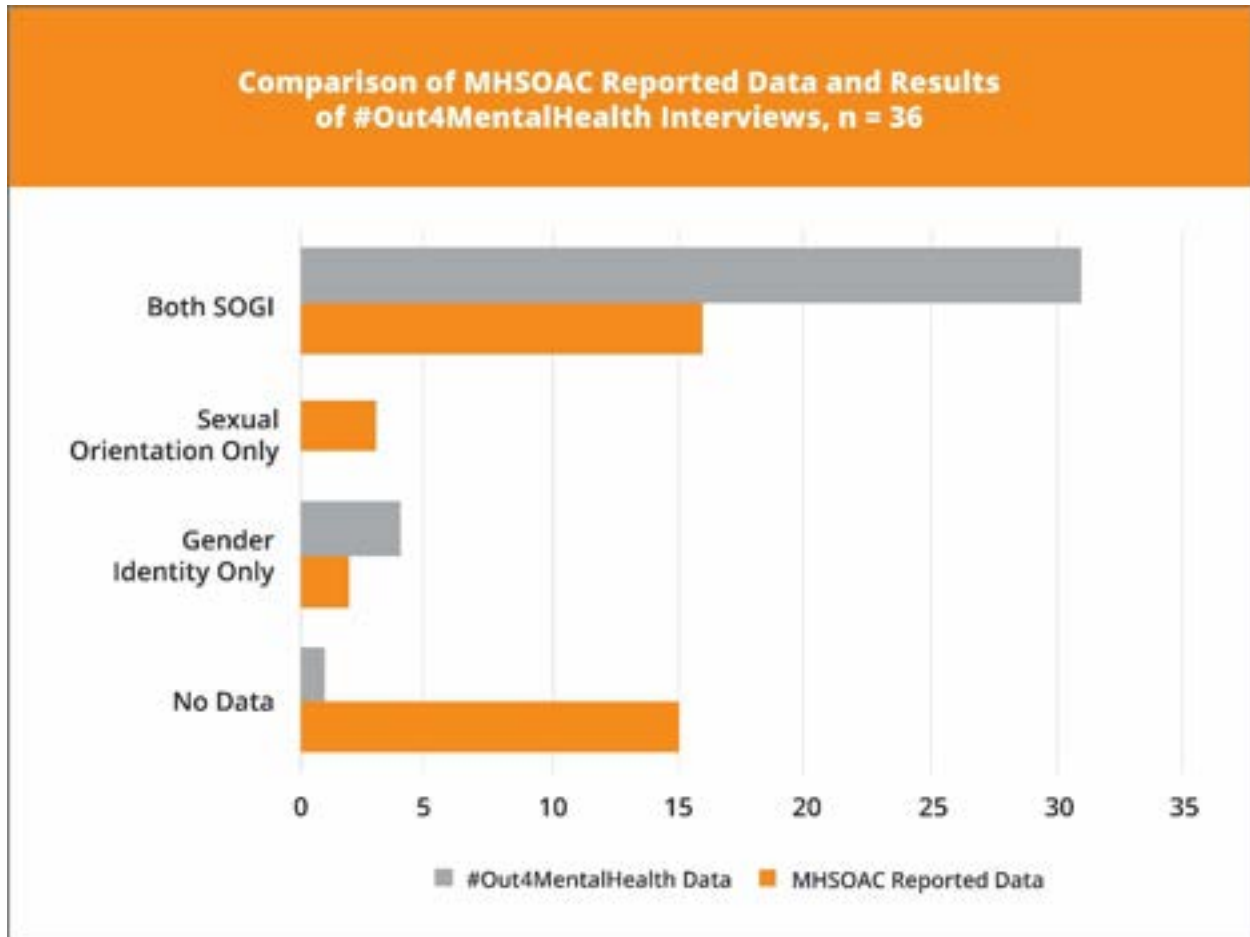
There are many plausible explanations for the discrepancies between what counties said to #Out4MentalHealth about the data they were collecting and the data they provided in their subsequent reports to the MHSOAC. #Out4MentalHealth has not researched whether any of the following possibilities may account for these inconsistencies. #Out4MentalHealth provides the following possible explanations based upon what it has learned about various barriers the counties have faced, and may continue to face, in collecting and reporting SOGI data:

- Changes occurred with county data collection protocol between the time of the interview (February - June 2018) and the reporting deadline (July 1, 2018);
- Program staff provided with the question(s) may not have asked the question(s) of program participants;
- Program staff provided with the question(s) may not have asked their clients, but simply answered on their behalf, and county personnel may have determined not to report data with obvious inaccuracies;
- Program staff may not have been trained on how to ask the question(s), which increases the likelihood of missing or inaccurate data;
- Individual county programs collected SO and/or GI data unbeknownst to interviewees, and the county then reported the unexpected data;
- Program participants may have opted out of answering the question(s);
- Program staff may not have provided the data to the reporting county staff;
- The county may not have received data from their contractors;
- County personnel may have decided not to submit the data due to the belief it would violate the confidentiality of their clients, despite the fact that data is reported as an aggregate;
- Discrepancies may exist between what interviewees honestly believe is included in their county's demographic forms versus what is actually included, or discrepancies in how staff use the forms;
- Delays occurred with the submission of SOGI data to the MHSOAC.

#Out4MentalHealth county interview results

#Out4MentalHealth interviewed 36 counties from all regions of California with a range of population sizes and demographics, funding and staff capacity, data collection and management systems, and types of programs. The county staff interviewed included MHSA coordinators, data and quality improvement analysts, diversity and cultural competency managers, and county behavioral/mental health directors. Some county personnel were interviewed alone, and some counties had a team of interviewees join the interview. Interviews were conducted by phone and typically lasted 20-40 minutes. #Out4MentalHealth is appreciative of all county staff who participated in these interviews. Further information on interview methods can be found in Appendix A3: SOGI Data Collection.

When interviewing county staff, #Out4MentalHealth asked what options were listed for each question on the PEI and/or INN demographic forms and then recorded their answers. Figures 6 and 7 below show the proportion of counties interviewed that provided specific regulation and non-regulation options.

Figure 6

Proportion of Sexual Orientation Options in County PEI and/or INN Programs, n = 35
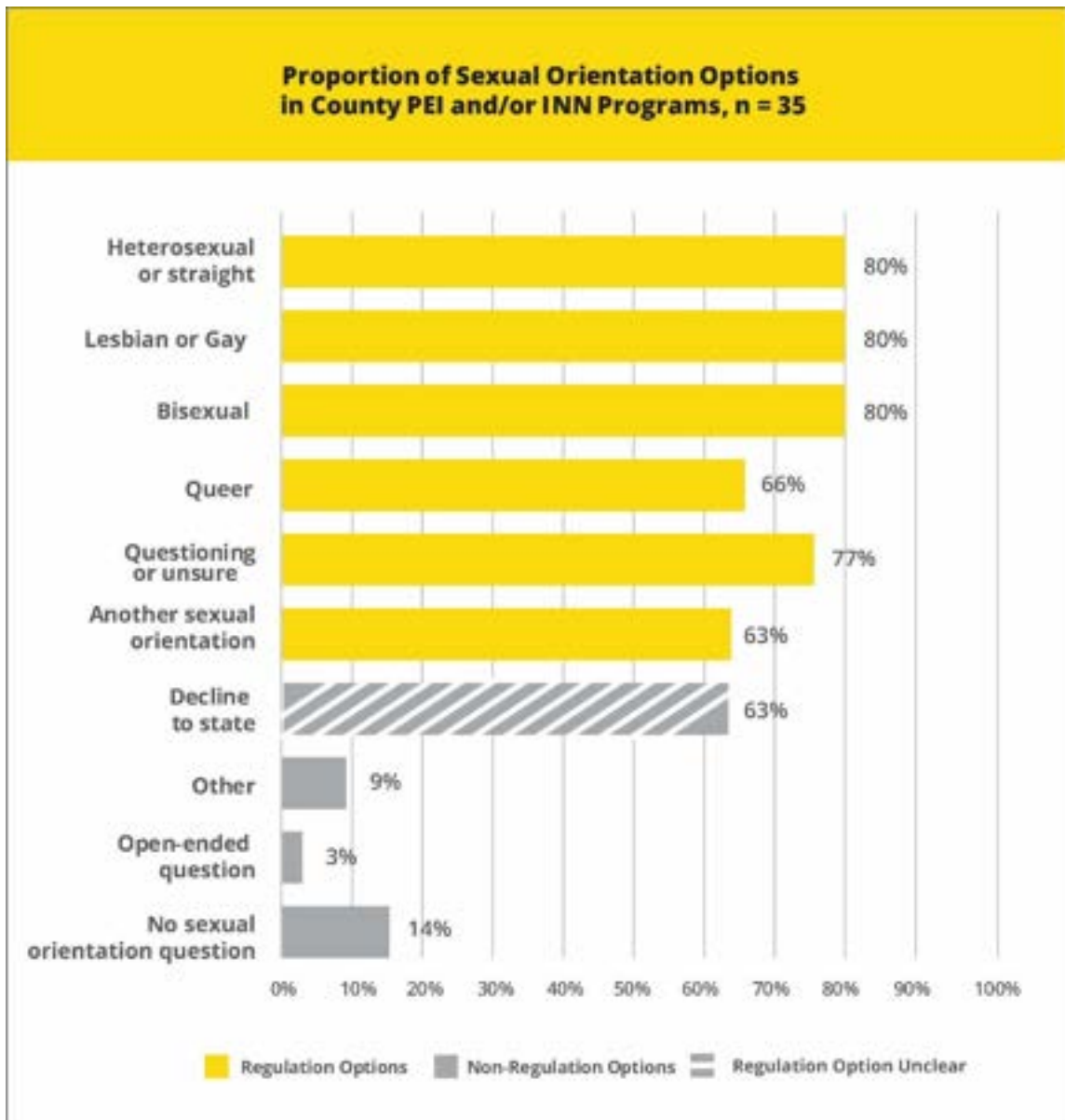
Figure 7
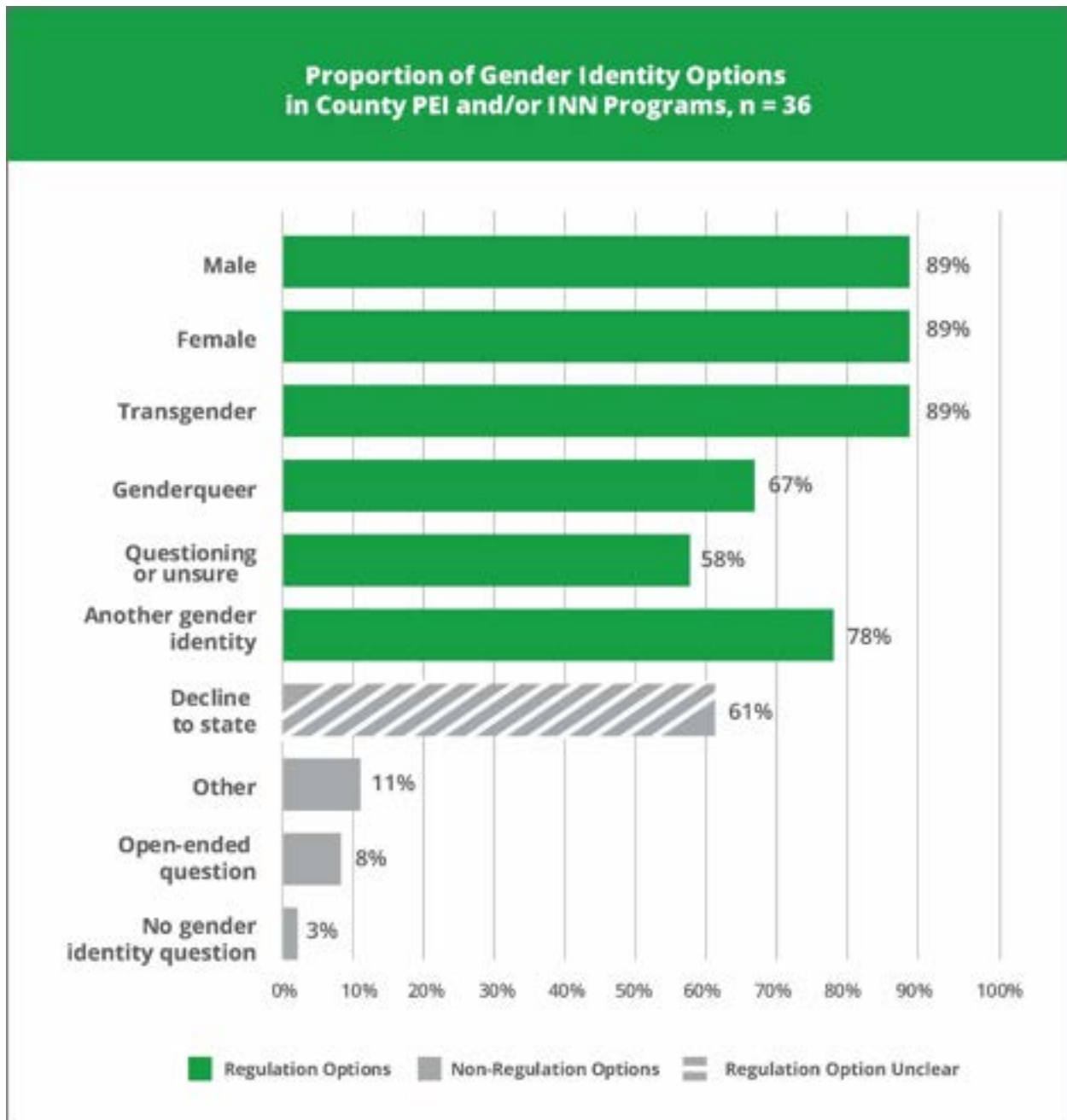
Notably, the gender identity question is included more often by counties than the sexual orientation question. There are also counties forgoing these questions entirely. In addition, some counties are simply leaving a blank space for the client to write in their sexual orientation and/or gender identity on the forms. From a research perspective, this creates a situation where county staff may have to interpret what category each identity falls in, ultimately making it difficult, if not impossible, for those counties to accurately report the regulation options.

Though language for several options in the sexual orientation and current gender identity questions are fairly analogous, counties offer "Questioning or Unsure of Sexual Orientation" more often than they offer "Questioning or Unsure of Gender Identity." Aside from the counties who are not asking any questions or simply offering a blank, counties offer "Questioning or Unsure" for sexual orientation 30% more often than for gender identity (96% compared to 66%). Despite the Regulations requiring the "Questioning or Unsure" option for both questions, this means fewer counties can identify the number of clients who are questioning their gender identity than the number of clients who are questioning their sexual orientation. In other words, clients can mark they are questioning their sexual orientation in more county public mental health systems than they can mark that they are questioning their gender identity.

One hypothesis to explain this discrepancy may be that county staff developing these forms relied upon the flawed societal belief that gender identity is static whereas sexual orientation is more fluid. This may be rooted in descriptions of gender identity as "an internal sense of self," whereas the concept of questioning one's sexual orientation may be a more familiar concept for some county staff. Regardless of whether counties include "Questioning" as an answer option for the gender identity question, they are required to report the data to the MHSOAC, which will likely mistakenly indicate that no one in those counties is questioning their gender identity. The inaccurate indication that no one is questioning their gender identity is a direct result of county staff's assumption that it is not necessary to include a Questioning

category for the gender identity question. In this case, the above hypothesis becomes a self-fulfilling prophecy: staff in these counties work from an assumption that gender identity is fixed, so they don't include "Questioning" as an option, and then report the data they collect, which makes it appear that no one is questioning their gender identity. This omission may hinder a focus on the needs of people who are in a period of exploration and self-discovery for their gender identity in requests for program funding and budget priorities.

Similarly, counties more frequently offer the "Decline to State" option for the sexual orientation question (79%) than the gender identity question (69%). While counties are mandated to report the number of respondents who do not answer each question, they are not required to offer a "Decline to State" option as an answer for those questions. Unfortunately, multiple county personnel expressed concerns about over-inflation of the frequency of "Decline to State" responses on the SOGI questions due to staff choosing to mark that option rather than asking the question as required. The number of "Decline to State" responses may be higher still because, in several counties, school districts with PEI and INN programs have reportedly refused to incorporate SOGI questions or share data. When asked why they included a "Decline to State" option, some counties expressed it is standard with their other demographic questions, and yet, due to various barriers in asking SOGI questions (discussed in the next subsection), the "Decline to State" option appears to present a unique opportunity for staff to avoid the requirement of accurate SOGI data collection in their programs.

Some counties offered "Other" as a category for sexual orientation (three counties) and gender identity (four counties), instead of the recommended "Another (sexual orientation/gender identity)" category, which was meant to prevent the marginalizing effect of the "Other" option. Though this was not the case with the "Other" option for the sexual orientation question, three of the four counties using the "Other" option for the gender identity question listed it with only "Male," "Female," and

"Transgender"—in effect replacing the regulation options of "Genderqueer," "Questioning or Unsure," and "Another gender identity" with "Other."

Six counties (17%) added variations of "Transgender man (Trans man / Trans male)" and "Transgender women (Trans woman / Trans female)," which tended to be offered as two separate categories instead of the "Transgender" option shown in the Regulations, and one county had those options appear as a dropdown menu in the online form if the respondent clicked on the "Transgender" answer category. Though not explicitly stated in the Regulations, counties are allowed to add categories and these additions reflect other best practices in SOGI Data Collection (The GenIUSS Group, 2014). Some counties stated they included categories in both sexual orientation (i.e., "Asexual," "Pansexual") and gender identity (i.e., "Gender Nonconforming," "Two-Spirit," "Genderfluid," "Agender") based on feedback from local LGBTQ communities. #Out4MentalHealth greatly appreciates and supports the inclusion of community input in all components of MHSA programs, and concern is warranted for how non-regulation data is handled—it remains unknown if such data is reported as "Another," folded into other related categories (i.e., combining gender nonconforming and non-binary people into the Genderqueer category), or not reported at all.

There were three outlier counties that used methods distinct from the PEI and INN Regulations. One county opted to fold an "LGBTQ" option into a long list of populations/affiliations, so that respondents could check LGBTQ in a list alongside Veteran, Homeless, and other statuses. Another county chose to ask "Are you LGBTQ?" with a "Yes" or "No" response.   The third county included "Transgender" as an option in the sexual orientation question, despite that the term describes a person's gender identity and is not a sexual orientation.

County personnel were asked to provide feedback on what may be barriers to staff asking SOGI questions. The 36 counties interviewed were divided into four categories by population size: Tiny (population < 50,000, n = 6), Small (50k - 200k, n =

12), Medium (200k - 500k, n = 10), and Large (+500k, n = 8). The proportion of barriers by size of county can be viewed in Figure 8 below.

Notably, only one county stated they did not have any barriers to SOGI data collection, whereas the other 35 counties all identified at least two barriers. Compared to the average of 4 barriers for all counties, Large and Tiny Counties each identified more barriers (average of 4.8 barriers), Small Counties reported just below the average (at 3.8 barriers), and Medium Counties had the lowest number of barriers (average of 3.1 barriers).   A review of Figure 8 shows that medium-sized counties appear to have fewer barriers than all other counties.

Figure 8

Proportion of Barriers by County Size, n=36
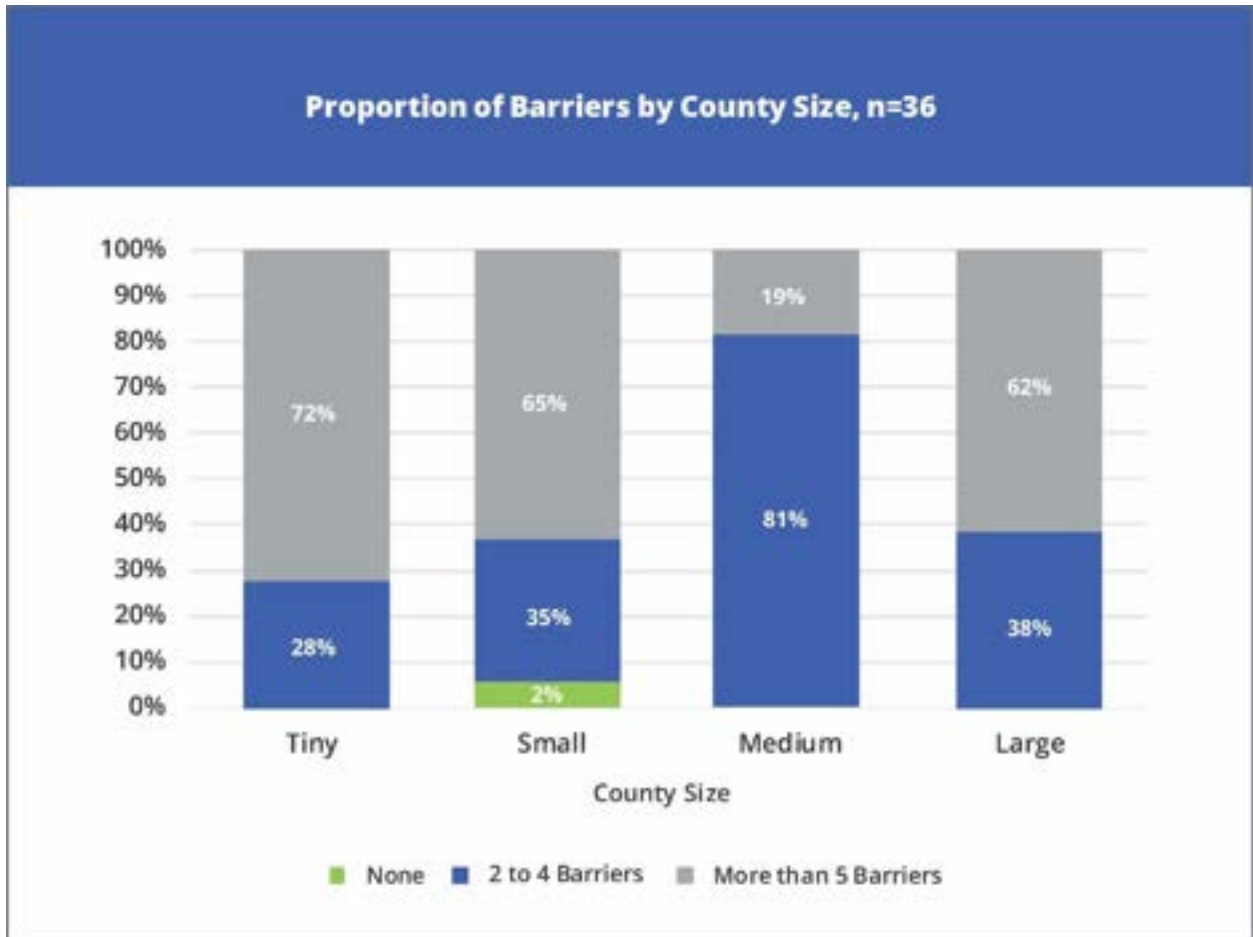
It may be there is a "Goldilocks" effect of counties with smaller populations and larger populations facing more barriers than counties with medium-size populations; if this was so, one might expect the option of "Funding" to be a barrier identified more often in Tiny, Small, or Large Counties. However, this was not the case—four of the six counties identifying "Funding" as a barrier to SOGI data collection were Medium Counties.

County staff were invited to review a list of potential barriers, state if any of them were of issue in SOGI data collection for their PEI and INN programs, and describe

other barriers not shown on the list. Funding, confidentiality concerns, and a fear of offending clients from specific racial, ethnic, or religious or spiritual communities were some of the listed barriers. Figure 9 below shows the top barriers county staff identified.

Figure 9

Proportion of Counties Facing Identified Barriers to SOGI Data Collection, n = 36
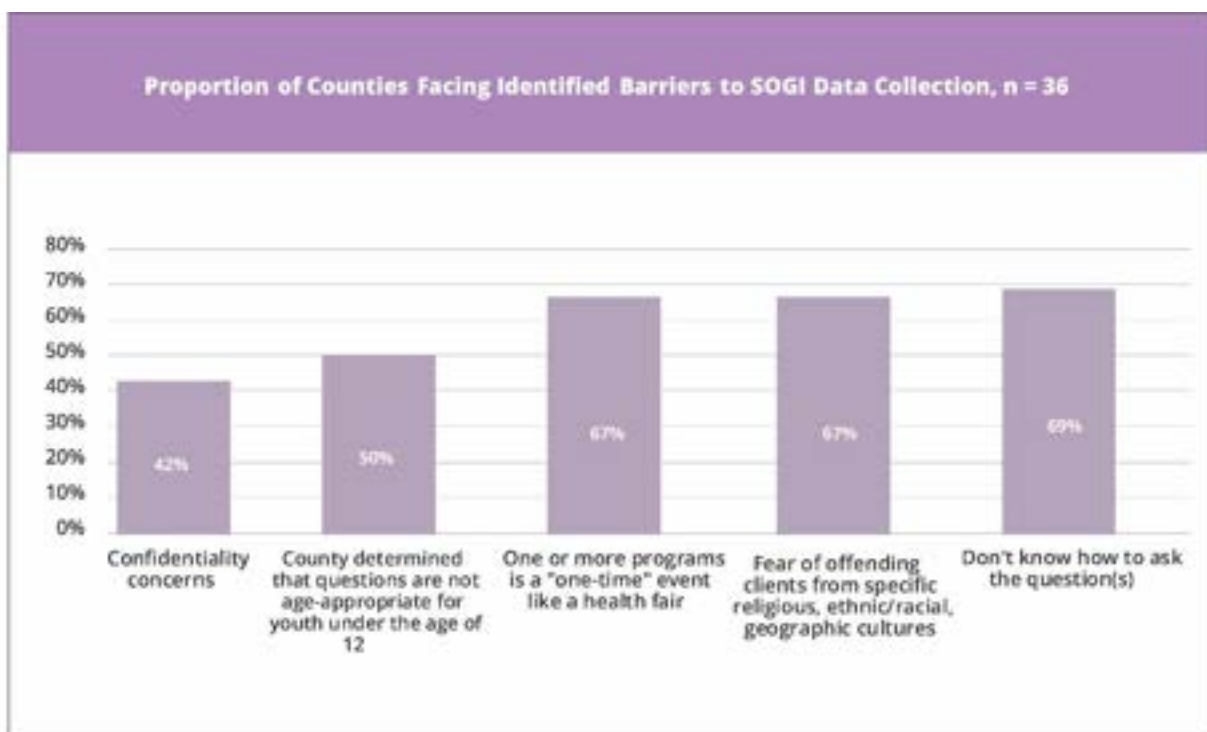
Most concerns with asking SOGI questions involve lack of training and expectations that these questions may make clients uncomfortable or upset. For SOGI questions, data is best collected from the individual respondent on paper or tablet. This allows the client to complete questions confidentially and creates greater consistency in how the questions are asked. Staff should nonetheless seek training in how to ask those questions with clients who cannot fill out the form on their own and address any concerns the clients may have about the questions.

Confidentiality concerns were particularly salient for Tiny Counties, who expressed concerns the information being collected, if not kept confidential, could pose safety risks to the client specifically because of the small population size and local anti-LGBTQ sentiments. The PEI and INN Regulations already stipulate that counties with a smaller population may report aggregated data as a means of protecting client privacy.

Half of the counties identified their personnel had determined, either in agency policy or practice, not to ask SOGI questions of clients under the age of 12; several other counties were uncertain as to whether their programs asked the questions of clients under 12. Counties electing not to collect SOGI demographic information of clients under 12 were asked if the clients' parents were provided the opportunity to answer the questions—most counties were uncertain. The MHSOAC amended the PEI and INN Regulations (effective July 1, 2018) such that sexual orientation and current gender identity questions should not be asked of clients under the age of 12, but can be asked of a parent, a guardian, or any other authorized source on behalf of clients under the age of 12 (MHSOAC, 2018). Counties are still required to ask clients under the age of 12 about sex assigned at birth, in an age-appropriate manner.

Multiple Tiny and Small Counties shared information on the barriers they face in their interactions with schools where they had embedded PEI programs. Some of these counties stated school districts gave in to parent complaints about SOGI data collection, others spoke of anti-LGBTQ harassment targeted at personnel and students involved in the PEI programs on campus, and still others spoke of school administrators refusing to cooperate in the collection and submission of student SOGI data. #Out4MentalHealth did not assess for whether counties have school-based PEI programs or, if they do, whether their staff or participants have experienced comparable situations. It is therefore unclear whether this barrier holds true for Medium and Large Counties or whether such occurrences are more commonplace for Tiny and Small Counties. However, it is apparent from these interviews that conflicts within local communities prevent accurate data collection on LGBTQ student access to services. Furthermore,

interviewees identified a need for technical assistance in managing community conflict. Given the interviewees' testimonials and the nature of these conflicts, #Out4MentalHealth appreciates the personal and professional risks taken by county staff living in small communities who stand up and advocate for LGBTQ people. Many interviewees, especially those in small communities, echoed their resistance to heterosexist beliefs that SOGI questions should not be asked and their commitment to ensuring SOGI data continues to be collected.

THE POLITICAL IS PERSONAL:

THE STATE OF LGBTQ POLICY & LEGISLATION

Federal Threats to LGBTQ Health and Well-Being

A decade of progress

Since the release of the *First, Do No Harm* Report in 2012, California and the nation have made tremendous strides in addressing LGBTQ health and well-being. The Supreme Court ruled the Defense of Marriage Act was unconstitutional as of 2013 and struck down all remaining anti-marriage initiatives two years later, making marriage equality the law of the land. Such decisions did not happen in a vacuum. The Supreme Court's rulings were made in the context of a well-documented shift in attitudes in favor of LGBTQ people, an increase in cultural representation of LGBTQ people and families, and an Obama administration that had successfully pushed through an unprecedented number of legal protections for LGBTQ people.

The Obama administration was the most LGBTQ-friendly administration in history. The eight years of his administration saw some of the swiftest and most significant progress for LGBTQ people, such as the repeal of the 1994 "Don't Ask, Don't Tell" Act and the addition of nondiscrimination protections for LGBTQ people in health care (Section 1557 of the Affordable Care Act), social services (Violence Against Women Act), and educational institutions (Title IX guidance). In 2016, the Obama administration finalized a rule specifying that homeless shelters must house transgender people in accordance with their gender identity (Margolin, 2016). This measure was crucial because rates of homelessness are especially high for transgender people, and prior to the rule the majority of shelters did not have inclusive policies for transgender clients.

The Patient Protection and Affordable Care Act

The Obama administration's signature policy accomplishment was the Patient Protection and Affordable Care Act (ACA), which was the largest expansion of the social

safety net since President Lyndon Johnson's Great Society initiative. For a variety of reasons—higher rates of poverty and unemployment, coupled with the inability to get coverage through a spouse's health insurance—LGBTQ people have historically had higher rates of uninsurance than the general population. Thanks to measures in the ACA that make health insurance more affordable, such as the Medicaid expansion and subsidies on the individual health insurance market, the uninsurance rate among LGBTQ people fell by 25% in just the first year of implementation (Baker, Durso, & Cray, 2014). Disparities still exist, especially for LGBTQ people of color and those living in states that did not expand their Medicaid programs, but the ACA has led to a significant increase in health care access for LGBTQ communities (Baker & Durso, 2017). The rulemaking process for Section 1557 also led to comprehensive gender identity protections at the national level, prohibiting health care discrimination on the basis of gender identity.

Since the end of the Obama administration, LGBTQ people have experienced a sharp turn in fortunes. President Trump vowed to repeal the ACA within his first 100 days in office, which would have meant a return to pre-ACA, or potentially even lower, levels of insurance for LGBTQ people. #Out4MentalHealth was active in California's #Fight4OurHealth efforts, drawing attention to the potential impacts of the ACA repeal for LGBTQ Californians. At the same time, the administration began walking back LGBTQ protections in veteran's benefits, education, health care, and more. The Trump administration recalled Section 1557 in 2017 in response to a federal lawsuit, initiated in Texas, contending that the rule's nondiscrimination requirements infringe on religious liberties. Advocates for transgender health have been preparing for potential changes that could include the reduction or elimination of protections for transgender people and the weakening of the guarantee of comprehensive reproductive health care access.

The Religious Refusal rule

Also in 2017, the United States Department of Health and Human Services released a proposed "Religious Refusal" rule and created the Conscience and Religious Freedom Division within the Office for Civil Rights. Analysis of the proposed rule has led advocates to believe some sections merely reiterate existing law, others carry no authority of enforcement, and still more represent blatant and illegal overreaches of federal authority. That being said, many working in LGBTQ health are concerned that even the introduction of the Religious Refusal rule could embolden health care providers to illegally refuse to serve LGBTQ patients. While there is no California legislative fix for the Religious Refusal rule—especially while the rule is still in draft form—it has sparked advocates to undertake conversations with state agencies that regulate health care providers and receive consumer discrimination complaints. Education and outreach will be needed to ensure LGBTQ Californians know this rule does not change their right to access health care free of discrimination, and that those facing discrimination know how to file reports in California.

Transgender military personnel, veterans, and students

The Department of Defense, the Department of Veterans Affairs, and the Department of Education have also acted swiftly to walk back some of their explicit protections for LGBTQ people. In the summer of 2017, President Trump announced his intention to reverse an Obama-era policy allowing transgender people to serve openly in the military. As of this Report, this pronouncement still lacks any concrete implementation plan and many questions remain about the ability for transgender Americans to serve in the military. While leaving transgender active-duty military personnel in limbo, the administration set its sights on transgender veterans. A year after President Trump's announcement, the Department of Veterans Affairs released a proposed change that would exclude coverage for transition-related health care.

Transgender students were not spared either, as Secretary of Education Betsy DeVos has rescinded guidance clarifying the nondiscrimination protections for their rights. While this guidance does not change the underlying law, as with the Religious Refusal rule, #Out4MentalHealth has already seen instances of school districts and personnel feeling emboldened to discriminate against LGBTQ youth.

Expanding Access to Quality and Affordable Health Care

#Health4All

Over the past several years, California policy makers have continued to push forward ambitious health care policies that build on the foundation of the ACA to realize the promise of affordable and high-quality health care for all Californians.

There have been some notable expansions in coverage during this time, including #Health4AllKids, which expanded Medi-Cal to all income-eligible children regardless of immigration status. This has made a significant dent in the uninsured population in California, as a disproportionate segment of uninsured Californians are undocumented immigrants (Kelch, Deborah, & Gallardo, 2017). With #Health4AllKids, 97% of all California children under the age of 18 have some form of health insurance (Lucille Packard Foundation for Children's Health, 2018). Many state legislators have worked to expand on the success of #Health4AllKids in order to cover the remaining uninsured.

Such efforts have encompassed a renewed #Health4All campaign to open the Medi-Cal program to all income-eligible individuals regardless of immigration status, which led legislative budget committees to include two related proposals in the budget negotiations this year: #Health4All Young Adults for ages 18-26, and #Health4All Seniors for ages 65 and over (Health Access, 2018). Neither expansion was included in

the final 2018-19 budget and #Health4All will continue to be a major priority for #CareforAllCA.

Improving health care affordability and quality

In addition to #Health4All, the #Care4AllCA campaign also pursues policy changes to increase subsidies on Covered California, reign in the high cost of health care services, and address federal efforts to undermine the private health care market (Care 4 All California, 2018). Finally, the #Care4AllCA priorities include improving the quality of health care for consumers.

The Medi-Cal Improvement and Disparities Reduction Act (AB 2275 by Assemblymember Joaquin Arambula) aimed to engage stakeholders to set quality improvement and performance targets, create disparity reduction plans, and establish financial incentives for achieving health equity benchmarks (Chen & Nguy, 2018). Unfortunately, Governor Brown vetoed the bill, citing redundancy with existing performance measures—which only require Medi-Cal Managed Care Plans to score in the 25th percentile nationally—and the cost to implement. Given the importance of Medi-Cal in providing health care for LGBTQ Californians, improving the quality of plans and reducing disparities for enrollees will continue to be a priority for addressing LGBTQ health equity.

Housing and Homelessness

No Place Like Home

LGBTQ youth make up approximately 40% of youth experiencing homelessness in California's major cities. Homelessness and housing insecurity is of major concern for LGBTQ Californians of all ages, as well (City and County of San Francisco, 2017).

Over the past two years, California's homeless population has risen by 13.7% to 135,000 people, and the state currently has the highest rate of unsheltered homeless people in the country, at 68.2% (U.S. Department of Housing and Urban Development [HUD], 2017). During #Out4MentalHealth Town Halls and Round Tables throughout the state, community members stated the high cost of housing has presented serious problems for their communities. Likewise, research from the Williams Institute shows LGBTQ people have an increased risk of living in poverty (Badget & Schneebaum, 2016).

The climbing costs of housing has catapulted the already serious issue of homelessness into a crisis throughout California. The governor, state legislature, and local governments have since then committed to addressing this growing problem, including dedicating billions of dollars toward the construction of affordable housing units and expanding services for people experiencing homelessness.

The largest and most high profile of these statewide initiatives is No Place Like Home (NPLH), which encompasses a series of legislative and budget items all focused on addressing homelessness. Signed in 2016, NPLH allocates $2.1 billion in bond funding and additional revenues from real estate transaction fees to build permanent supportive housing for people living with a serious mental illness who are also experiencing homelessness—particularly those who are chronically homeless or at risk of becoming chronically homeless. The Department of Housing and Community Development has spent the past two years establishing a framework for distributing these funds and collecting community and expert feedback on the procurement process. The planning, however, is contingent on voter approval of Proposition 2 (the No Place Like Home Act) in the upcoming November 2018 election, which authorizes the government to take out bonds to fund NPLH (California Department of Housing and Community Development, 2018).

In the meantime, the state is dedicating resources to immediately address the shortage of emergency and permanent housing, provide planning support for local communities, and fund partnerships with county health and human services agencies

providing wraparound services for people experiencing homelessness. The 2018-19

California State budget includes approximately $1 billion spread across a variety of

programs, including additional aid provided through CalWORKS, outreach and

treatment through DHCS, block grants for Continuum of Care and cities to build

permanent supportive housing, and emergency shelters for youth and victims of

domestic violence (Brown, Jr., 2018). The state also anticipates the provision of billions

of dollars to increase access to affordable housing for low- and middle-income

Californians. These funds come in the form of loans, grants, and incentives for

affordable housing builders and homebuyers, including first-time buyers, veterans,

farmworkers, and other income-eligible Californians. Overall, the 2018-19 State budget

allocates over $5 billion for housing and homelessness assistance (Brown, Jr., 2018).

Even with the increased attention and resources directed at addressing

homelessness, advocates must remain vigilant. With the overrepresentation of LGBTQ

people experiencing homelessness, #Out4MentalHealth has supported, and will

continue to support, efforts to create effective, culturally-responsive programs that can

address these disparities. #Out4MentalHealth has advocated at the Homelessness

Coordinating Council and in counties for (1) processes that involve meaningful input

from stakeholders, including people with lived experience, and from communities

disproportionately impacted by homelessness; (2) cultural competency plans that

specifically address LGBTQ Californians; (3) requirements to collect and report on SOGI

data; and (4) funding criteria that rewards applicants for having comprehensive equity

plans.

Additionally, there is a need for more support to address youth homelessness.

Although data is sparse, it is estimated that "up to 50% of chronically homeless adults

were homeless as transition-age youth" (Gillen & Smukowski, 2018). Yet only 2.7% of

shelter beds nationally are dedicated to youth under the age of 25 (Henry, Watt,

Rosenthal, & Shivji, 2017) and the final California state budget allocates only $1 million

in funding to specifically address youth homelessness. The legislature has attempted to

address this issue through the budget process for the last several years, but the funds for youth homelessness account for less than 1% of state funds to address homelessness overall. Many youth do not feel comfortable accessing adult services, so while some youth may marginally benefit from the increase in funding for general homeless populations, specific funding and strategies are necessary to make a dent in youth homelessness. At this time, the state does not provide any funding for transitional housing, which incorporates strategies to address the specific needs of transition-age youth, such as building life skills, family reunification services, education- and employment-relevant support, and more. Transitional housing should be a component of the state's ongoing plans to end chronic homelessness.

Strengthening service coordination for homeless patients

Finally, progress also has occurred for people who experience homelessness and who access medical services through the emergency room. Signed by the governor, SB 1152 requires health facilities to provide a written homeless patient discharge plan policy and process (Strengthening Service Coordination for Homeless Patients Act, 2018). This measure is necessary because there have been cases reported throughout the state of homeless patients being discharged without the proper arrangements, including being dropped off after dark or transported to shelters without any available beds. The lack of comprehensive patient discharge policies contributed to the revolving door of patients seeking care in emergency rooms.

Substance Use

The Adult Use of Marijuana Act

In November 2016, California voters passed the Adult Use of Marijuana Act (Prop 64), legalizing marijuana for recreational use by adults in California and establishing a fund for the education, prevention, early intervention, and treatment of youth substance use. The new revenues generated by state taxes on marijuana represent a unique opportunity to invest in community-based public health education, prevention, early intervention, treatment, and recovery. #Out4MentalHealth has advocated as a member of several statewide coalitions for these revenues to be prioritized through the lens of racial and health equity with a focus on the underlying conditions that lead to substance abuse, such as toxic stress, trauma, multigenerational impacts, stigma, and co-occurring mental illness. These coalitions also weigh how policy and funding decisions can prioritize communities that have been disproportionately impacted by the war on drugs.

Revenues for the 2018-19 fiscal year—the first year for which revenues have been collected —are estimated to reach $630 million (Brown, Jr., 2018). Revenues were lower than expected for the first few months of 2018, and revenues overall are likely to be volatile for at least the first several years of implementation. That being the case, the 2018-19 budget does not allocate any funds to the Youth Prevention, Early Intervention, and Treatment Fund; the budget states that the first year of such funding is likely to be available in the 2019-20 fiscal year.

This year, revenues collected pursuant to Prop 64 will primarily go toward regulation and administration, including paying back the initial general fund loans to establish a regulatory structure. The budget also provides $20 million in new funding for local equity programs—including $10 million for equity applicants for local business licenses in marijuana-related industries and $10 million for community reinvestment to

provide substance use treatment, job placement, and other services in communities impacted by the war on drugs. Recently, #Out4MentalHealth has partnered with health equity organizations to monitor and provide recommendations related to Prop 64's resultant funding.

Harm reduction

#Out4MentalHealth also supports ongoing efforts to implement innovative harm reduction programs throughout California. When the City of Santa Ana attempted to revoke the license for the county's only needle exchange program, Project partners facilitated a connection between the Harm Reduction Coalition and the LGBT Center in Orange County. Due to the on-the-ground social mobilization, and legal challenges, the needle exchange program has been reinstated. Additionally, Project partners have supported AB 186 (Assembly member Susan Eggman), a bill that would allow San Francisco to pilot a first-in-the-nation safe injection service. Supervised injection sites have been shown to be effective in Canada and elsewhere at reducing opioid overdose deaths and connecting people who use drugs with available health care and social services. Although Governor Brown vetoed the bill, elected leaders in San Francisco and advocates are continuing their work to bring safe injection site programs to California.

Expanding Requirements: SOGI Data Collection and Reporting

LGBTQ advocates have been working for years to improve the availability of SOGI (sexual orientation and gender identity) data. We know through community-based participatory research, university-sponsored research, and through anecdotal information that LGBTQ people experience significant health disparities in mental health, sexual health, cancer, and many other areas. The lack of population-level data, however, has made it difficult for community advocates to pinpoint disparities within LGBTQ communities and drive policy change and investment in strategies to address them.

The state has made a significant commitment to improving the availability and quality of SOGI data. As previously mentioned, Governor Brown signed AB 959 (Assemblymember Chiu) in 2015, which requires four departments within California Health and Human Services (CHHS) to collect SOGI data: the Department of Public Health, the Department of Aging, the Department of Health Care Services, and the Department of Social Services. This was a major milestone in setting the expectation that government-funded health programs will collect SOGI data. The California LGBTQ Health and Human Services Network convened a working group of LGBTQ advocates, health experts, and researchers to provide overarching recommendations to CHHS in their AB 959 implementation (Chiu, 2015; AB 959 Working Group, 2017) and answer questions from the departments with the goal of securing high-quality, consistent, and analyzable data across all four departments. Despite efforts from advocates, #Out4MentalHealth interviews with department staff indicate the initial implementation varies across the four departments. Improving the quality of data available as a result of AB 959 will be a continued focus for #Out4MentalHealth, as well as other LGBTQ health advocates. Meanwhile, Assemblymember David Chiu also

championed AB 677, the Reducing LGBT Disparities in Education and Employment Act, which builds on the foundation laid by AB 959 by requiring SOGI data collection for seven state departments focused on education and employment, such as CalWORKS and CalJOBS (Equality California, 2018a; personal communication, Jo Michael, August 1, 2018).

LGBTQ advocates also supported the Mental Health Equity Act or AB 470, a bill written by Assemblymember Joaquin Arambula and sponsored by the California Pan-Ethnic Health Network (CPEHN) that requires the Department of Health Care Services to "update the performance and outcome reporting system (POS) on mental health outcomes and utilization for beneficiaries receiving [Specialty Mental Health Services] in order to focus the POS on disparities" (California Pan-Ethnic Health Network [CPEHN], 2018). The new reporting requirements will help advocates and policymakers understand LGBTQ mental health disparities by identifying whether LGBTQ people are accessing services and being served appropriately. Outcome and quality measures include access, quality, network adequacy, and diagnoses. For example, these measures may include: languages in which a service is offered, the time between the date of first contact to the date of first service and follow-up assessments, referrals, follow-ups after hospitalization, and any gaps in service. While the first round of AB 470 reporting will not include SOGI data measures, #Out4MentalHealth is working with DHCS to implement these measures in future reporting.

The findings from #Out4MentalHealth's research regarding how counties and state agencies are implementing SOGI data collection will inform future advocacy efforts to improve the quality and consistency of SOGI data. While California has made great strides in its efforts to collect this data, more can be done to remove barriers to collecting SOGI data and reporting on LGBTQ health disparities.

Schools: From Law to Reality

LGBTQ youth use substances at twice the rate of their peers and are more likely to have depression or anxiety (Youth.gov, 2018). Approximately 40% of LGBTQ youth report having seriously contemplated suicide (CDC, 2016). Experiences of stigma, isolation, and rejection contribute to these conditions and can have long-lasting impacts on future health. LGBTQ youth report hearing biased language, anti-LGBT slurs, and being verbally or physically harassed at alarmingly high rates. In the 2015 National School Climate Survey, over 95% reported hearing homophobic language while at school—including over 50% who heard these remarks from teachers or other staff—while only 22% were taught positive representations of LGBTQ people in school (Kosciw et al., 2016).

In order to address these disparities, the state has committed to taking steps to reduce stigma and make schools safer and more welcoming for LGBTQ students.

State law generally prohibits discrimination of students based on gender, gender identity, and gender expression, and specifically prohibits discrimination on the basis of gender in enrollment, counseling, physical education, and athletics (Educ. Code § 220, 221.5). AB 1266 adds the requirement that a student must be "permitted to participate in sex-segregated school programs and activities . . . and use facilities consistent with his or her gender identity, irrespective of the gender listed on the pupil's records" (California School Boards Association, 2014, p. 1).

Although laws governing LGBTQ nondiscrimination and inclusion have been on the books for several years, it is only recently that students, staff, and parents have seen meaningful implementation in local schools. According to Jo Michael, the Legislative

Manager for Equality California, after years of hearing from parents whose schools were not following these existing laws "CDE [California Department of Education] complaint processing has improved significantly. There is no longer a backlog and they are now able to say clearly that they received 'X' number of complaints on this or that in this or that year. We have also heard from people on the ground that they are getting responses to their complaints" (J. Michael, personal communication, August 1, 2018).

CDE has also made progress on the implementation of the FAIR Education Act and California Healthy Youth Act (CHYA) in the last two years. The State Board of Education approved new history and social science curriculum in 2017, which is the first to align with the FAIR Education framework. The FAIR Education Act requires school history and social science curriculum to include gender and family diversity, LGBTQ people, and LGBTQ-specific events in history (California Department of Education, 2018). Throughout 2016 and 2017, the board reviewed and approved textbooks based on whether they comply with the FAIR Education framework. It is important for all youth to learn a full and accurate story of our state and nation's history, for LGBTQ youth to see themselves reflected in the pages of their textbooks, and for LGBTQ and non-LGBTQ youth alike to learn about the contributions of traditionally marginalized populations, including LGBTQ people.

The state is also in the midst of updating its K-12 health education framework to align with the CHYA, which requires schools to provide comprehensive LGBTQ-affirming health education. The draft framework under consideration includes vital information and affirmation for California students of all sexual orientations and gender identities. #Out4MentalHealth will monitor the implementation of CHYA, and its success in addressing disparities and improving the health of LGBTQ youth.

Together, these changes are a crucial step toward reducing health disparities LGBTQ youth have experienced and continue to experience.

Protecting Trans, Gender Nonbinary & Intersex Californians

In the years since the publication of *First, Do No Harm* (2012), California has affirmed the right to access gender affirming health and mental health care through new legislation, regulations, and guidance. In fact, protections for transgender, gender nonbinary, and intersex Californians has been one of the areas of most rapid and significant improvement. In addition to advances already described—such as AB 1266 and expanded gender identity data collection—California has taken steps to address challenges specific to transgender Californians.

Governor Brown signed two pieces of legislation in 2017 that expanded and improved the accessibility of identification documents that match a person's gender identity. The Gender Recognition Act of 2017 (SB 179) by Senator Atkins "creates a third, nonbinary gender marker on California birth certificates, drivers' licenses, identity cards, and gender-change court orders, in addition to streamlining the processes for a person to change their gender marker and name on these identifying documents" (Equality California, 2018b). This is breaking new grounds for nonbinary people who identify as neither male or female and have had no opportunity to obtain a state identification document that reflects their gender identity up to this point. The legislative changes made to streamline the name and gender change process are also crucial for many transgender Californians. SB 179 altered the requirements for name and gender changes to make the process less burdensome, less costly, and less time-intensive. Californians who wish to change their name and/or gender now can provide a self-attestation without a physician's verification, do not have to appear in court unless a timely appeal has been filed, and have the opportunity to change their gender marker while under the age of 18 (Gender Recognition Act, 2017). Additionally, the Name and Dignity Act (SB 310) by Senator Atkins ensures that transgender people who

are incarcerated also have the right to legal documents matching a person's name and gender identity (Equality California, 2018c).

 In 2013, the Department of Managed Health Care (DMHC) released guidance affirming that it is illegal for health insurers to discriminate against people on the basis of gender identity and plans must cover transition-related services (California Department of Managed Health Care, 2013). The state's other health plan regulators, the Department of Insurance and the Department of Health Care Services, released similar guidance around the same time.

Post-guidance, the availability of transition-related health care has been further clarified through legal challenges and the independent medical review process. One of the areas with the greatest evolution has been the definition of "medically necessary" care. Even after the 2013 guidance, many health insurers continued to deny coverage for transition-related care on the basis that such procedures were cosmetic or elective, rather than medically necessary treatments for transgender patients. Transition-related health care encompasses various services: mental health care, primary care, hormone therapy, and transition-related or gender affirming surgeries. This last category encompasses many different procedures that may or may not be a part of an individual patient's medical transition: hysterectomy, vaginoplasty, phalloplasty, electrolysis, and tracheal shave are just some examples (World Professional Association for Transgender Health, [WPATH], 2011). Today, after many challenges, health plans cover a wider range of available transition-related care.

In 2018, the legislature also took the step of adding the right to access gender affirming care to the Foster Youth Bill of Rights (Gender Health in Foster Care Act, 2018). This law clarifies that foster youth have the right to access gender affirming health and mental health care, removing any ambiguity for family court judges who make determinations about a child or young adult's health care rights.

Law Enforcement and Criminal Justice

A decade of reforms

LGBTQ Californians are disproportionately represented in the criminal justice system and many of the causes of these disparities are addressed in the Law Enforcement and Criminal Justice section of this Report. California policy changes have impacted the criminalization of LGBTQ people both through policies that reduce incarceration overall and others that specifically address LGBTQ disparities.

Through a series of lawsuits, legislative changes and ballot initiatives, California has initiated reforms over the past decade "aimed to reduce incarceration, promote more effective pathways to rehabilitation, prevent crime, and spend tax revenues more wisely" (Graves & Rose, 2017). Passed over the course of a decade, these initiatives reverse some of the highly punitive laws passed in the 1990s in favor of an approach more focused on community-based intervention and rehabilitation. There have been dozens of reforms aimed at reducing California's prison population, some of which include: sentencing reforms (Proposition 57), reclassification of drug-related offenses (Proposition 47 & Proposition 64), amending the "three strikes law" (Proposition 36), and the elimination of cash bail (SB 10, 2018). Such reforms will undoubtedly benefit LGBTQ people who are involved in the criminal justice system.

The state has also taken steps to reduce LGBTQ disparities in the criminal justice system by modernizing laws that criminalize HIV. In 2017, Governor Brown signed SB 239 (Senator Scott Wiener and Assemblymember Todd Gloria), which eliminated sentence enhancements for sex workers who are HIV-positive and aligned punishments for exposure to HIV with those of other communicable diseases (Equality California, 2017). The former laws had been on the book since the early 1990s, when there was limited information about how HIV was transmitted and before modern prevention and treatment options. Prosecution under these laws disproportionately affected

transgender women, gay and bisexual men, people of color, and people engaging in sex work. Criminalization of HIV status is just one example of how LGBTQ Californians have historically been impacted by status offenses, and the legislature has taken on this issue in the past. For example, it is now illegal for prosecutors to use the fact that someone was in possession of condoms as evidence they were engaging in sex work—which had been common practice for many years (AIDS Healthcare Foundation, 2014). However, there is much left to do to decriminalize homelessness, sex work, and status offenses such as truancy.

"Together We Can"

The MHSOAC also took steps in 2017 to address the overrepresentation of people with mental health needs in the criminal justice system. #Out4MentalHealth supports the stated goal of *Together We Can, Reducing Criminal Justice Involvement For People with Mental Illness* "to prevent people with mental health needs from getting into the criminal justice system in the first place" (MHSOAC, 2017, p. 7), and specifically the use of the Sequential Intercept Model and a focus on Intercept Zero (Community, 2017; McAllister-Wallner & Walker, 2017). In the coming years, there will be opportunities for the MHSOAC, legislature, the new administration, and advocates to implement these recommendations.

Improving conditions for incarcerated LGBTQ people

For LGBTQ people who are incarcerated, prisons can be particularly dangerous for both their physical and mental health. Rape and sexual assault are a problem in prisons, and one that particularly affects LGBTQ people. In 2003, Congress passed the Prison Rape Elimination Act (PREA) and the U.S. Department of Justice later approved regulations implementing the law in 2012. The new regulations require prison officials

to take a variety of measures to prevent sexual assaults, including risk assessments that take a person's sexual orientation and gender identity into account, prohibiting cross-gender strip searches, and separating youth from adult inmates (National Center for Transgender Equality, 2012). While the new regulations are welcomed, there remains a great deal of room for improvement. For example, PREA allows correctional facilities to make decisions about housing transgender inmates on a case-by-case basis. In practice, many facilities make this determination based on what surgeries a transgender person has had, leaving many vulnerable to violence while in sex-segregated facilities that do not match their gender identity. Additionally, advocates from the National Center for Lesbian Rights in California are calling for correctional agencies to "house transgender women in female housing units, ensuring transgender prisoners' access to hormone therapy, and implementing policies and procedures that protect LGBT prisoners from sexual and physical violence" (National Center for Lesbian Rights, 2017).

Emerging Issues: LGBTQ Older Adults & Disaster Response

An emerging area of focus for the state legislature has been the disparities LGBTQ older adults face. SB 219 (Senator Scott Wiener) was signed into law in 2017, creating a bill of rights for LGBTQ seniors in assisted living facilities (LGBT Senior Bill of Rights, 2017). Older adults at #Out4MentalHealth Town Halls and Round Tables spoke of experiencing discrimination or rejection from service providers, shared their feelings of isolation, and expressed fears of being mistreated in assisted living facilities. Due to SB 219, LGBTQ older adults in assisted living facilities—who are among the most vulnerable— now have additional protections:

> The new state law requires facilities to refer to residents by their preferred name or pronoun and prohibits facilities from denying admission, involuntarily

discharging, evicting or transferring a resident within a facility or to another

facility based on anti-LGBT attitudes of other residents or a person's actual or

perceived sexual orientation, gender, gender identity, gender expression or HIV

status. Facilities also are required to post a notice regarding LGBT

discrimination where the current nondiscrimination policy is posted (Bowers,

2017).

Earlier this year, Governor Brown signed another law expanding resources for

LGBTQ older adults. AB 2719, by Assemblymember Irwin, "adds sexual orientation,

gender identity, and gender expression to the definition of elderly communities to be

given priority consideration for programs and services administered through the

California Department of Aging" (Irwin, 2018). By identifying LGBTQ older adults as a

population of "greatest social need" (Recognizing the Needs of LGBT Older Adults Act,

2018), California is declaring its intent to prioritize strategies and programs that

specifically address their needs.

Another emerging topic of concern is how LGBTQ communities are impacted by

natural disasters and other emergency situations. #Out4MentalHealth is not aware of

any recent policies related to the needs of LGBTQ people during emergency situations.

However, given feedback from several #Out4MentalHealth Task Forces, this is an area

for future policy consideration. Since the beginning of #Out4MentalHealth's work a

year ago, California has been hit by several major natural disasters, including three

major wildfires that overlap with #Out4MentalHealth Task Forces: the Tubbs and

Pocket Fires in Sonoma County and the Carr Fire in Shasta County. #Out4MentalHealth

heard from local LGBTQ communities about several ways in which these fires impacted

them. First, some emergency shelters for people who were forced to evacuate their

homes were not LGBTQ-inclusive. As an example, the Salvation Army has been known

to discriminate against LGBTQ employees, refuse service to LGBTQ people, and require

transgender people to be housed according to their sex assigned at birth rather than

their current gender identity (Glass, 2017). Second, wildfires and other disasters can set

off ripple effects throughout communities that last long after the immediate danger has passed, as with climbing Santa Rosa rents in the aftermath of several fires that devastated the local housing supply. LGBTQ people are especially vulnerable in these situations as they already face disproportionate rates of poverty, housing insecurity, and homelessness. In the coming years, the state and counties can address these concerns by codifying protections for LGBTQ Californians seeking emergency services, requiring the Office of Emergency Management to work with county diversity officers during crisis planning and response, and engaging LGBTQ stakeholders to develop additional strategies to ensure equitable access to services during a crisis.

RECOMMENDATIONS

Directions for Equity

The following recommendations are based on the research and findings reflected in *Mapping the Road to Equity: The Annual State of LGBTQ Communities, 2018*. These recommendations are meant as guidance for state and local agencies to reduce disparities faced by LGBTQ people and advance LGBTQ health and mental health equity. This list is by no means exhaustive and does not cover all of the possible ways state and local agencies can support their LGBTQ residents. #Out4MentalHealth hopes these recommendations can pave the way for healthier lives for LGBTQ Californians and communities where all can be welcomed and affirmed.

Law Enforcement & Criminal Justice

- Improve accountability and transparency of state and local law enforcement agencies, including thorough implementation of an Independent Commission for Police Activity Review. (For examples in California and nationwide, visit the National Association for Civilian Oversight of Law Enforcement at www.nacole.org.)
- Implement rigorous training for state and local law enforcement personnel, including CIT trainings and anti-bias trainings in accordance with the Peace Officer Training Act.
- Ensure jail and prison housing policies provide transgender detainees housing in accordance with their gender identity, in safe and appropriate sex-segregated facilities.
- Enforce the right to be searched by someone of the detainee's own gender identity.
- Increase the use of crisis intervention teams consisting of mental health professionals and peers. Support education and outreach efforts ensuring community members know about the existence of these teams. Provide sufficient crisis support resources whenever needed to divert people experiencing a mental health crisis away from law enforcement involvement.
- Eliminate laws criminalizing people for being homeless, engaging in sex work, or other status offenses (i.e., truancy and running away from home).
- Increase resources to programs diverting people in crisis to social services rather than jail, juvenile justice facilities, or prison.

Homelessness and Housing

- Expand funding for accessible and affordable public transportation from under-resourced areas into service-rich areas.
- Ensure policies allow LGBTQ-safe access within sex-segregated and family shelters and enforce federal regulations requiring that transgender people have the opportunity to be housed in accordance with their gender identity.
- Fund the incorporation of LGBTQ peer providers in shelters.
- Increase funding for dedicated services for homeless and runaway youth programs and ban high-barrier shelters that reduce access for LGBTQ youth.
- Expand transitional housing programs, offering support for transition-age youth.
- Address the lack of affordable housing—particularly in areas where LGBTQ services are located.
- Ensure LGBTQ-affirming emergency housing is available during natural disasters and other states of emergency.

Schools and Families

- Engage LGBTQ stakeholders in the Local Control Accountability Plans (LCAPs) process and dedicate Local Control Funding Formula (LCFF) resources for LGBTQ-inclusion programming and curriculum in schools.
- Enforce compliance with AB 1266, which requires students to have equal access to sex-segregated facilities (i.e., restrooms and locker rooms) in accordance with their current gender identity.
- Interrupt the school-to-prison pipeline by prioritizing alternatives to police presence in schools, such as:
    - investments in after school programming;

- ○ parent engagement;

- ○ mental health services in schools;

- ○ student re-housing and teen independent living initiatives; and

- ○ de-gendered dress code policies.

- Support students and staff to develop and strengthen GSA organizations in schools and facilitate connections between in-school GSA organizations and local LGBTQ services and organizations.

- Robust implementation of the FAIR Education Act, including replacing outdated history and social science text books and using the FAIR Coalition rubric to inform school district curriculum adoption.

- Require teachers, administrators, and other school staff to receive training in LGBTQ cultural competency and suicide prevention.

- Partner with local LGBTQ-specific organizations to connect students and staff to culturally-responsive health, mental health, educational, and social programming.

- Provide education and training for parents about how to be supportive of their LGBTQ children.

- Enforce provision of LGBTQ competency training for all resource families by child welfare agencies.

Health Care Access

- Reorient county safety-net services, also known as indigent health services, to best serve the remaining uninsured, using the model of My Health LA, which expanded services to cover low-income Angelenos regardless of immigration status and shifted the focus of safety-net services from emergency care to primary and preventative care (Health Access Foundation, 2016).

- Fund programs to help transgender people access covered transition-related care, such as health system navigators or community liaisons.
- Expand Medi-Cal to cover all income-eligible Californians, regardless of immigration status.
- Increase the accessibility of transition-related services through workforce development programs, such as tuition assistance for providers of transition-related care, incentives for providers to increase their scope of practice, and offering continuing education.
- Increase Covered California subsidies for low- and middle-income Californians, and expand measures to reign in high health care costs.

SOGI Data Collection

- Standardize questions and SOGI data measures across all state and county programs required to ask demographic questions under AB 959, AB 677, and the MHSOAC's PEI & INN Regulations.
- Implement consistent use of paper or tablet for collection of demographic data.
- Follow DHCS Privacy Guidelines for data de-identification in collection and reporting.
- Revise demographic data collection procedures such that counties are responsible for collecting and reporting disaggregated data, and state departments are responsible for analyzing that data and making it available to researchers, advocates, and other stakeholders.
- Provide training to counties on standard procedures to collect and report SOGI data across all programs, including best practices that protect client population privacy in data collection and reporting.

- Translate recommended SOGI data measures into all threshold languages for consistent use across all programs and counties collecting demographic data.
- Incorporate sexual orientation and gender identity measures into Medi-Cal Specialty Mental Health performance and quality reporting.

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Appendices

A. Methods & Sources Informing This Report

1. Literature Review

  #Out4MentalHealth conducted a database search of the peer-reviewed literature for information on current major mental health issues for LGBTQ communities. Other activities informed the focus of this literature review; for example, participants in #Out4MentalHealth Town Halls and Round Tables frequently spoke about policing, and therefore the review of the literature and this Report includes a section on law enforcement practices.

2. Town Halls & Round Tables

  #Out4MentalHealth worked alongside local organizations to hold events for the purpose of asking LGBTQ Californians about the positives and negatives of their communities, their experiences accessing mental health services, and what affirming and rejecting provision of care looks like to them.

  The Town Halls and Round Tables took place in April and May of 2018 with the help of local partners who hosted and sponsored these events, including:

- Bay Area Town Hall: Positive Images, LGBTQ Connections, and Buckelew Programs
- Veterans Round Table: The San Diego LGBT Community Center, San Diego Pride, Veterans Village of San Diego, Veterans Wall of Honor, and TAVA
- LA Older Adults Round Table: The Los Angeles LGBT Center

- Queer and Trans People of Color Town Hall: Bienestar, the San Fernando Valley LGBT Center, the TransLatin@ Coalition, Tarzana Treatment Centers, CSU Northridge Pride Center, and PFLAG
- Bisexual / Pansexual / Fluid Round Table: the Orange County LGBT Center on 4th
- Central Region Town Hall: Centro la Familia and Pink Panthers
- Southern Region Town Hall: The Center for Sexuality & Gender Diversity and Kern County Behavioral Health and Recovery Services
- Superior Region Town Hall: Stonewall Alliance and Sam White-Swan Perkins Consulting

At least 193 people attended the eight #Out4MentalHealth Town Halls and Round Tables. Not all attendees signed in or completed demographic forms. #Out4MentalHealth determined that 193 people attended by comparing the zip codes reported by attendees who signed in at the events (n = 187) and reported by attendees who completed demographic forms (n = 173). Attendees shared with #Out4MentalHealth their experiences as students, parents, service providers, people of color, older adults, veterans, community organizers, and mental health clients/consumers. Attendees were asked to sign in at #Out4MentalHealth events and complete demographic forms that asked sex assigned at birth, current gender identity, sexual orientation, race / ethnicity, ability status, and veteran status. Attendees were not asked about medical or mental health conditions, marital status, or behaviors that may or may not be associated with their identities. The following demographic information shows whose voices were included at our events.

Table 1. Town Hall & Round Table Participants by County

REGION	COUNTY	TOTAL
Superior Region	Butte	11
	Lake	1
Bay	Sonoma	45
	Solano	2
Central	Fresno	14
	Tulare	2
	Yuba	1
Southern	Kern	34
	Orange	19
	San Diego	14
	Ventura	1
	San Bernardino	1
Los Angeles	Los Angeles	48
	TOTAL	193

Participants completed demographic forms when participating in #Out4MentalHealth Town Halls and Round Tables. On some questions, like sex assigned at birth, participants only marked one distinct answer for their response. For many other questions, participants often marked multiple choices to identify their gender identity, sexual orientation, race and ethnicity. The demographic tables below therefore show the number of times demographic options were selected by Town Hall

and Round Table attendees. The sums of each section do not equal the total respondents per question; rather, the total number of respondents is equal to the number of people who answered the question at all. Similarly, the percentages sometimes add up to more than 100% because many people marked multiple options per question.

Tables 2 - 7: Town Hall & Round Table Participant Demographics

"What sex were you assigned at birth (check one)?"			
Sex Assigned at Birth	Female	92	55%
	Male	73	44%
	Intersex	2	1%
	Total	**167**	**100%**

"Which BEST describes your current gender identity?"			
Current Gender Identity	Woman	70	41%
	Man	60	36%
	Trans and/or Transgender	17	10%
	Genderqueer/Nonbinary	22	13%
	Questioning my gender identity	6	4%
	Another gender identity	6[1]	4%
	Total	**169**	**108%**

[1] Examples of "Another gender identity" include Two Spirit, Agender, Androgynous, and Transmasculine.

"Do you think of yourself as:"			
Sexual Orientation	Lesbian or Gay	78	46%
	Bisexual Pansexual Sexually Fluid	53	31%
	Queer	38[2]	22%
	Heterosexual	20[3]	12%
	Questioning or unsure of sexual orientation	1	.01%
	Another sexual orientation	6	.04%
	Total	**170**	**111%**

[2] Of the 38 Queer people who attended, 15 also identified as Bisexual / Pansexual / Sexually Fluid.

[3] Of the 20 Heterosexual people who attended, 2 identified as trans or transgender and 18 of them responded with congruent current gender identity and sex assigned at birth. Some were parents or family of LGBTQ children, but the demographic survey did not ask for this information.

"What is your Race/Ethnicity (please check all that apply)?"			
Race and Ethnicity	Asian/Pacific Islander	14	8%
	Black African American African Ancestry	8	5%
	Latinx/Latino	47	27%
	Middle Eastern	4	2%
	Native American Alaskan Native	15	9%
	Pacific Islander	1	1%
	White/European	109	63%
	Total	**173**	**115%**
Representation of People of Color	White (marked only White on the form)	74	43%
	People of Color	99	57%
	Total	**173**	**100%**

"Do you identify yourself as an individual living with a disability?"		
Living with a disability	Yes	62	37%
	No	106	63%
	Total	**168**	**100%**

"Have you ever served in the military?"		
Military Veteran	Yes	18	11%
	No	150	89%
	Total	**168**	**100%**

The structure of Town Halls and Round Tables does not always allow for asking detailed questions of individual experiences and identities. #Out4MentalHealth heard the voices of people who self-identified as pansexual, gender nonconforming, gender nonbinary, two-spirit, asexual, polyamorous, and intersex. It is unclear from the events whether #Out4MentalHealth heard from same-sex attracted people who do not identify with LGBTQ identities, same-gender loving people, people who engage in kink and/or BDSM, or people who are in the closet. Some community members whose identities were not listed wrote in their identities, as shown in the table above, but other identities may not have surfaced in their responses.

Town Hall and Round Table participants were all asked the same questions, listed below.

- What in [city or region] makes it easier to be LGBTQ?
  (En [ciudad o región], ¿qué nos hace más fácil ser LGBTQ?)

- What do you think are the greatest challenges facing LGBTQ people in your [city
  or region]?
  (¿Cuáles crees que son los retos más grandes que LGBTQ enfrentan
  en [ciudad o región]?")

- In your experience, what makes a provider feel rejecting to you?
  (En tu experiencia, ¿cómo es que un proveedor te hace sentir rechazo?)

- In your experience, what makes a provider feel affirming to you?
  (En tu experiencia, ¿cómo es que un proveedor te hace sentir aceptado?)

#Out4MentalHealth staff scribed (wrote on large papers) what they heard at the Town
Halls and Round Tables and then looked for major themes across all of the events. The
following themes are discussed because participants across California consistently
spoke to these concerns. Quotations intersperse this Report to feature community
voice and to show the shared and diverse experiences of LGBTQ people across
California. Responses are maintained in their original language (with in-text English
translations) to maintain the greatest integrity of LGBTQ Californians' voices.

At most of the events, the questions were spoken in English and written on a
projected screen in English and Spanish, as shown in the format above. Planning,
funding, and other barriers prevented consistent and formal Spanish translation
services from being offered at the events in the robust manner diverse communities
deserve, and community members and local partners graciously filled in the gaps when
needed and possible. Following the Queer and Trans People of Color (QTPOC) Town
Hall in the San Fernando Valley, partners at Bienestar collected additional written
responses to questions in Spanish to make sure the voices of Spanish-speaking
participants were included in this Report. Additionally, #Out4MentalHealth events were

inaccessible for monolingual speakers of languages other than English and Spanish, like ASL (American Sign Language), Mandarin, and Hmong.

3. County SOGI Data Surveys

The Mental Health Services Oversight and Accountability Commission (MHSOAC), which oversees the use of mental health services funding in California, requires county mental health and behavioral health programs to ask specific demographic questions of service recipients.

Prevention & Early Intervention (PEI) programs and Innovation (INN) programs are specific types of mental health services under the Mental Health Services Act (MHSA). Such programs are required by the MHSOAC to ask questions on sex assigned at birth, current gender identity, and sexual orientation, and counties are required to report back to the MHSOAC on specific categories for each of these questions.

#Out4MentalHealth identified county personnel to interview with the help of the California Behavioral Health Directors Association (CBHDA), who sent invitations to participate to all 59 Behavioral Health Directors in California. #Out4MentalHealth interviewed 37 of the 59 counties and mental health authorities in California to learn whether or not they are collecting SOGI data, how they are collecting that data, and what barriers they are facing in the process. Responses from one of the 37 counties were not included due to the interviewee lacking sufficient expertise to answer the questions asked. Each interview lasted approximately 30 minutes, including introductions to the phone call. Some interviewees provided additional information after the call if, for example, they did not know the answer and wished to consult with other staff. Outcomes of these surveys are provided in this Report. The data collected is de-identified for confidentiality; however, counties are grouped by size to assess for potential trends.

Interviewees were asked in advance to have their county PEI and INN demographic forms available for their reference during the call; some counties offered to send these forms to #Out4MentalHealth to ensure accuracy and ease of data collection. The interviews included some of the following questions, all of which were asked verbally over the phone. The interviewer read questions and reviewed each answer option out loud with the interviewee. Interview questions reported on in this Report are shown below:

- **"Which of the following demographic information does your county ask?"**
    - Sexual orientation only
    - Gender identity only
    - Both sexual orientation and gender identity
    - Neither

- **"What categories of sexual orientation does your county include as options?"**
    - Heterosexual or straight
    - Lesbian or gay
    - Bisexual
    - Queer
    - Questioning or unsure of sexual orientation
    - Another sexual orientation
        - Is there a space to write in or specify?
    - Other
        - Is there a space to write in or specify?
    - Decline to State
    - We ask "Sexual orientation" with a blank to write in and offer no specific options
    - We ask if they are LGBTQ or not and we offer a Yes or No Response

- **"What categories of current gender identity does your county include as options?"**
    - Male
    - Female
    - Transgender
    - Genderqueer
    - Questioning or unsure of gender identity

- ○ Another gender identity
  - ■ Is there a space to write in or specify?
- ○ Other
  - ■ Is there a space to write in or specify?
- ○ Decline to State

- **"What barriers prevent staff in your county from collecting or reporting SOGI data?"**
  - ○ Confidentiality concerns
  - ○ Funding
  - ○ Staff do not know how to ask the question(s)
  - ○ Fear of offending clients from specific religious, ethnic/racial, geographic or other cultures
  - ○ There is a belief that LGBTQ people do not access our programs
  - ○ County contractors cannot or do not report their data
  - ○ Our county has determined that these questions are not age-appropriate for youth under (please specify age: ___)
  - ○ Staff believe that there is no requirement to ask these questions in one or more programs
  - ○ One or more of our programs is a "one-time" event like a health fair
  - ○ Our county has many residents who are unsupportive of LGBTQ people and these questions may elicit an angry response
  - ○ Other (invitation to add barriers not mentioned above)

4. Key Informant Interviews

#Out4MentalHealth interviewed two people who carry a statewide perspective on LGBTQ issues. Special thanks to Jo Michael at Equality California and to Jennifer Susskind for participating in these interviews. Jo Michael provided insight on current legislative projects and LGBTQ-related policies to look forward to. Jennifer Susskind spoke to her expertise on county SOGI data collection, which has helped in the analysis of the County SOGI Data Collection surveys.

In addition to the statewide key informant interviews, the county SOGI surveys greatly contributed to #Out4MentalHealth's knowledge of local trends in county programming and data collection. This local key information, such as new LGBTQ-oriented community projects and stories of school personnel not cooperating with county efforts to collect data, provided the project with important insight into local struggles and successes. Special thanks to all county interviewees who participated in this process.

B. Abridged List of Resources Online LGBTQ Clearinghouse

The following table includes organizations throughout California that serve the health, community, and legal needs of LGBTQ Californians or advocate for policy change on their behalf. This list is a subset of the #Out4MentalHealth online resource clearinghouse, which can be found at www.californialgbthealth.org/resourcesbycounty.html. In addition to statewide resources, the online clearinghouse includes a regularly-updated list of LGBTQ-serving organizations and resources in each county in California.

Organization	Website	County	City	Population Served
American Institute of Bisexuality	http://www.bisexual.org/home.html	National	National	Bisexual
API Equality - Los Angeles	https://www.apiequalityla.org/	Los Angeles	Los Angeles	POC
API Equality - Northern California	http://www.apiequalitync.org/	San Francisco	San Francisco	POC
California Commission on Aging	http://www.ccoa.ca.gov/	California	Sacramento	Elders
California Latinas for Reproductive Justice	http://www.californialatinas.org/	California	Los Angeles	POC
California Pan-Ethnic Health Network	https://cpehn.org/	California	Sacramento, Oakland, Los Angeles	POC
California Partnership to End Domestic Violence	http://www.cpedv.org/	California	Sacramento	

California Rural Legal Assistance	http://www.crla.org/	California	Oakland	
Center of Excellence for Transgender Health	www.transhealth.ucsf.edu	San Francisco	San Francisco	Trans
Children's Hospital Los Angeles - The Center for Transyouth Health and Development	http://www.chla.org/the-center-transyouth-health-and-development	Los Angeles	Los Angeles	Youth
Community United Against Violence (CUAV)	http://cuav.org/	San Francisco	San Francisco	
Courage Campaign	https://www.couragecampaign.org/	California	State wide	
Equality California	www.eqca.org	Los Angeles	Los Angeles	
Familia: TQLM	http://familiatqlm.org/	National	Los Angeles	POC
Gay and Lesbian Medical Association	www.glma.org	National	National	
Gender Spectrum	https://www.genderspectrum.org/	California		Trans
Genders and Sexualities Alliance Network	https://gsanetwork.org/	California, National	Oakland	Youth
GetEQUAL	http://www.getequal.org/	National	National	
Latino Equality Alliance	http://www.latinoequalityalliance.org/	Los Angeles	Los Angeles	POC
Nat'l Center for Lesbian Rights	www.nclrights.org	National	National	

National Black Justice Coalition	http://nbjc.org/	National	National	POC
National Queer and Trans Therapists of Color	https://www.nqttcn.com/	National	Oakland	POC
NorCal Mental Health America	www.norcalmha.org	California	Sacramento	
Our Family Coalition	http://www.ourfamily.org/	Alameda and San Francisco	SF and East Bay	
PFLAG	http://www.pflag.org/	National	National	Families
Racial and Ethnic Mental Health Disparities Coalition	http://remhdco.org/	Sacramento	Sacramento	POC
Transgender Law Center	www.transgenderlawcenter.org	Alameda	Oakland	Trans
Trevor Project	https://www.thetrevorproject.org/	National	National	Youth

C. Acronym Glossary

AB 959: The LGBT Disparities Reduction Act of 2015 - Assembly Bill 959

ACA: Affordable Care Act

Bi/pan/fluid: bisexual/pansexual/sexually fluid

BRFSS: Behavioral Risk Factor Surveillance System

CBHDA: California Behavioral Health Directors Association

CDC: Centers for Disease Control and Prevention

CDE: California Department of Education

CHHS: California Health and Human Services Agency

CHYA: California Healthy Youth Act

CPEHN: California Pan-Ethnic Health Network

DHCS: Department of Health Care Services

DMHC: Department of Managed Health Care

DSS: Department of Social Services

EHR: Electronic Health Record

GSA: Gender and Sexuality Alliance

HIPAA: Health Information Portability and Accountability Act

INN: Innovation

LGB: Lesbian, Gay, Bisexual

LGBQ: Lesbian, Gay, Bisexual, Queer

LGBTQ: Lesbian, Gay, Bisexual, Transgender, Queer, & Questioning

MHSA: Mental Health Services Act

MHSOAC: Mental Health Services Oversight and Accountability Commission

NPLH: No Place Like Home Initiative

PEI: Prevention and Early Intervention

POS: Performance and Outcome Reporting System

PREA: Prison Rape Elimination Act

PrEP: Pre-Exposure Prophylaxis

QTPOC: Queer and Trans People of Color

RHY: Runaway and Homeless Youth

SESTA-FOSTA: Stop Enabling Sex Traffickers Act and Fight Online Sex Trafficking Act

SOGI: Sexual Orientation and Gender Identity

SRO: School Resource Officers

STI: Sexually Transmitted Infection

D. #Out4MentalHealth Project Fact Sheets

#Out4MentalHealth produced fact sheets to distribute to the general public, community members, providers, county staff, and policy makers. Available fact sheets as of October 2018 are included here. PDF versions of the fact sheets can be found by visiting www.out4mentalhealth.org. The following fact sheets include:

1. **Pronouns**
2. **Hiring an Affirming Therapist**
3. **Creating Visibility: Why & How to Collect SOGI Data**
4. **Importance of Access to Gender Affirming Care**
5. **LGBTQ Youth and the School-to-Prison Pipeline**
6. **County Local Boards and Commissions Websites**
7. **Making Public Comment**

#Out4MentalHealth

A project of the CA LGBT Health & Human Service Network and NorCal Mental Health America

Pronouns: Why, how, when, and what if I mess up?

When people refer to us in the third person, they use gendered pronouns. Pronouns can be useful to avoid clunky phrasing, like repeating a person's name over and over. Some examples of pronouns and the ways that they are used are shown below:

Subject	Object	Possessive	Reflexive
He	Him	His	Himself
He loves his dog and his dog loves him. He walks his dog himself.			
She	Her	Her(s)	Herself
She loves her dog and her dog loves her. She walks her dog herself.			
They	Them	Their(s)	Themself / Themselves
They love their dog and their dog loves them. They walk their dog themself.			
Ey ("ay")	Em ("em")	Eir ("air")	Eirself
Ey loves eir dog and eir dog loves em. Ey walks eir dog emself.			
Ze ("zee")	Zir or Hir ("zee" or "here")	Zir(s) or Hir(s)	Zirself or Hirself
Ze loves zir dog and zir dog loves zir. Ze walks zir dog zirself.			
[Name]	[Name]	[Name]'s	[Name]self
Reed loves Reed's dog and Reed's dog loves Reed. Reed walks Reed's dog Reedself.			

Why do we ask about pronouns?

People use a variety of pronouns. You cannot tell just by how a person looks what pronouns to use. Asking a person their gender pronoun is the direct, respectful, and simple way to learn about their pronouns.

A project of the CA LGBT Health & Human Service Network and NorCal Mental Health America

How do I ask about pronouns?

If you're asking a group, you should propose that the group share their pronouns while introducing themselves and then model for the group how to share pronouns by sharing your own. If you're asking an individual, just ask! You can ask by saying "What pronouns do you use?" or "What pronouns can I use to refer to you?"

How should I respond when people ask me and people around me about pronouns?

For a lot of people, pronouns are deeply personal and important, regardless of which pronouns they use or why they use those pronouns. When someone asks you, they are telling you that they care and that they want to treat you with respect.

Sometimes we laugh or giggle when we find ourselves in unfamiliar circumstances. People who are not used to thinking about their gender or their pronouns may feel uncomfortable. Don't giggle or roll your eyes when saying your own pronouns or when hearing other people's pronouns.

When and in what spaces should this happen?

Trans people[1] exist in all spaces, so you should make asking this question a regular practice. Asking a person or group to share their pronouns helps to signal that the space is trans-affirming. It creates an opportunity for cisgender[2] people to think about the common spaces that they share with trans people and how to respectfully interact with trans people in their lives. Finally, it provides everyone with the knowledge and skills to treat each other with respect.

What if I mess up?

Humans make mistakes. What matters is to show that you're trying. If you mess up, simply repeat what you just said using the correct pronoun and don't make a big deal of it. Whoever you're talking to will most likely appreciate the effort.

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[1] Trans is an umbrella term to refer to people who identify as a broad variety of genders other than the sex assigned to them at birth. It includes transgender, genderqueer, gender nonconforming, two-spirit, and more.

[2] Cisgender = not trans

#Out4MentalHealth

Finding a Therapist:
You Deserve Care from an LGBTQ-Affirming Provider

The Need

For many of us, mental health services help to support our health and stability. LGBTQ people not only face the usual life struggles that bring people to therapy, but also experience stress because of homophobia and transphobia.

We deserve to have providers who treat us with respect, have experience providing LGBTQ-affirming care, and take initiative to continue their learning so that they can provide us with the best possible care.

Hiring your LGBTQ-affirming Therapist

Your therapist works for *you.* For anyone doing any other job on your behalf, you would interview them--and you can (and should) interview your potential therapist.

Here are some questions you may want to ask:

- How long have you been in practice?

- What experience do you have in working with [LGB, trans/transgender, queer, intersex, polyamorous, asexual, kink, etc.] people?

- Are you able to support me as I explore my experiences as an LGBTQ person [of color, of faith, from another culture, etc.]?

- What background do you have working with people with my experience [people living with HIV, survivors of violence, sex workers, substance users, people with eating disorders, etc.]?

- If needed, will you work as a team with my general practitioner, social worker, faith leader, and/or my other care professionals?

- What experience do you have working with a family or relationship like mine? (If you are seeking family or couples counseling.)

- What expertise do you have working with the issue I'm coming to therapy for [depression, anxiety, grief, sexual orientation/gender identity exploration, gender transition, relationship concerns, etc.]?

- Do you provide and have experience writing letters for hormone therapy and/or other gender-affirming medical care? What are your requirements for writing those letters?

- How will you interact with me if we run into each other in public? (This is especially important if you live in a small town or are part of a small LGBTQ community.)

You Deserve Affirming Care

As a community we have experienced rejection and discrimination, therefore we may feel satisfied if a provider is simply nice to us. There is a difference, however, between "typical" or "non-rejecting" care and "affirming" care. You deserve affirming care that is culturally informed and LGBTQ-specific.

"Typical Care"	Affirming Care We Deserve
"I've never heard that term. What does genderqueer mean?"	"I've heard people use the term genderqueer. What does it mean for you?"
"It sounds like your relationship is really complicated."	"I admit, I'm not familiar with working with polyamorous people, and I should be. I'm going to seek education so I can better support you."
"I like working with LGBT people."	"I've been specializing in transgender care for the past 10 years."
"I had problem with your pronouns in the beginning, too."	"That must have been really painful for you to be misgendered"

The Respect You Should Expect From Providers

Your provider should not:

- Focus on your sexual orientation or gender identity, unless that is why you sought care
- Assume that you are (or should be) straight, cisgender, or monogamous
- Assume that a negative experience made you LGBTQ
- Ask unnecessary and invasive questions about your body
- Expect you to educate them about LGBTQ identities, cultures, and experiences
- Expect or encourage you to have a personal, physical, or sexual relationship with them

Something to Remember: Providers are not perfect. You can question their observations and let them know if something is not working for you. You are the expert of your own life and your therapist is a tool for change, not a director for change.

Creating Visibility:

Why and How You Should Collect Data on Sexual Orientation & Gender Identity

Lesbian, gay, bisexual, transgender, and queer (LGBTQ) people experience numerous health disparities that frequently bring them into contact with mental and physical health providers, and yet those providers often do not collect—or are inadequately collecting—information on sexual orientation and gender identity (SOGI). SOGI information has also not been included in many traditional forms of data collection, rendering LGBTQ populations invisible to policy makers and others who make decisions that affect our health. Creating visibility through SOGI[1] data collection has multiple benefits including the ability to measure and report disparities in healthcare access and outcomes, support the development of culturally appropriate interventions with LGBTQ individuals, justify the allocation of funds towards LGBTQ-specific services, and track improvements in community health for the achievement of health equity. Not only will collecting SOGI data improve programming and reduce disparities, it's also the law for many publicly-funded programs.

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[1]Holloway, I. W., & Jordan, S. P. (2018). Health disparities, HIV/AIDS, and framing a public health agenda. In M. P. Denato (Ed.), Social work practice with the LGBTQ Community: The intersection of history, health, mental health, and policy factors (pp. 494-513). New York, NY: Oxford University Press.

How to gather SOGI data
using just three questions

CURRENT GENDER IDENTITY
(The person's current internal sense of gender.)

"How do you describe yourself?"

- Male
- Female
- Trans male / Trans man
- Trans female / Trans woman
- Genderqueer / Nonbinary
- Questioning or unsure of gender identity
- Another gender identity not listed (please fill in the blank): _____

SEX ASSIGNED AT BIRTH
(The sex perceived at birth based typically on genitalia and listed on their birth certificate.)

"What sex were you assigned at birth?"

- Male
- Female

SEXUAL ORIENTATION
(A person's romantic, relational, and sexual orientation toward one or multiple genders.)

"Do you think of yourself as:"

- Straight / Heterosexual
- Gay / Lesbian
- Bisexual / Pansexual / Sexually Fluid
- Queer
- Questioning or unsure
- Another sexual orientation not listed (please fill in the blank): _____

#Out4MentalHealth

When should I ask SOGI questions?

You should ask SOGI questions anytime you collect any other demographic information. Asking SOGI questions may be a specific requirement for recipients of state or county funds, such as programs that use Mental Health Services Act funding or are administered under the California Departments of Health Care Services, Social Services, Public Health, and/or Aging.

What if I have to ask the client SOGI questions face-to-face?

Some work environments require you to ask clients demographic questions face-to-face, or the client needs assistance in filling out their forms. In those situations, your agency should have trained you how to do this comfortably, including how to respond if the client is confused by any of the terms. You can find the recommended wording of the SOGI questions in this fact sheet. Make sure you look up any terms you do not understand before you begin asking clients the SOGI questions.

How do I make sure SOGI information is kept confidential?

HIPAA and confidentiality policies should guide all your data collection. If your agency has not done so already, ask them to develop procedures for effective SOGI data collection which also ensures that clients are not "outed" to other staff or the community. You and your colleagues should be trained how to comply with these procedures.

How should I ask SOGI questions?

The best practice for asking any demographic information, including SOGI questions, is to allow the client the ability to respond confidentially and anonymously. You can accomplish this by giving the client a paper form, a tablet, or a dedicated computer so the client can answer the questions themselves. Providing a safe and private environment increases the likelihood clients will answer the questions fully and honestly, and also ensures consistency in how the questions are asked.

What if asking SOGI questions offends the client?

Most clients will answer the question and move on: in fact, studies show that respondents are more sensitive to questions about income than SOGI. If a client responds in a negative way to a SOGI question (for example, "Don't I look like a man to you?!"), you should simply explain that you ask every person these questions and you do not assume how a person identifies based on their appearance. In fact, you really cannot be sure of a person's demographic information without asking. Therefore, you should never assume a client's identity or mark a demographic question as "declined to state" if you did not ask the client the question(s).

Who do I contact if I have any other questions?

If you have additional inquiries about or encounter issues with the inclusion of SOGI demographic questions in your agency, you can reach the #Out4MentalHealth Project Team directly at info@out4mentalhealth.org.

# Importance of Access to Gender Affirming Care

According to a 2016 study by the Williams Institute, an estimated 1.4 million adults (age 18 and older) and 150,000 youth (age 13 to 17) in the U.S. identify as transgender, more than double the previous estimate.[1] The lack of consistent gender identity data collection and the fact that many people are still in the process of discovering their identity in adolescence present challenges for fully understanding the needs of transgender and gender non-conforming youth. However, what data we do have, illustrates a need to prioritize the significant disparities in health, mental health, and well-being these youth experience.

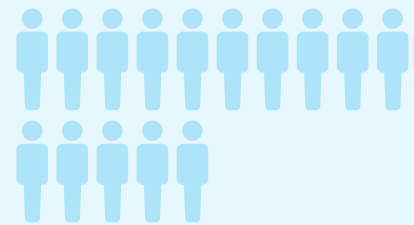## Gender Identity & Gender Dysphoria

For some transgender people and gender non-conforming people, the disconnect between their biological sex and the gender with which they identify (the internal sense of who they are) can lead to serious emotional distress and confusion that affects their health and everyday lives if not addressed. **Gender dysphoria** is the medical diagnosis for an individual who experiences pain and distress as a result of this disconnect.

Not all transgender or gender non-conforming people have gender

Number of people in the U.S. who identify as transgender
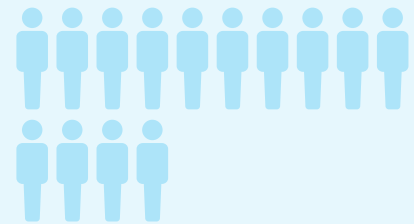
1,400,000 ADULTS
(age 18 and older)

150,000 YOUTH
(age 13 to 17)

Source: Flores, A.R. et al. How many adults identify as transgender in the United States. The Williams Institute, 2016.

dysphoria. On its own, being transgender or gender non-conforming is *not* considered a medical condition or mental illness. Many transgender and gender non-conforming people do not experience serious anxiety or stress associated with the difference between their gender identity and their sex assigned at birth. However, for those who do, living according to one's gender identity is an effective, safe, and medically necessary treatment.

Transgender and gender non-conforming youth can be particularly impacted by gender dysphoria, especially during the onset of puberty and accompanying development of secondary sex characteristics. Studies show that an increasing number of adolescents are identifying as transgender and gender non-conforming, and are seeking medical services to relieve their gender dysphoria.[2]
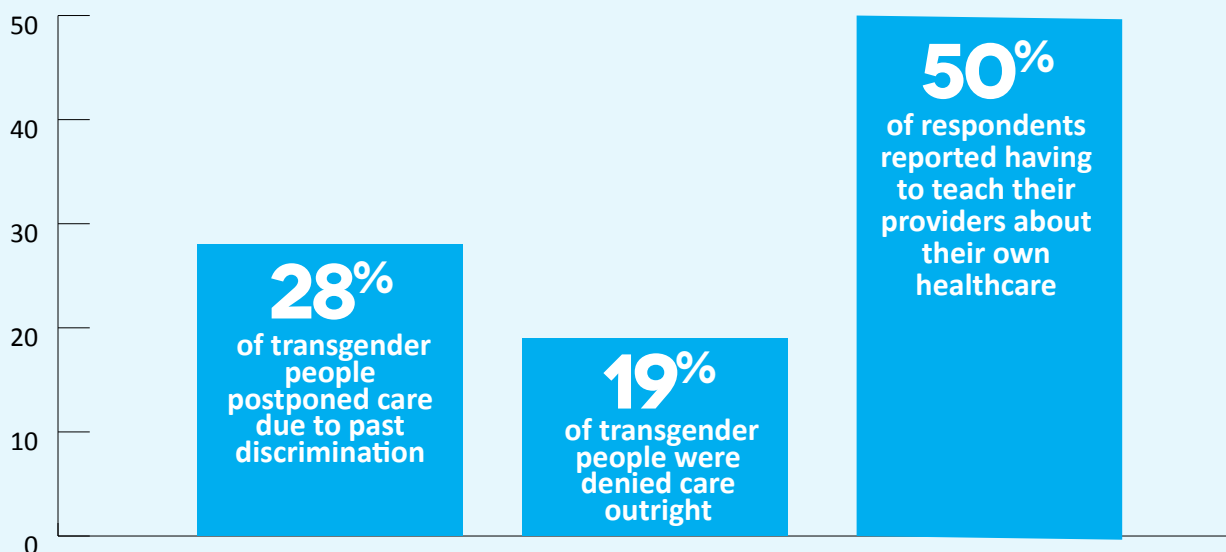
Additionally, research shows that gender identity usually forms at an even earlier age, usually between the ages of 3 and 5.[3] Children typically have a very strong sense of their gender regardless of whether it matches the sex they were assigned at birth. Unfortunately, when children begin to express an identity that does not match the sex they were assigned at birth, they often face discouragement at best, and outright rejection at worst, from the adults in their lives. Both of which can amplify any ongoing distress from gender dysphoria.

On top of the discrimination transgender and gender non-conforming young people often experience at home, in schools, and in society, they also face significant hurdles when it comes to receiving the **gender affirming care** and support they need as they develop into adults or to alleviate any gender dysphoria. A 2011 national survey of transgender people found that 28% had postponed seeking medical care due to previous experiences of disrespect or discrimination.[4]

Gender Affirming Care

Gender affirming care is an effective, important, and individualized approach in providing evidenced-based primary care for transgender and gender non-conforming youth. General guidelines for gender affirming care aim to address disparities faced by transgender and gender non-conforming young people by equipping healthcare and primary care providers with the tools and knowledge to meet the unique healthcare needs of transgender and gender non-conforming patients, including in settings with limited resources. This includes helping youth explore and understand their gender identity at their own pace, relieving gender dysphoria by supporting any transition-related care to allow individuals to express their own gender in a way they are comfortable with, and improving overall health and well-being. Studies have found that gender-affirming medical and hormonal care can improve mental health for transgender people,

A 2011 national transgender survey of 6450 respondents found

28% of transgender people postponed care due to past discrimination

19% of transgender people were denied care outright

50% of respondents reported having to teach their providers about their own healthcare

Source: Grant et al. Injustice at every turn: a report of the National Transgender Discrimination Survey, 2011.

including reduced anxiety and depression.[6]

Transgender and gender non-conforming people *may* seek any number of gender affirming interventions, including counseling, social transitioning, facial or body hair removal, speech and communication adaptations, pubertal suppression, hormone replacement therapy, and gender affirming surgery. These interventions prevent young people from enduring both the physical and mental health impacts of their body changing in potentially traumatizing ways.

Not all transgender and gender non-conforming people seek all interventions, and some may seek none. The current standard of care is to allow each transgender and gender non-conforming person to lead their own social and medical transition and seek only those interventions which they desire to affirm their own gender identity.

Mental Health Disparities & Impact of Lack of Gender Affirming Care

Transgender and gender non-conforming individuals, especially young people, often experience stigma, bullying, and abuse and suffer from higher rates mental illness, including anxiety and depression. A 2018 study revealed that the risk of developing a mental health condition was 3 to 13 times higher for transgender and gender non-conforming youth than gender conforming youth.[7] Another study found that 17% of transgender and gender non-conforming youth experience some form of severe psychological distress compared to only 7% of
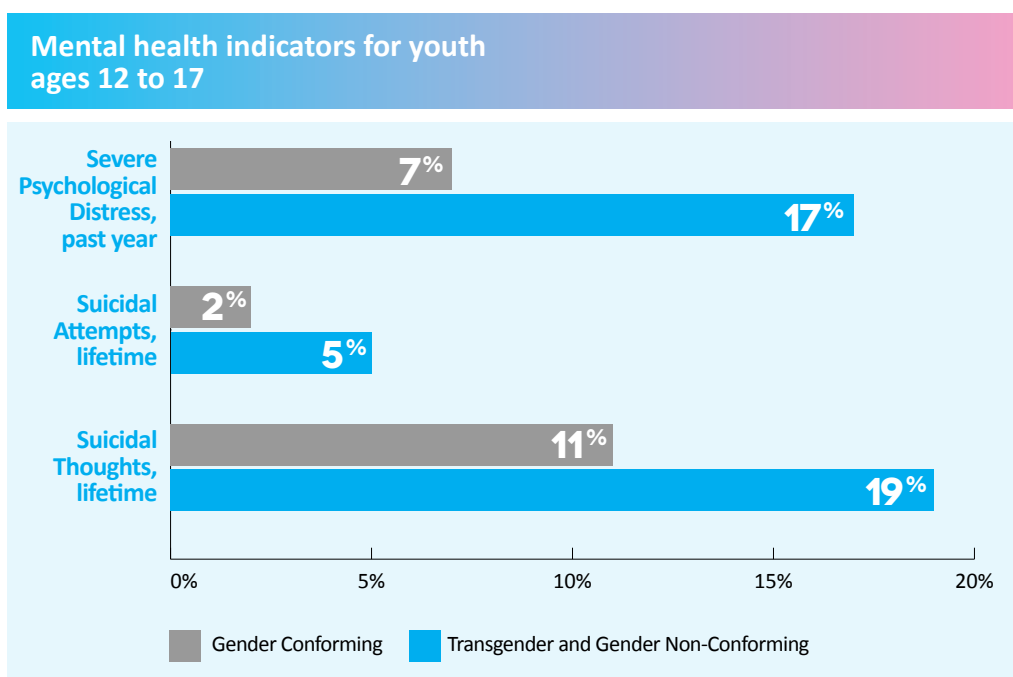
gender conforming youth. Suicidal attempts and suicidal thoughts were also markedly higher.[8]

These problems are amplified without the support of affirming parents, guardians, healthcare providers, or other caregivers. This is true even if they try to understand what transgender or gender non-conforming people are experiencing through research. Young people who experience rejection and maltreatment based on their gender identity or expression are also at significantly increased risk for school drop out, homelessness, and involvement in foster care and juvenile justice systems.

Denial of gender affirmation is associated with various healthcare disparities, high risk behaviors, and increased rates of HIV acquisition.[9] Transgender and gender non-conforming people who had negative experiences related to obtaining medical care also reported a higher prevalence of lifetime suicide attempts. A 2014 study from the Williams Institute found that 60% of respondents who said they had been refused medical care because of anti-transgender bias reported a lifetime suicide attempt.[10] Lack of access to gender affirming care can therefore cause significant and lasting harm to transgender and gender non-conforming youth.

Current Laws

Assemblymember Todd Gloria introduced AB 2119 which would establish that youth in the foster care system have the right to access gendering affirming health care. The goal is to ensure that transgender and gender non-conforming youth receive the care they need to avoid

Mental health indicators for youth ages 12 to 17

Indicator	Gender Conforming	Transgender and Gender Non-Conforming
Severe Psychological Distress, past year	7%	17%
Suicidal Attempts, lifetime	2%	5%
Suicidal Thoughts, lifetime	11%	19%

Gender Conforming · Transgender and Gender Non-Conforming

Source: Wilson, Bianca D.M. et al. Characteristics and mental health of gender nonconforming adolescents in California, 2017.

> "Transgender and gender non-conforming individuals, especially young people, often experience stigma, bullying, and abuse and suffer from higher rates mental illness, including anxiety and depression."

Source: Becerra-Culqu, Tracy A. et al. Mental health of transgender and gender non-conforming youth compared with their peers, 2018.

posing harm to their development and that California's child welfare agencies maintain their obligation to protect foster youth's safety and well-being. This is important because transgender youth are overrepresented in the foster care system and yet often face bias and ignorance of the law from foster parents and case workers. A 2014 study on foster children in Los Angeles County found that 5.6 percent identified as transgender, more than twice the percentage in the general population.[11]

Recommendations

- Ensure transgender and gender non-conforming youth who are covered under public health and welfare services have access to the gender affirming care they need to transition from childhood to adulthood.

- Develop and make available a comprehensive list of gender-affirming providers, including those in more rural cities and counties.

For More Information

Contact **info@out4mentalhealth.org** or visit out4mentalhealth.org.

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# LGBTQ Youth & the School-to-Prison Pipeline

Lesbian, gay, bisexual, transgender and queer (LGBTQ) youth are disproportionately entering the school-to-prison pipeline, a pathway to repeated encounters with the criminal justice system.[1] This is especially true for LGBTQ youth of color.[2] This situation is caused by a number of interrelated factors, most of which are linked to stigma and discrimination against LGBTQ people. Factors contributing to overrepresentation of LGBTQ youth in the school-to-prison pipeline include:

- family rejection;
- instability and poverty;
- zero-tolerance policies within schools;
- the disproportionate targeting and disciplining of LGBTQ students; and
- an increase in policy presence in schools.[3]

In surveys of juvenile detention centers and correction facilities across the United States, 20% of *all* incarcerated youth identified as LGBTQ or gender non-conforming and of girls nearly 40% identify as LGBTQ.[4]

LGBTQ youth over-represented in juvenile justice facilities

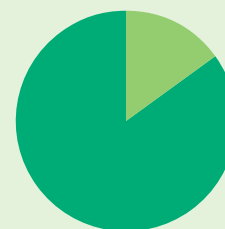*% of youth who identify as LGBTQ or gender non-conforming*
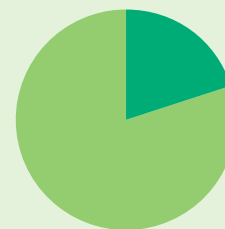
20%
of all youth in juvenile justice facilities
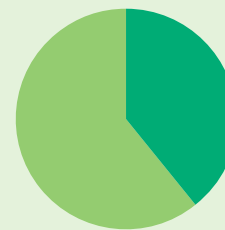
39.4%
of girls in juvenile justice facilities

Of LGBTQ and gender non-conforming youth in juvenile justice facilities

85%
are youth of color

Source: Center for American Progress, Movement Advancement Project, Youth First. Unjust: LGBTQ youth incarcerated in the juvenile justice system, 2017.

Family Rejection, Instability & Poverty

Young people need their families for basic resources like love, housing, food, and security, but unfortunately some LGBTQ youth are met with hostility, violence, or rejection when their families learn that they identify as a sexual and/or gender minority. Also, as families struggle to make ends meet and provide stability for their children, youth may find themselves without a home or pushed into unsafe living situations, including public spaces.[5]

At some point these LGBTQ youth may leave their families because home is no longer a safe and supportive place.[6] For instance, the National Transgender Discrimination Survey reports that one in five transgender people report having experienced homelessness at some time in their lives because of discrimination and family rejection.[7]

LGBTQ young people at risk of homelessness face substantial challenges, including risks to their physical safety and emotional and mental health. They may begin shoplifting, trading sex, selling drugs, or engaging in other illegal activities as a way to survive, increasing the chances that young people may be stopped and arrested, and enter the juvenile justice system.[8]

In a survey of youth in the juvenile justice system, 28% of gay and bisexual boys had been detained for running away compared to 12% of heterosexual-identified boys.[9] The percentage of girls reporting being detained for running away was even higher—38% of lesbian and bisexual girls compared to 17% of heterosexual-identified girls.[10]
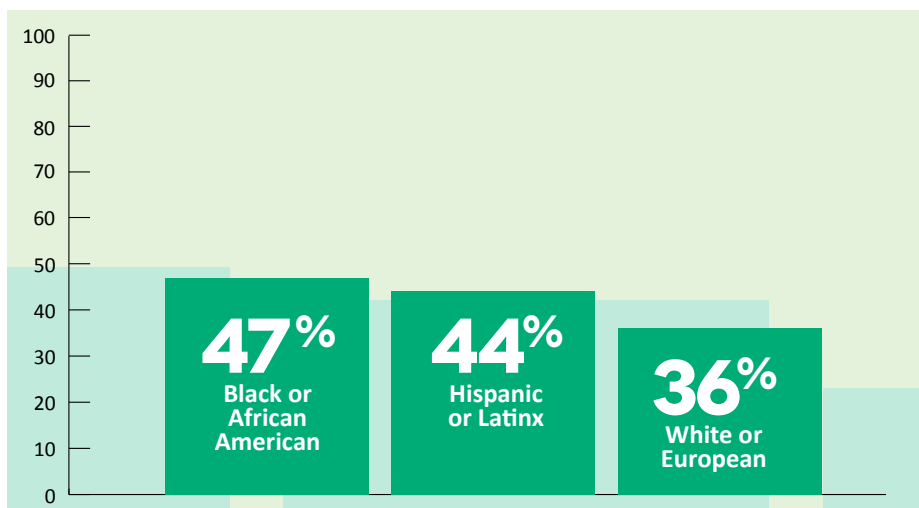
Zero-Tolerance Policies

LGBTQ youth are disproportionately burdened by school-based, automatic punitive disciplinary action, also called "Zero-Tolerance Policy," which serves as a pathway to early and long-lasting encounters with the criminal justice system. This is because LGBTQ youth face increased discrimination, bullying and harassment at school from their peers, and they are often punished for their own victimization, or for their attempts to defend themselves in a hostile school climate.[11] Additionally, LGBTQ youth face unfair punitive action for violating sexuality and gender norms at school. This can include receiving punishment for violating gendered school dress code policies, or engaging in adolescent behaviors for which their non-LGBTQ peers are not disciplined. Research suggests that these policies fail to improve school safety or to create positive learning environments, and that they actually make schools and communities less safe.[12]

Disproportionate Disciplinary Action

LGBTQ youth are at a higher risk for school sanctions – such as being suspended and expelled from school, or being stopped and arrested by police.[13] This cannot be explained by increased engagement in illegal or transgressive behavior, and puts these youth at an increased risk for juvenile arrest and conviction, or worse, adult conviction.[14] LGBTQ youth of color are at an increased risk for these problems. In one survey, 47% of Black/African American and 44% of Hispanic/Latino students reported ever being disciplined at school compared with only 36% of White peers.[15] Of incarcerated LGBTQ and gender non-conforming youth, 85-90% are youth of color.[16]

% of LGBTQ students who have reported ever being disciplined at school

47% Black or African American
44% Hispanic or Latinx
36% White or European

Source: GLSEN. Educational Exclusion: Drop Out, Push Out, and the School-to-Prison Pipeline among LGBTQ Youth, 2016.

> LGBTQ youth are at a higher risk for sanctions, such as being stopped by the police, expelled from school, arrested, or convicted.

Source: Kathryn E.W. Himmelstein & Hannah Bruckner. Criminal-justice and School Sanctions Against Nonheterosexual Youth: A National Longitudinal Study, 2011.

Police Presence Within Schools

Increased security and police presence can turn school from a place of safety and learning to a place where students feel unsafe and on edge. More than two-thirds of LGBTQ youth ages 18 to 24 reported having school security or police at their middle or high schools and stated that this made them feel untrustworthy and that any misstep would be treated as a crime.[16] This is especially true for students at schools where the administration has deferred their disciplinary authority to police officers, otherwise known as School Resource Officers (SROs). Combined with zero-tolerance policy and disproportionate disciplinary action against LGBTQ youth, a school with an SRO is more likely to refer LGBTQ youth to the juvenile justice system. As police get involved, students are further pushed out and into the school-to-prison pipeline. LGBTQ youth's disciplinary infractions at school are the beginnings of a criminal record that can follow them throughout their life.

Recommendations

To alleviate the burden of family rejection, instability, and poverty, state and local government should invest in research, interventions, education, and policy initiatives that seek to help families support their LGBTQ children, teach health risk prevention, and address the social determinants of health. For instance, the Family Assistance Project (FAP) has developed the first evidence-based family support approach to help ethnically and religiously diverse families to support their LGBTQ children and provides training on this model for families, healthcare providers, religious leaders, child welfare agencies, schools, juvenile justice, homeless services, congregations, and communities.

State leaders and local school districts should take initiative to restructure their disciplinary strategies to reduce the number of youth that are pushed out of schools and into the juvenile justice system by:

- revising disciplinary codes to prevent suspensions for minor offenses;
- increasing academic counselors and offering after-school programming;
- implementing restorative justice programs and eliminating automatic expulsions for all offenses other than bringing weapons or firearms to school;
- reducing reliance on local and school police departments and providing teachers and school staff with trainings for conflict resolution and mediation;
- funding and providing LGBTQ cultural competency

trainings for all school staff, judges, public defenders, district attorneys, probation officers, and other justice stakeholders; and
- prioritizing diversion and increasing the use of community-based alternatives to youth incarceration.

For More Information

Contact **info@out4mentalhealth.org** or visit out4mentalhealth.org.

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CA County/Local Boards & Commissions Websites

SOUTHERN REGION	
Imperial	http://www.co.imperial.ca.us/behavioralhealth/index.asp?fileinc=board
Kern	http://www.kernmentalhealth.org/behavioral-health-board
Orange	http://ochealthinfo.com/bhs/about/mhb
Riverside	http://www.rcdmh.org/Mental-Health-Board
San Bernardino	http://wp.sbcounty.gov/dbh/admin/behavioral-health-commission/
San Diego	http://sandiego.networkofcare.org/mh/content.aspx?id=257
San Luis Obispo	www.slocounty.ca.gov/Departments/Health-Agency/Behavioral-Health/Forms Documents...
Santa Barbara	http://www.countyofsb.org/behavioral-wellness/bwc-home.sbc
Ventura	http://www.vchca.org/behavioral-health-advisory-board-bhab
Tri-City	http://www.tricitymhs.org/about-us/mental-health-commission

LOS ANGELES	
Los Angeles	http://dmh.lacounty.gov/wps/portal/dmh/about_dmh/mhc

SUPERIOR REGION	
Butte	https://www.buttecounty.net/behavioralhealth/Administration/AdvisoryBoard.aspx
Colusa	http://www.countyofcolusa.org/index.aspx?NID=378
Del Norte	http://www.co.del-norte.ca.us/departments/health-human-services/mental-health-branch
Glenn	http://www.countyofglenn.net/committee/mental-health-alcohol-and-drug-advisory-board/welcome
Humboldt	http://humboldtgov.org/426/Behavioral-Health-Board
Lake	http://www.co.lake.ca.us/Government/Boards/MHB.htm
Lassen	http://www.lassencounty.org/dept/behavioral-health/behavioral-health
Mendocino	http://www.co.mendocino.ca.us/hhsa/mh_board.htm
Modoc	http://www.co.modoc.ca.us/departments/board-of-supervisors/standing-committees
Nevada	https://www.mynevadacounty.com/nc/hhsa/bh/Pages/Mental-Health-Board-Member-Application.aspx
Plumas	http://www.countyofplumas.com/index.aspx?NID=2412
Shasta	http://www.co.shasta.ca.us/index/hhsa_index/About_us/AdvisoryBoards/mhad_advisory_board.aspx
Sierra	http://www.sierracounty.ca.gov/index.aspx?nid=332
Siskiyou	https://www.co.siskiyou.ca.us/content/behavioral-health-board
Tehama	http://www.tehamacohealthservices.net/MentalHealth/directory_mh.htm
Trinity	http://www.trinitycounty.org/index.aspx?page=60

CENTRAL REGION

Alpine	http://www.alpinecountyca.gov/index.aspx?NID=443
Amador	http://www.amadorgov.org/services/behavioral-health
Calaveras	http://mentalhealth.calaverasgov.us/Advisory-Board
El Dorado	https://www.edcgov.us/mentalhealth/MH_Commission_Meetings/Mental_Health_Commission.aspx
Fresno	http://www.co.fresno.ca.us/DepartmentPage.aspx?id=384
Inyo	http://elections.inyocounty.us/p/your-elected-officials.html
Kings	http://www.kcbh.org/advisory-board.html
Madera	http://www.madera-county.com/index.php/behavioral-health-board
Mariposa	http://mariposacountyca.iqm2.com/citizens/default.aspx?
Merced	http://www.co.merced.ca.us/index.aspx?NID=2212
Mono	https://www.monocounty.ca.gov/bos/event/behavioral-health-advisory-board-0
Placer	https://www.placer.ca.gov/departments/hhs/adult/mental-health-alcohol-drug-board
Sacramento	dhhs.saccounty.net/BHS/Pages/Advisory-Boards-Committees/Mental-Health-Board/BC-Mental-Health-Board.aspx
San Joaquin	https://www.sjgov.org/mhs/general_info/mental_health_board.htm
Stanislaus	http://www.stancounty.com/bhrs/bh-board.shtm
Sutter-Yuba	https://www.co.sutter.ca.us/agenda/bhab_agendas
Tulare	http://tchhsa.org/hhsa/index.cfm/the-hhsa-community/mental-health-board/description/
Tuolumne	https://www.tuolumnecounty.ca.gov/861/Behavioral-Health-Advisory-Committee
Yolo	http://www.yolocounty.org/health-human-services/adult-aging/local-mental-health-board

BAY AREA

Alameda	http://www.acbhcs.org/mental-health-board-and-committees-meetings/
Contra Costa	https://cchealth.org/mentalhealth/mhc/agendas-minutes.php
Marin	http://apps.marincounty.org/bosboardsandcomm/boardpage.aspx?BrdID=53&return=search.aspx
Monterey	http://www.co.monterey.ca.us/bcandc/menthealth.htm
Napa	https://www.countyofnapa.org/1018/Mental-Health-Board
San Benito	http://www.cosb.us/county-departments/health/#.V7NGuZgrLcs
San Francisco	http://www.mhbsf.org/
San Mateo	http://www.smchealth.org/mhsarc
Santa Clara	https://www.sccgov.org/sites/mhd/MentalHealthBoard/Pages/default.aspx
Santa Cruz	http://www.santacruzhealth.org/HSAHome/HSADivisions/BehavioralHealth/MentalHealthAdvisoryBoard.aspx
Solano	http://www.solanocounty.com/depts/mhs/mhab.asp
Sonoma	http://sonomacounty.ca.gov/Mental-Health-Board/
City of Berkeley	http://www.cityofberkeley.info/ContentDisplay.aspx?id=13036

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Making Public Comment

You have the right to voice your concerns at public meetings. When you speak at public meetings, you are providing what is called a "Public Comment". Organizations running public meetings are required to offer some time for public comment, but they can limit each public comment to 2 - 3 minutes. Organizations can also choose to receive only a certain number of public comments in order to manage their time. They are not allowed to require you to sign in with your name or address.

This information is intended to help you manage your expectations when you are making public comment.

1. You are entitled not to be interrupted unless you have exceeded the time limit of the public comment, which is typically 2 or 3 minutes.
2. There are typically opportunities for public comment after specific agenda items in the meeting as well as an opportunity for "General Public Comment." This can often give you a chance
3. There is usually a form that you asked to fill out in order to provide public comment. By law, you are not required to fill out this form. If you are comfortable filling it out, it can help the organization to call you by name to provide public comment. If you are not comfortable filling out the form, then you are entitled to step up to the microphone during the public comment period anyway.
   a. *Note*: Some organizations may not know that you have this right; you can inform the organization of your right to speak without identifying yourself during your public comment.
4. It typical to simply receive a "thank you for your comment" after you have said your piece. This does not mean that they have ignored you. The flat response is procedural.
5. Some organizations allow for written public comment.
6. Your public comment is required to be written into the publicly accessible Meeting Minutes within a couple of weeks after the meeting. At the following meeting of that organization, the organization is required to "approve the minutes." *Note*: If your public comment is not included or is not accurately reflected, you can make public comment before approval of the minutes at the following meeting to call for edits to the minutes. It is important that your voice be heard and accurately reflected.

#Out4MentalHealth

Template for Making Public Comment

The template below may help you plan your public comment. You do not have to share your name, but it is an excellent idea to share why you are there and what experiences make you passionate and form your knowledge. Your public comment should always finish with an actionable demand, like "I ask you to pass a motion." You have a fantastic opportunity - and a right - to be heard by people who are entrusted and empowered by the people to make decisions.

Template:

Hello, my name is _____

I identity as a [consumer / parent / teacher / provider / youth / student / member of the LGBTQ community] _____

with experience in [using mental health services / raising children who attend public school / providing mental health services / working on the local mental health board] __
_____

I am concerned about _____
_____
_____

I ask that you support / oppose / consider _____

Thank you.

Example:
"**Hello, my name is** Sam and **I identity** as a member of the LGBTQ community **with particular experience** receiving mental health care services that made assumptions about me based on my sexual orientation and presumed gender identity. **I am concerned** about the Commission's lack of inclusion of LGBTQ-affirming practices as a requirement of the proposed mental health services program. **I ask that you make a motion** requiring that service providers in this proposed program receive ongoing training on how to provide culturally appropriate mental health services to LGBTQ people. **Thank you**"

CALIFORNIA LGBTQ HEALTH AND HUMAN SERVICES NETWORK

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