FAMILY COURT OF THE STATE OF NEW YORK
COUNTY OF QUEENS

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In the Matter of

[NAME OF CHILDREN]

A Child Protective Proceeding Under
ARTICLE TEN of the Family Court Act

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JUDICIAL SUBPOENA DUCES TECUM

Docket No. XX-XXXXX

THE PEOPLE OF THE STATE OF NEW YORK

TO: **[NAME OF PROVIDER]**
[ADDRESS OF PROVIDER]
Attn: **[SPECIFIED RECORDS DEPARTMENT]**

WE COMMAND YOU, that all business and excuses being laid aside, you and each of you produce before the Family Court, **Hon. XXXXX presiding, at Jamaica, New York 11432, Part XX**, within seven (7) days receipt of this Subpoena, records relating to **[PATIENT] for date(s) of treatment from [XXXXX] to [XXXXXXX]**, specifically, the following:

☐ **Psychiatric/Psychological Records** pursuant to a finding that the interests of justice significantly outweigh the need for confidentiality and that no other less-intrusive method exists to obtain the information in accordance with Section 33.13 of the Mental Health and Hygiene Law:

- ☐ intake/admission report;
- ☐ evaluations and tests;
- ☐ admission diagnoses; discharge diagnoses; list of medications prescribed, if any;
- ☐ social work notes;
- ☐ individual psychotherapy and group therapy notes;
- ☐ treatment recommendations; service referrals; discharge notes;
- ☐ other _____.

☐ **Medical Records** pursuant to 45 C.F.R. § 164.512(j); provided that subpoena accompanied by i) proof that satisfactory notice of subpoena and opportunity to be heard to individual whose records are sought under 45 C.F.R. § 164.512(e)(1)(iii) and ii) qualified protective order:

- ☐ intake/admission report;
- ☐ evaluations; X-rays; photographs; laboratory tests;
- ☐ admission diagnoses; discharge diagnoses; list of medications prescribed, if any;
- ☐ physician's notes; social work notes;
- ☐ treatment recommendations; service referrals; discharge notes;
- ☐ other _____.

☐ **Substance Abuse Records** pursuant to M.H.L § 22.05 and 42 C.F.R Part 2:

- ☐ intake/admission report;
- ☐ admission diagnoses; discharge diagnoses;
- ☐ list of medications prescribed, if any;
- ☐ toxicology screens; referrals, results and methodology;
- ☐ treatment recommendations; service referrals; discharge notes;
- ☐ other _____.

To the extent that the subject records contain any of the following information, all such information shall be **redacted prior to disclosure**: (i) confidential HIV-related information as defined under Public Health Law § 2780[7] and 2782, and 10 NYCRR § 63.1(g); (ii) predisposition genetic test records and information subject to the provisions of Civil Rights Law § 79-1; (iii) reports and information concerning sexually transmitted diseases subject to the confidentiality provisions of 24 RCNY Health Code Reg. § 11.07(a) or Public Health Law §2306; and (iv)

records and information concerning cases of gonorrhea, Chlamydia trachomatis infection or syphilis subject to the confidentiality provisions of 10 NYCRR § 2.32.

The records must be properly certified and delegated; the certification must bear an original signature of the head of your hospital or agency or of the person delegated to certify records. **All records must be delivered by hand messenger or other method which provides proof of delivery to the Clerk of [Borough] Family Court.**

FAILURE TO COMPLY WITH THIS SUBPOENA, WHICH IS DULY ISSUED BY AN OFFICER OF THE COURT PURSUANT TO THE FAMILY COURT ACT 1038, 1046 (a) (vii) AND THE CIVIL PRACTICE LAW AND RULES 2308 (a), MAY BE PUNISHABLE AS CONTEMPT OF COURT. THIS IS A CHILD PROTECTIVE PROCEEDING. For any questions immediately contact the attorney indicated below.

A copy of this subpoena is to be served promptly to all counsel pursuant to CPLR § 2303(a).

cc: [ATTORNEYS]

SO ORDERED

_____

, Esq.

_____

J.F.C.

Dated:

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Gender-Nonconforming Lesbian, Gay, Bisexual, and Transgender Youth: School Victimization and Young Adult Psychosocial Adjustment

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Past research documents that both adolescent gender nonconformity and the experience of school victimization are associated with high rates of negative psychosocial adjustment. Using data from the Family Acceptance Project's young adult survey, we examined associations among retrospective reports of adolescent gender nonconformity and adolescent school victimization due to perceived or actual lesbian, gay, bisexual, or transgender (LGBT) status, along with current reports of life satisfaction and depression. The participants included 245 LGBT young adults ranging in age from 21 to 25 years. Using structural equation modeling, we found that victimization due to perceived or actual LGBT status fully mediates the association between adolescent gender nonconformity and young adult psychosocial adjustment (i.e., life satisfaction and depression). Implications are addressed, including specific strategies that schools can implement to provide safer environments for gender-nonconforming LGBT students.

Keywords: gender nonconformity, LGBT youth, victimization, safe schools

In 2008 Larry King was murdered by a fellow eighth grader during a class at school because of his gender expression and his openness about his gay sexual orientation (Pringle & Saillant, 2008). He was referred to as an "effeminate" boy by his classmates and various school personnel when they were interviewed by the media after the shooting (Setoodeh, 2008). King's murder is not an isolated case, and the association between gender nonconformity and victimization is at the forefront of the public awareness and discussions about school safety (Hoffman, 2009). King's murder is an extreme example of school victimization motivated by a student's gender nonconformity.

A growing body of literature suggests that young people who do not conform to heteronormative societal values are at risk for victimization during adolescence (Meyer, 2003; Oswald, Blume, & Marks, 2005). Lesbian, gay, bisexual, transgender (LGBT), and gender-nonconforming youth are at elevated risk levels for experiencing victimization (e.g., Kosciw, Diaz, & Greytak, 2008; O'Shaughnessy, Russell, Heck, Calhoun, & Laub, 2004) and negative psychosocial adjustment (e.g., suicidality, depression, anxiety; D'Augelli, Grossman, & Starks, 2006; Pilkington & D'Augelli, 1995). A number of studies document the direct effects of individual-level characteristics (i.e., gender nonconformity and sexual minority status) and social experiences (e.g., school victimization, negative family experiences) on psychosocial adjustment (Carver, Yunger, & Perry, 2003; D'Augelli, Pilkington, & Hershberger, 2002; Rivers, 2001a; Russell & Joyner, 2001; Yunger, Carver, & Perry, 2004). What remains unknown is whether experiences of victimization during adolescence are largely responsible for the elevated levels of negative psychosocial adjustment and health among gender-nonconforming youth and young adults.

This study extends prior research that documents the associations between gender nonconformity, victimization, and adjustment by directly testing the degree to which experiences of school victimization account for the link between adolescent gender nonconformity and young adult well-being. By examining both direct and indirect effects simultaneously, we were able to account for the unique association each predictor has on two psychosocial adjustment indicators: young adult life satisfaction and depression. Our goal was to build on previous research that separately documents the direct effects of gender nonconformity and victimization on psychosocial outcomes: We sought to provide an explanation of the mechanisms through which gender nonconformity influences young adult psychosocial adjustment.

One theoretical explanation that may help to explain the high prevalence of psychosocial problems that gender-nonconforming individuals experience is Meyer's (1995, 2003) minority stress model. Meyer's (1995, 2003) minority stress model posits that lesbian, gay, and bisexual individuals are at increased risk for mental health distress because of their stigmatized sexual identities. Meyer (2003) discussed that the unique stressors that sexual minority individuals experience range on a continuum from more

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distal processes that occur externally (i.e., actual experience of discrimination and/or violence) to proximal processes that occur internally (i.e., expectations of discrimination and/or violence, internalized homophobia). As explained by Meyer (2003), the experiences of distal minority stress processes (e.g., school victimization due to minority status) are likely to be associated with an increase in proximal minority stress processes (e.g., expectations of victimization). Combined with general life stressors, unique minority stress can plausibly cause poor psychosocial adjustment. That is, it is school victimization specifically due to gender nonconformity that is crucial in the model. Meyer (2003) suggested that these associations are modified by coping strategies, available social support, and other personal characteristics.

In this study, school victimization represents the distal process by which gender-nonconforming LGBT young people experience stigma. Our study is limited in that we cannot fully assess Meyer's (1995, 2003) minority stress model. Specifically, data were not collected about proximal minority stress processes (i.e., expectations of victimization). It is also beyond the scope of this article to examine potential moderators of the link between school victimization and psychosocial adjustment. Nonetheless, we expect that the unique social stigma experienced by gender-nonconforming LGBT young people in adolescence has lasting negative effects into young adulthood and that these lasting negative effects are the product of victimization based on gender nonconformity, not of their gender nonconformity. Further, it is victimization due to gender nonconformity rather than victimization for other reasons that should explain the association between gender nonconformity and negative effects in young adulthood.

Gender Nonconformity

Western culture engrains gender stereotypes within individuals during the earliest stages of life (S. E. Hill & Flom, 2007; Poulin-Dubois, Serbin, Eichstedt, Sen, & Beissel, 2002). By preschool, children understand gender categories and the social pressure to conform to the category associated with their biological sex (Carver et al., 2003; Yunger et al., 2004). Kessels (2005) defined gender stereotypes as "a set of specific beliefs about the characteristics that women and men are likely to possess" (p. 310). Gender identity refers to the "maleness and femaleness a person feels on the inside; how that identity is projected to the world; and how others mirror that identity back to the individual" (Israel, 2005, p. 55). Individuals are expected to assume the roles and characteristics (e.g., clothing, hobbies, mannerisms) associated with their respective biological sex (Grossman & D'Augelli, 2006). Those who do not assume the expected roles and characteristics of the gender associated with their biological sex often experience a myriad of negative consequences because of their nonconformity to these cultural rules.

Gender-nonconforming individuals, such as boys who are more feminine than other boys or girls who are more masculine than other girls, can be described as those who transgress social gender norms. These individuals, however, may or may not decide to label themselves as transgender, an umbrella category that includes individuals who identify as transsexuals, gender queers, cross-dressers, drag kings, drag queens, and other various labels (Israel, 2005).

A multidimensional framework proposed by Egan and Perry (2001) suggests that the construct of gender includes five major components including membership knowledge, gender typicality, gender contentedness, pressure to conform, and intergroup bias. Thus, this multidimensional framework not only incorporates the degree to which an individual feels nonconforming but also warrants attention to the pressure to conform to gendered norms from others. In this study, we sought to further understanding of two influences on adjustment: gender typicality and pressure to conform to gender norms through the experience of victimization by peers.

Gender Nonconformity and Young Adult Adjustment

Gender nonconformity is just one of the individual-level characteristics that previous research has linked to poor psychosocial adjustment and suicidality in adolescence (Carver et al., 2003; Morrow, 2004; Yunger et al., 2004) and adulthood (Sandfort, Melendez, & Diaz, 2007; Skidmore, Linsenmeier, & Bailey, 2006). Although the research on risk-taking behavior (e.g., risky sexual behavior, substance abuse) among gender-nonconforming and transgender individuals is growing, researchers know much less about the psychosocial adjustment (e.g., life satisfaction, anxiety, depression) experienced among this population (Garofalo, Deleon, Osmer, Doll, & Harper, 2006; Kenagy, 2002, 2005; Kenagy & Hsieh, 2005a, 2005b). Of the research that does exist, most has been based on studies of adults. For instance, Skidmore et al. (2006) found that higher levels of gender nonconformity among adult gay men were associated with more psychological distress. Similarly, Sandfort et al. (2007) found that higher levels of gender nonconformity among gay and bisexual Latino men were associated with higher levels of mental distress. However, Sandfort et al. found that this association could be explained by experiences of homophobia during one's lifetime. We sought to examine how adolescent experiences of school victimization may account for the association between gender nonconformity and psychosocial adjustment.

Victimization at School

Peer reactions to gender nonconformity change across developmental stages. By middle childhood, children's cognitive development allows them to make social comparisons and to form an abstract concept of the self (Yunger et al., 2004). In adolescence, gender differences observed between girls and boys can be partially explained by the intense socialization of stereotypical gender roles prior to and during that developmental period (J. P. Hill & Lynch, 1983). Because of a heightened awareness and a sense of an imaginary audience during adolescence, shame often controls or holds in place strictly gendered rules (Ma'ayan, 2003). The shame felt by gender-nonconforming adolescents may be compounded by the reactions from their peers. Peer reactions to gender-nonconforming behavior are often negative, ranging from verbal questioning of another's biological sex to physical abuse (Grossman & D'Augelli, 2006).

Previous research documents the intersection between sexual orientation and gender nonconformity in Western culture (Ma'ayan, 2003). Because of this intersection, negative reactions toward gender-nonconforming adolescents may actually

be related to the perpetrator's perceptions that the adolescent is lesbian, gay, or bisexual (D'Augelli et al., 2006; Friedman, Koeske, Silvestre, Korr, & Sites, 2006; Pilkington & D'Augelli, 1995). In Pilkington and D'Augelli's (1995) sample of lesbian, gay, and bisexual adolescents, students who were gender atypical and more open about their lesbian, gay, or bisexual status to peers were more likely to report victimization than students who conformed to stereotypical gender norms. Thus, the more young people present as gender nonconforming, the more likely they will be victimized or abused at school (Grossman, D'Augelli, Howell, & Hubbard, 2005).

The abuse experienced by gender-nonconforming adolescents frequently occurs at school (D'Augelli et al., 2006; Henning-Stout, James, & Macintosh, 2000). The school context is one of the primary settings where social interactions occur during adolescence, and for gender-nonconforming and LGBT youth, school can be one of the most dangerous social contexts (Morrow, 2004). Previous research documents the high prevalence rate of harassment that occurs in schools because of actual or perceived lesbian, gay, or bisexual status (see Kosciw et al., 2008; Lasser & Tharinger, 2003; Russell, 2005; Ryan & Rivers, 2003; van Wormer & McKinney, 2003). Information about the prevalence of harassment in schools associated with gender nonconformity or transgender status, however, is lacking.

In a recent study, gender-nonconforming youth reported that school was the location of their first experience of physical victimization more than any other context (e.g., home or community; D'Augelli et al., 2006). Another recent study found that nearly two thirds of gender-nonconforming youth report verbal harassment and nearly one third report physical harassment at school (Kosciw et al., 2008). Within the category of gender-nonconforming youth, transgender young people are perhaps most at risk for experiencing victimization at school. Sausa (2005) found that 96% of transgender participants experienced physical harassment and 83% experienced verbal harassment at school. Furthermore, transgender youth are at risk for dropping out of school, running away from home, and becoming homeless (Grossman & D'Augelli, 2006). Thus, whereas the prevalence of victimization due to gender nonconformity or transgender status in school is underdocumented, it is clear that victimization does occur because of this personal characteristic and warrants further investigation.

Finally, biological sex may be a moderator in the backlash toward gender nonconformity: Biological men face more peer harassment and victimization than biological women. In fact, D'Augelli et al. (2006) found that male youth who were gender nonconforming were more likely to receive negative responses from parents than were gender-nonconforming female youth. Gender nonconformity by girls is generally accepted and even rewarded until puberty. However, once puberty occurs, girls who still project a masculine appearance are often characterized as immature (Carr, 2007) and face harassment from their peers (Carr, 2007; Ma'ayan, 2003). In fact, young people report hearing more negative remarks about gender nonconformity toward boys (53.8%) than girls (39.4%; Kosciw et al., 2008) and perceive their schools as safer for gender-nonconforming girls compared with nonconforming boys (O'Shaughnessy et al., 2004).

School Victimization and Young Adult Psychosocial Adjustment

Repeated negative responses from peer groups often leads to negative feelings about one's self (Ellis & Eriksen, 2002). Not only does victimization affect students emotionally at the time it occurs, victimization also negatively affects future psychosocial adjustment (Olweus, 1993; Rivers, 2001a). Recent research documents the lasting negative effects of victimization during adolescence into adulthood. For example, D'Augelli et al. (2006) found that gender-nonconforming individuals who experienced victimization due to sexual orientation status during childhood were at greater risk for developing posttraumatic stress disorder later in life than those who were not gender nonconforming. Similarly, Friedman, Marshal, Stall, Cheong, and Wright (2008) found that early violence (i.e., in adolescence) experienced by gay boys is predictive of young adult well-being above and beyond the effects of young adult violence. In a retrospective study, Friedman et al. (2006) examined the link between gender nonconformity and suicidality during adolescence and found that the experience of victimization mediated this association for boys. Similarly, Williams, Connolly, Pepler, and Craig (2005) found that school victimization mediated the association between sexual orientation and depression and externalizing problems in adolescence. We sought to extend the findings of these two studies through the inclusion of both male and female participants and the examination of multiple psychosocial adjustment indicators in young adulthood.

The Current Study

The purpose of this study was to expand understanding regarding the associations among adolescent gender nonconformity, school victimization, and young adult psychosocial adjustment experienced by LGBT individuals. Specifically, the hypotheses tested in this study include the following (see Figure 1 for hypothesized model):

Hypothesis 1: Higher levels of gender nonconformity during adolescence are associated with more instances of victimization specific to perceptions of LGBT status.

Hypothesis 2: Biological sex moderates the effects of gender nonconformity on LGBT school victimization, such that gender-nonconforming boys experience more victimization than gender-nonconforming girls.

Hypothesis 3: Experience of LGBT school victimization during adolescence mediates the direct effect of gender nonconformity on young adult psychosocial adjustment, such that victimization becomes the salient predictor of young adult psychosocial adjustment.

Method

Sample

This study used data from the Family Acceptance Project's young adult survey that included 245 LGBT young adult participants, who were recruited at multiple venues frequented by LGBT young adults within a 100-mile radius of the San Francisco Bay

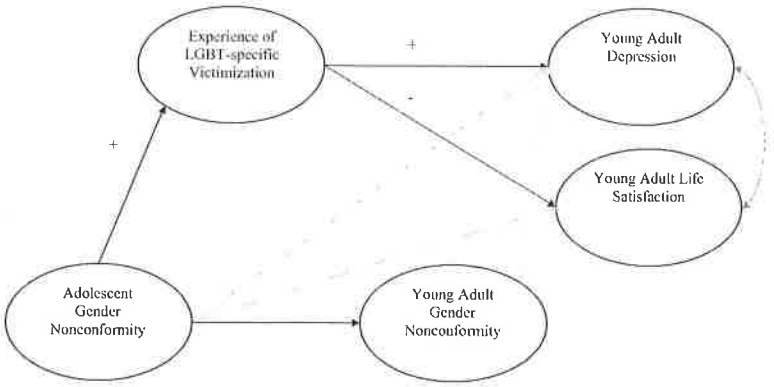

Figure 1. Conceptual model.

Area. The Family Acceptance Project is a network of research studies, intervention development, and policy activities aimed at increasing family acceptance and societal support for LGBT youth and young adults. Criteria for participation in the young adult study included age (21–25 years); ethnicity (White, Latino, or Latino mixed); self-identification as LGBT during adolescence; outness to at least one parent during adolescence; and at minimum, part-time residence with at least one parent during adolescence. The survey was available in both English and Spanish, as well as in paper-and-pencil and computer-assisted formats. The university's institutional review board approved the study protocol.

The mean age of the sample was 22.8 years (SD = 1.4). Participants self-identified their sexual orientation on the survey: 42.5% gay, 27.8% lesbian, 13.1% bisexual, and 16.7% other (e.g., queer, dyke, or homosexual). Participants reported on LGBT milestones: Average age of awareness was 10.7, labeling oneself as LGBT was 13.9, and coming out to anyone was 15.2. In terms of ethnicity, 51.4% identified as Latino, and 48.6% as White, non-Latino young adults. Trained interviewers obtained a measurement of biological sex that resulted in the following distribution: 51.4% male and 48.6% female. Participants also self-identified their young adult gender identity on the survey: 46.5% male, 44.9% female, and 8.6% transgender. To test for the sex moderation proposed in the model, we used biological sex instead of gender identity to examine the hypothesized negative effects of crossing gendered norms (i.e., male-to-female transgender individuals would be included with other boys instead of girls because they would be perceived by their classmates as breaking male gendered norms). Finally, a retrospective report of family-of-origin socioeconomic status was assessed (1 = *both parents in unskilled positions or unemployed*, 16 = *both parents in professional positions*; M = 6.75, SD = 4.77).

Measures

Adolescent and young adult gender nonconformity. One item assessed retrospective adolescent gender nonconformity: "On a scale from 1–9, where 1 is extremely feminine and 9 is extremely masculine, how would you describe yourself when you were a teenager (age 13–19)?" After reverse-coding male scores on this question, higher scores are reflective of greater levels of adolescent gender nonconformity, whereas lower scores represent greater levels of concordance.

The same item was also asked about current (young adult) gender nonconformity: "On a scale from 1–9, where 1 is extremely feminine and 9 is extremely masculine, how would you describe yourself at this point in your life?" To test the validity, we also included an item of comparative gender nonconformity: "Compared to other people who are your same age, do you see yourself as: Much more feminine (1), more feminine (2), about the same (3), more masculine (4), or much more masculine (5)?" The three items highly correlated with one another, such that adolescent gender nonconformity was significantly associated with young adult gender nonconformity (r = .62, $p < .001$) and with young adult comparisons to others regarding gender conformity (r = .50, $p < .001$). Finally, young adult gender nonconformity correlated with young adult comparison of gender conformity (r = .65, $p <$ .001).

Self-reported past school victimization due to actual or perceived LGBT status. A 10-item retrospective scale measured school victimization due to actual or perceived LGBT status during adolescence (ages 13–19). A sample item includes "During my middle or high school years, while at school (in other words, while on school property or at a school event), I was pushed, shoved, slapped, hit, or kicked by someone who wasn't just kidding around." The 10 items were followed by "How often did this occur because people knew or assumed you were LGBT?" (0 = *never*, 3 = *many times*). All the items loaded onto one factor in preliminary exploratory factor analysis, leaving no distinct factors. The Cronbach α reliability coefficient for the 10-item scale was .91. For a structurally stable latent construct, three parcels were created to balance items with high and low factor loadings (Little, Cunningham, Shahar, & Widaman, 2002). Following the questions about LGBT school victimization, participants were asked whether school victimization occurred due to race, weight, or other reasons. The presence of this measure limits the possibility that reports of LGBT school victimization were due to other reasons and provides a counterpoint to allow us to compare LGBT school victimization to school victimization for other reasons.

Young adult depression. The 20-item version of the Center for Epidemiologic Studies Depression Scale (Radloff, 1977, 1991)

assessed young adult depression. The reliability for the complete measure was strong (α = .94). The four factors identified in past research were consistent with the factor structure found in this sample: positive affect (four items, α = .83), negative affect (seven items, α = .87), somatic symptoms (seven items, α = .82), and interpersonal (two items, α = .64). The items that make up the four subscales of the Depression Scale were respectively parceled into four manifest variables used as the structure for the latent construct of depression (i.e., facet-representative parceling; Little et al, 2002).

Young adult life satisfaction. An eight-item scale evaluated young adult life satisfaction. A sample question includes "At the present time, how satisfied are you with your living situation?" (1 = *very dissatisfied*, 3 = *very satisfied*). The complete measure had acceptable reliability (α = .75). An exploratory factor analysis revealed that the eight items loaded onto a single factor. To create a structurally stable latent construct, we used the item-to-construct balance approach and created three parcels (Little et al., 2002).

Covariates. We controlled for gender (two dichotomous variables were created for female and transgender; male was the reference group), sexual orientation (two dichotomous variables were created for bisexual orientation and "other" orientation; gay or lesbian orientation was the reference group), outness to others during high school (0 = *not out to no one at school*, 4 = *out to everyone*); immigrant status (0 = *not immigrant*, 1 = *immigrant*), ethnicity (0 = *White*; 1 = *Latino/mixed*), and family-of-origin socioeconomic status.

Results

Overview of Analysis

To maximize power and to minimize exclusion of participants due to missing data, we used PRELIS, a component of LISREL 8.80 (Jöreskog & Sörbom, 2006; Graham, Cumsille, & Elek-Fisk, 2003), to impute missing data (total < 5%). All numeric variables were entered into the expectation maximization algorithm for imputation. We used SAS to conduct all descriptive statistical analyses. Assumptions of normality were checked for all variables. Items from the depression and the adolescent LGBT school victimization measures were positively skewed, but after square-root transformations were performed, the items met assumptions of normality.

To test for associations between the variables of interest, we used structural equation modeling in LISREL. To test the predicted moderator, we conducted a multigroup confirmatory factor analysis (CFA) and examined latent differences in correlations and means (Little, Card, Slegers, & Ledford, 2007). Mediation analyses were performed after the multigroup CFA allowed for the collapse of all participants into one group. We used Sobel's (1982) products-of-coefficients approach to evaluate the indirect effects (MacKinnon, Lockwood, Hoffman, West, & Sheets, 2002). The eight covariates were entered after the completion of CFA multigroup analyses and were allowed to covary freely. In examining all structural equation model fit tests, we used standard measures of practical fit: root-mean-square error of approximation, comparative fit index, and nonnormed fit index.

Descriptive Statistics

See Table 1 for the bivariate correlations, means, and standard deviations of the manifest variables. The mean level of gender nonconformity for the sample was 4.44 (SD = 1.80). Female participants reported the lowest levels of adolescent gender nonconformity (M = 4.17, SD = 1.77), male participants (M = 4.45, SD = 1.66) reported higher levels than girls, and transgender participants reported the highest levels (M = 5.86, SD = 2.15), $F(2, 242) = 8.13$, $p < .001$. No significant mean-level differences on gender nonconformity were found for outness to others during high school, ethnicity, immigrant status, or socioeconomic status. Manifest variable correlations provide preliminary support of our hypotheses: Specifically, both adolescent and young adult levels of gender nonconformity and LGBT school victimization were positively correlated, both adolescent and young adult levels of gender nonconformity were associated with higher young adult depression and lower young adult life satisfaction, and adolescent LGBT school victimization was also associated with higher young adult depression and lower young adult life satisfaction.

Model Results: Hypotheses 1 and 2

Our model was first tested in a multigroup CFA framework to examine factorial invariance across male and female participants. See Table 2 for the model fit statistics for the multigroup CFA (i.e., configural invariance, weak factorial invariance, strong factorial invariance; Little, 1997). We allowed the constraints to be tenable for strong invariance, even though the change in comparative fit index was greater than .01, because the model fit indices still indicated good overall model fit. Thus, our hypothesis that biological sex would moderate the association between adolescent gender nonconformity and adolescent LGBT victimization was not supported.

Table 1
Manifest Scale Correlations, Means, and Standard Deviations

Variable	M	SD	1	2	3	4	5
1. Gender nonconformity (A)	4.44	1.80	—				
2. LGBT school victimization (A)	5.33	4.91	.33***	—			
3. Depression (YA)	12.41	8.24	.22**	.32***	—		
4. Life satisfaction (YA)	22.78	4.19	−.18**	−.29***	−.62***	—	
5. Gender nonconformity (YA)	4.40	1.87	.62***	.21***	.21***	−.19**	—

Note. A = adolescent; LGBT = lesbian, gay, bisexual, transgender; YA = young adult.
** $p < .01$. *** $p < .001$.

Table 2
Multigroup Factorial Invariance Comparisons

Model	χ^2	*df*	*p*	RMSEA	90% CI	NNFI	CFI	Constraint tenable
Configural	112.17	92	>.05	.031	[.000, .059]	.987	.991	
Weak	120.37	99	>.05	.032	[.000, .059]	.987	.990	Yes
Strong	158.06	106	<.05	.058	[.035, .079]	.971	.977	Yes

Note. RMSEA = root-mean-square error of approximation; CI = confidence interval; NNFI = nonnormed fit index; CFI = comparative fit index.

Table 3 shows the model fit indices for latent covariance, variance, and mean structure analyses. The latent variance and covariance structures could be equated, which allowed male and female participants to be combined into one group for all future analyses. Investigation of the latent mean structure indicated significant differences between male and female participants even though the means could be constrained to be equal. We calculated Cohen's *d* effect sizes for the mean difference scores on all latent constructs. In examining the difference in latent mean scores for the experience of LGBT school victimization, we found a medium effect size ($d = -0.66$) between male ($M = 0.00$) and female participants ($M = -0.61$). Differences in mean scores for male ($M_{\text{depression}} = 0.00$, $M_{\text{satisfaction}} = 0.00$) and female participants ($M_{\text{depression}} = -0.38$, $M_{\text{satisfaction}} = -0.58$) on depression ($d = -0.35$) and satisfaction ($d = 0.58$) are considered to be small to medium. The difference in reported adolescent gender nonconformity between male ($M = 0.00$) and female participants ($M = -0.07$) was minimal ($d = -0.06$). Similarly, the difference in reported adult gender nonconformity was minimal ($d = -0.09$, $M_{\text{male}} = 0.00$, $M_{\text{female}} = -0.09$).

After collapsing male and female participants into one group, the structural model was tested. The model achieved excellent model fit, $\chi^2(103, N = 245) = 147.19$, $p < .01$, root-mean-square error of approximation = .04 (.02|.06), nonnormed fit index = .97, comparative fit index = .99. Female and young adults from families with higher economic backgrounds reported less LGBT-related school victimization, whereas young adults who identified as queer, who were more out to others during high school, and who were White (non-Latino) reported more LGBT school victimization. Transgender young adults reported greater levels of adolescent and young adult gender nonconformity. Immigrants reported higher levels of depression, and female and young adults from higher economic backgrounds reported more life satisfaction. Outness to others during high school was associated with lower levels of depression and higher levels of life satisfaction. We found support for our first hypothesis: Higher levels of self-reported adolescent gender nonconformity were associated with more LGBT school victimization.

Model Findings: Hypothesis 3

Only the direct and indirect effects between latent constructs are shown on Figure 2 for clarity (see Table 4 for manifest variable factor loadings). The pathway between gender nonconformity and depression was mediated by the experience of LGBT school victimization ($z = 3.14$, $p < .01$). The proportion mediated (as calculated by the formula $a\beta/c$) is 43.95%. Likewise, the experience of LGBT school victimization mediated the pathway between gender nonconformity and life satisfaction ($z = -2.70$, $p < .01$). The proportion mediated is 51.22%. The direct paths of adolescent gender nonconformity to both young adult outcomes were not significant. Thus, our third hypothesis was supported. The results indicate that gender nonconformity predicts victimization specific to perceptions of LGBT status and that victimization—not the characteristic of gender nonconformity—accounts for long-term psychosocial adjustment problems.[1]

Finally, we replicated the model using the measure of school victimization due to other (non-LGBT) reasons. Results (available from the authors upon request) were distinctly different: School victimization for other reasons did not mediate the pathway between gender nonconformity and depression or between gender nonconformity and life satisfaction. These results further strengthen the conclusion that it is LGBT school victimization that accounts for compromised long-term psychosocial adjustment.

Discussion

Gender-nonconforming youth face many obstacles and challenges in school that they carry with them into young adulthood. This finding is consistent with a growing body of literature that suggests that adolescent experiences of gender-nonconforming and sexual minority individuals are important for understanding young adult health disparities among this population (Friedman et al., 2008; Sandfort et al., 2007). Consistent with previous studies (D'Augelli et al., 2006; Ma'ayan, 2003), the mean level of victimization experienced due to LGBT status in school was significantly different for boys and girls, with boys experiencing greater amounts of victimization at school. Also consistent with prior research and the minority stress model (D'Augelli et al., 2006; Friedman et al., 2006; Meyer, 1995, 2003; Morrow, 2004), victimization due to LGBT status was significantly associated with negative psychosocial adjustment. We also found that school victimization due to LGBT status between the ages of 13 and 19 fully accounts for the associations between gender nonconformity and young adult adjustment, measured as depression and life satisfaction. However, school victimization for other reasons does not mediate this association. On the other hand, we did not find support for our hypothesis that the strength between gender nonconformity and school LGBT victimization would be stronger for boys: The process through which early gender nonconformity

[1] We also tested the model without transgender participants. The findings (available upon request) were similar to the results based on the full sample (i.e., the indirect pathway was significant and all pathways were of similar strength and the same direction). On the basis of these results, and because our measure of LGBT school victimization was inclusive of transgender experiences, we present finding based on the full sample.

Table 3
Tests of Equivalence of Covariance, Variance, Latent Correlations, and Means

Model	χ^2	*df*	*P*	$\Delta\chi^2$	Δdf	*p*	Constraint tenable
Homogeneity of variances and covariances	134.67	114	>.05	14.30	15	>.05	Yes
Equality of variances	127.59	104	>.05	7.22	5	>.05	Yes
Equality of correlations	128.96	109	>.05	8.59	10	>.05	Yes
Equality of means	166.83	116	<.01	8.77	10	>.05	Yes

affects later psychosocial adjustment is similar for boys and girls. Overall, our results provide partial support for the minority stress model. We found that the negative impact of specifically homophobic school victimization continues into the young adult years and affects quality of life and capacity to enjoy life.

Because victimization due to perceived or actual LGBT status occurs within the school context, the results of this study have several implications for school administrators, teachers, school-based providers, and staff, as well as social service and mental health providers and other providers who directly work with LGBT and gender-nonconforming young people. Although boys experience victimization in school due to actual or perceived LGBT status and gender nonconformity at higher rates than girls, school policies and practices affect all students regardless of gender. Enactment of school policies that specifically prohibit victimization due to LGBT status, gender nonconformity, and other types of bias-related harassment can help reduce negative psychosocial outcomes in LGBT and gender-nonconforming young people. Thus, although it is clear that all victimization should be prohibited in schools, these findings specifically indicate the need for antibullying policies that enumerate categories often targeted by bullies.[2]

Recommendations for Safe Schools

In line with recent research and guidance on LGBT student safety (Chesir-Teran, 2003; Kosciw et al., 2008; O'Shaughnessy et al., 2004; Perrotti & Westheimer, 2001; Sausa, 2005), we recommend that schools implement policies and procedures to prevent harassment due to LGBT status and gender nonconformity. The most basic change schools can make includes adopting and implementing enumerated antiharassment policies to prevent harassment based on gender nonconformity and LGBT status. Antiharassment policies, however, need to have follow-up procedures and other policies and programs to further promote a safe school environment. Providing education about gender expression and LGBT issues to students, administrators, staff, and teachers is another key strategy for increasing safety in schools. Schools should provide the opportunity for a support or social group for gender-nonconforming and LGBT students, such as a Gay–Straight Alliance, to provide an institutional venue for social support, student involvement, and student voice (Goodenow, Szalacha, & Westheimer, 2006; Human Rights Watch, 2001). In fact, Goodenow et al. (2006) found that sexual minority youth in schools with Gay–Straight Alliances reported fewer suicide attempts than students without Gay–Straight Alliances in their schools. School administrators, teachers, and staff members should examine the physical structure of their schools to find new opportunities to create safer environments for gender-nonconforming and LGBT students (Chesir-Teran, 2003). For example, providing gender-neutral bathroom options for students, staff, and teachers and avoiding the use of gendered segregation in practices such as school uniforms, school dances, and extracurricular activities are structural ways to provide safer school environments.

Limitations

This study has several limitations. Although we used the best sampling strategies available to reach stigmatized populations (Diamond, 2003), the results cannot establish causality and cannot be generalized to all gender-nonconforming youth in other settings outside California. The data collection was retrospective, which does not allow for measurements to be taken at unique data points (Frazier, Tix, & Barron, 2004). The order of measurements in the survey may have led to measurement bias because participants were asked to report retrospectively on prevalence of LGBT school-related victimization prior to being asked about their current life situations. This order of questions may have prompted respondents to report more negative psychosocial adjustment. Our methods attempt to establish temporal order by asking participants to report retrospectively on gender nonconformity and victimization while reporting current life adjustment. Although this is a potential concern, prior research has found that results of retrospective reports of school bullying are stable over time, a finding that gives us confidence that reports of adolescent school victimization were not overly influenced by young adult mental health (Rivers, 2001b). Another limitation of our construct of LGBT school victimization and our test of the minority stress model is that we do not have a measure of expectations of victimization; those who expect more victimization may report more victimization experiences.

Our focus on school victimization as the sole context for our measure of LGBT-related victimization and violence is limited. A more comprehensive approach to studying the mechanisms that place LGBT and gender-nonconforming youth at greater risk for concurrent and later psychosocial maladjustment would include experiences of victimization and rejection from multiple contexts (e.g., family, community, work). Our measurement of gender nonconformity is also limited in that it was assessed only with a single item. Future work could examine the associations among gender nonconformity, victimization experiences, and adjustment

[2] For example, the Safe Schools Improvement Act (H.R. 2262), currently under consideration by Congress, is the first proposed federal school antibullying law that includes enumerated categories. Currently 10 U.S. states have enumerated school antibullying laws designed to protect students based on sexual orientation and gender identity or expression.

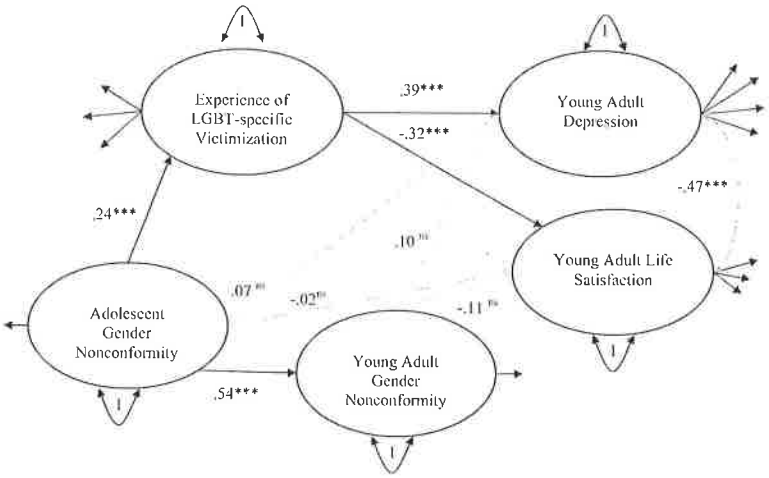

Figure 2. Model with standardized estimates.

from a multidimensional view of gender such as the one proposed by Egan and Perry (2001).

Conclusions

Despite the limitations, this study contributes new knowledge about the negative impact school victimization has for young adult well-being among gender-nonconforming LGBT young adults. Specifically, the direct effect of adolescent gender nonconformity on young adult adjustment was fully mediated by the experience of victimization. This finding is particularly important when framed in the context of the murder of Larry King (Pringle & Saillant, 2008). We acknowledge that this is only one recent example, but the media attention it received highlights growing public concern about the most extreme form of victimization that LGBT and gender-nonconforming youth experience in school. King's brutal experience with victimization because of his sexual orientation and gender nonconformity ended with his teenage murder, but our findings indicate that the experience of victimization has lasting consequences that fully account for any previous association between gender nonconformity and young adult adjustment.

Prior to this study, the authors are aware of no other studies that have attempted to examine simultaneously the associations between gender nonconformity, LGBT school victimization, young adult depression, and life satisfaction. The results of this study warrant future research to examine other factors that may be crucial in the lives of LGBT youth in preventing negative psychosocial outcomes. For instance, what other factors influence the association between victimization and psychosocial outcomes: family acceptance, family rejection, peer support, or other life situations (e.g., socioeconomic status, quality of other relationships, personality factors)? Finally, future research should examine the school context to gain a deeper understanding of effective protective measures that schools use to prevent the victimization and harassment of LGBT and gender-nonconforming students.

Table 4
Unstandardized and Standardized Factor Loadings

Construct	Unstandardized (*SE*)	Standardized
Adolescent gender nonconformity	1.73 (0.08)	1.00
Adolescent LGBT school victimization		
Parcel 1	0.40 (0.02)	.94
Parcel 2	0.37 (0.02)	.87
Parcel 3	0.36 (0.02)	.88
Depression		
Positive affect	0.35 (0.02)	.80
Negative affect	0.35 (0.02)	.91
Somatic symptoms	0.31 (0.02)	.88
Interpersonal	0.27 (0.02)	.66
Young adult life satisfaction		
Parcel 1	0.36 (0.04)	.64
Parcel 2	0.41 (0.04)	.76
Parcel 3	0.36 (0.03)	.70
Young adult gender nonconformity	1.34 (0.06)	1.00

Note. All factor ladings are significant at $p < .001$. LGBT = lesbian, gay, bisexual, transgender.

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Family Acceptance in Adolescence and the Health of LGBT Young Adults

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ISSUE: *The role of family acceptance as a protective factor for lesbian, gay, bisexual, and transgender (LGBT) adolescents and young adults has not been established.*

METHODS: *A quantitative measure with items derived from prior qualitative work retrospectively assessed family accepting behaviors in response to LGBT adolescents' sexual orientation and gender expression and their relationship to mental health, substance abuse, and sexual risk in young adults (N = 245).*

FINDINGS: *Family acceptance predicts greater self-esteem, social support, and general health status; it also protects against depression, substance abuse, and suicidal ideation and behaviors.*

CONCLUSIONS: *Family acceptance of LGBT adolescents is associated with positive young adult mental and physical health. Interventions that promote parental and caregiver acceptance of LGBT adolescents are needed to reduce health disparities.*

Search terms: *Gender identity, homosexuality, LGBT adolescent, protective factors, sexual orientation, transgender*

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Extensive research has focused on the nurturing and protective role of families, in general, and connections to family have been shown to be protective against major health risk behaviors (e.g., Resnick et al., 1997). Although family relationships are understood to be a primary context for adolescent development, only a small number of studies have focused on the role of parent–adolescent relationships for lesbian, gay, and bisexual (LGB) youth and young adults. Literature addressing the family relationships for transgender adolescents and young people is miniscule. Given the crucial role of parents in promoting adolescent well-being, it is surprising that so little attention has focused on the parenting of lesbian, gay, bisexual, and transgender (LGBT) adolescents. Most existing research has focused on negativity in the relationships between LGB youth and their parents; no known research has considered the possible developmental benefits of family acceptance and supportive behaviors for LGBT youth. One study has assessed the relationship between LGB young adults' perceived family support (e.g., general closeness, warmth, and enjoying time together) and depression, substance use, and suicidality (Needham & Austin, 2010).

The lack of literature on family support is particularly surprising because LGB youth and adults (Cochran, Sullivan, & Mays, 2003; D'Augelli, 2002; Meyer, 2003) and youth with same-gender attractions (Russell & Joyner, 2001) are known to be at risk for compromised physical and emotional health. Research over the past decade has begun to trace the origins of health disparities associated with sexual identity; these studies have focused largely on the role of victimization and negative peer relationships during adolescence and associated health risks in adolescence and young adulthood

(Diamond & Lucas, 2004; Lasser & Tharinger, 2003; Russell, 2005; Russell, Seif, & Truong, 2001; Ryan & Rivers, 2003; van Wormer & McKinney, 2003).

Studies show that LGB adolescents' relationships with their parents are often challenged, particularly around the time of disclosure of sexual identity or "coming out" (D'Augelli, Grossman, & Starks, 2005; Patterson, 2000; Savin-Williams, 1998a, 1998b; Savin-Williams & Dubé, 1998; Tharinger & Wells, 2000) or when parents learn that their children are LGBT. Researchers in one study (Rosario, Schrimshaw, & Hunter, 2009) examined substance use among LGB youth and asked youth whether they perceived reactions to their LGB identity from a range of people (including family members, coaches, teachers, therapists, neighbors, and friends) to be accepting, neutral, or rejecting. The number of perceived rejecting reactions were reported to predict substance use; although accepting reactions did not directly reduce substance use, such reactions buffered the link between rejections and substance use.

Another recent study assessed the relationship between family rejection in adolescence and the health of LGB young adults (Ryan, Huebner, Diaz, & Sanchez, 2009). That study showed clear associations between parental rejecting behaviors during adolescence and the use of illegal drugs, depression, attempted suicide, and sexual health risk by LGB young adults. Prior research clearly points to the role of family rejection in predicting health and mental health problems among LGB adolescents and adults, yet at the same time, while it is known that initial parental reactions to the disclosure of LGB identity may be negative—sometimes including ejection from the home—research has also shown that after parents become sensitized to the needs and well-being of their LGB children, many family relationships improve (D'Augelli et al., 2005).

Reports about researchers who study family reactions to their children's LGBT identity indicate that parental acceptance and rejection are different constructs (e.g., Perrin et al., 2004); thus, accepting and rejecting behaviors can co-occur as families adjust to learning about their child's LGBT identity. Nevertheless, the focus of prior research has been largely on compromised parent–adolescent relationships for LGB young people. Yet given the changes in public visibility and attitudes about LGBT people and issues over the course of past decades (Savin-Williams, 2005), some families react to learning about their child's LGBT identity with acceptance (Ryan, 2009a).

Further, given the links between parental rejection and negative health outcomes (Ryan et al., 2009), we expect that affirmation or acceptance of LGBT adolescents will be associated with positive adjustment and decreased mental health and behavioral health risks in young adulthood: higher self-esteem, increased social support, and better general health status, along with decreased depression, substance abuse, sexual risk behavior, suicidal ideation, and behaviors.

This article presents findings related to family acceptance from the Family Acceptance Project (FAP), a research and intervention initiative to study the influence of family reactions on the health and mental health of LGBT adolescents and young adults. To our knowledge, no prior studies have examined the relationship between specific family reactions to their children's sexual orientation and gender expression with health and mental health status in emerging adulthood.

Methods

Sampling and Procedures

This study used a participatory research approach that was advised at all stages by individuals who will use and apply the findings—LGBT adolescents, young adults, and families—as well as health and mental health providers, teachers, social workers, and advocates. Providers, youth, and family members provided guidance on all aspects of the research, including methods, recruitment, instrumentation, analysis, coding, materials development, and dissemination and application of findings. This type of participatory research has been shown to increase the representativeness and cultural competence of sampling and research strategies (Viswanathan et al., 2004).

We recruited a sample of 245 LGBT Latino and non-Latino white young adults from 249 LGBT venues within a 100-mile radius of our office. Half of the sites were community, social, and recreational agencies and organizations that serve LGBT young adults, and half were from clubs and bars serving this group. Bilingual recruiters (English and Spanish) conducted venue-based recruitment from bars and clubs and contacted program directors at each agency to access all young adults who use their services.

Preliminary screening procedures were used to select participants who matched the study criteria. Inclusion criteria were age (21–25), self-identified ethnicity (non-Latino white, Latino, or Latino mixed), self-identification as LGBT, homosexual, or nonheterosexual (e.g., queer) during adolescence, knowledge of their LGBT identity by at least one parent or guardian during adolescence, and having lived with at least one parent or guardian during adolescence at least part of the time. The survey was available in computer-assisted and pencil and paper formats. The study protocol was approved by the university's IRB.

Measures

Family Acceptance

The measure of family acceptance was developed based on individual in-depth interviews of 2–4 hr each with 53 socioeconomically diverse Latino and non-Latino white self-identified LGBT adolescents and their families in urban,

suburban, and rural communities across California. Interviews were conducted in English and Spanish, audio-taped, translated, and transcribed. Each participant provided narrative descriptions of family interaction and experiences related to gender identity and expression, sexual orientation, cultural and religious beliefs, family, school and community life, and sources of support and described instances or examples of times when parents, foster parents, caregivers, and guardians had shown acceptance and support of the adolescent's LGBT identity.

From these transcripts, a list of 55 positive family experiences (comments, behaviors, and interactions) was generated. We created 55 close-ended items that assessed the presence and frequency of each accepting parental or caregiver reaction to participants' sexual orientation and gender expression when they were teenagers (ages 13–19). At least three close-ended items were generated for each type of outwardly observable accepting reaction documented in the transcripts. Additional information on constructing and scoring the items is included in a previous article (Ryan et al., 2009).

Participants indicated the frequency with which they experienced each positive reaction using a 4-point scale (0 = never, 3 = many times). Reliability analyses indicate high consistency in participants' responses across items (Cronbach's $\alpha = 0.88$). Family acceptance scale scores were calculated as the sum of whether each event occurred (dichotomized as never versus ever). For example, survey items include:

- How often did any of your parents/caregivers talk openly about your sexual orientation?
- How often were your openly LGBT friends invited to join family activities?
- How often did any of your parents/caregivers bring you to an LGBT youth organization or event?
- How often did any of your parents/caregivers appreciate your clothing or hairstyle, even though it might not have been typical for your gender?

In addition to this scale, we calculated a categorical indicator of family acceptance, dividing the distribution into even thirds. The measure is used to illustrate differences between adolescents who reported low ($n = 81$, range = 0–15, mean = 7.13), moderate ($n = 83$, range = 16–30, mean = 22.60), or high ($n = 81$, range = 31–55, mean = 42.00) levels of family acceptance.

Demographic Measures

The measure of sexual identity includes categories for those who self-identified as gay/lesbian, bisexual, or other sexual identity (including "homosexual" or "other"). We also included measures of *immigrant status* (1 = born outside the United States, 0 = born in the United States), *childhood religious affiliation* (1 = any religious affiliation, 0 = no religious affiliation), and *childhood family religiosity* (How religious or spiritual was your family while you were growing up? 0 = not at all; 3 = extremely). *Parents' occupational status* was measured by coding written responses for the primary occupation of each parent or caregiver (1 = unskilled manual labor, 2 = semiskilled labor, 3 = skilled labor, 4 = professional) and multiplying the score for mothers and fathers (in the small number of cases with missing data, the mean maternal or paternal occupation code was used to calculate the total parental occupation status score).

Young Adult Adjustment and Health

We report on three indicators of positive adjustment and health, and five negative indicators. The indicators of positive adjustment include the 10-item Rosenberg (1965) *self-esteem* scale. *Social support* was based on the average of 12 items, including: "There is a special person who is around when I am in need," "I get the emotional help and support I need from my family," "My friends really try to help me" (1 = strongly disagree, 5 = strongly agree; Cronbach's $\alpha = 0.89$). General health is assessed with one item: "How is your health in general?" (1 = poor; 5 = excellent).

We assessed negative health outcomes with five measures. For *depression* we used the 20-item Center for Epidemiological Studies Depression scale, originally developed to measure somatic and affective symptoms of depression in community samples of adults (Radloff, 1977). *Substance abuse* was measured as the sum of four items that asked about substance use problems: "[I]n the past five years": " . . . have you had problems with the law because of your alcohol or drug use?" " . . . have you lost a job because of your alcohol or drug use?" " . . . have you passed out or lost consciousness because of your alcohol or drug use?" " . . . have you had conflicts with family, lovers, or friends because of your alcohol or drug use?" (0 = no; 1 = somewhat yes/yes). *Sexual behavior risk* was defined as reporting any unprotected anal or vaginal intercourse within the past 6 months with a casual partner or a steady partner who was nonmonogamous or serodiscordant for HIV (0 = no; 1 = yes). *Suicidal thoughts or behaviors* were measured as follows: "During the past six months did you have any thoughts of ending your life?" (0 = no; 1 = yes); "Have you ever, at any point in your life, attempted to take your own life?" (0 = no; 1 = yes).

Analysis

We first examined the associations between our measure of family acceptance and the background characteristics of study participants. For the health outcome measures we present average scores for the three categories of family acceptance (to test for statistical differences across groups using one-way ANOVA); for categorical measures we present

proportions of the sample in each of the family acceptance categories (differences tested with chi-square). Finally, we use ordinary least squares and logistic regression analyses to test the degree to which family acceptance predicts young adult health outcomes, controlling for background characteristics.

Results

Scores on family acceptance range from lowest to highest possible: 0–55. The average score is 23.9, with a standard deviation of 15.2. The distribution is remarkably flat (the skewness is 0.25 and Kurtosis is –0.98): The participants in this study included a wide range of family accepting experiences during adolescence.

The sample included roughly equal numbers of young adults who self-identified as male and female; 9% of the sample identified as transgender. Seventy percent identified as gay or lesbian (42% gay; 28% lesbian), 13% identified as bisexual, and 17% reported an alternative sexual identity (among these, 35 participants wrote in "queer"). There were no statistical differences in the average levels of family acceptance based on sexual identity (gay/lesbian, bisexual, versus other sexual orientation), gender (male versus female), or transgender identity.

The sample was evenly divided between Latino and non-Latino white participants; 19% were born outside the United States. Whites reported higher average levels of family acceptance. Immigrant status was strongly associated with family acceptance: Those born in the United States reported higher family acceptance compared with immigrants. Childhood religious affiliation was linked to family acceptance; participants who reported a childhood religious affiliation reported lower family acceptance compared with those with no religious affiliation in childhood. Childhood family religiosity was also linked to family acceptance; highly accepting families reported low religiosity compared with the high religiosity among low accepting families. Finally, we find evidence of a link between social class and family acceptance such that highly accepting families had higher parental occupational status compared with those that scored low on acceptance (statistical analyses available from authors on request).

Associations between young adult health and the three levels of family acceptance are presented in Table 1. There are clear links between family acceptance in adolescence and health status in young adulthood. Young adults who reported high levels of family acceptance scored higher on all three measures of positive adjustment and health: self-esteem, social support, and general health. For the measures of negative health outcomes, young adults who reported low levels of family acceptance had scores that were significantly worse for depression, substance abuse, and suicidal ideation and attempts. Half as many participants from highly accepting families reported suicidal thoughts in the past 6 months compared with those who reported low acceptance (18.5% versus 38.3%). Similarly, the prevalence of suicide attempts among participants who reported high levels of family acceptance was nearly half (30.9% versus 56.8%) the rate of those who reported family acceptance. Sexual risk behavior was the only young adult health indicator for which there was no strong association with family acceptance in adolescence; this outcome was not examined in subsequent analyses.

The final analyses examined the degree to which associations between family acceptance and young adult well-being were independent of the background characteristics of study participants. Regression results are presented in Table 2. For all health outcomes, the link between family acceptance and young adult health is present regardless of background characteristics. Table 2 shows that, consistent with prior research on gay and lesbian youth and young adults, and in contrast to studies of heterosexual women and men, females reported higher self-esteem and social support and lower

Table 1. Family Acceptance as Predictors of Health Outcomes

Outcome variable	Family acceptance categories			Between-group difference
	Low acceptance	Moderate acceptance	High acceptance	$F/\chi 2$ (df = 2)
Self-esteem	2.62	2.83	2.95	$F = 17.10^{***}$
Social support	3.26	3.78	4.10	$F = 19.90^{***}$
General health	3.35	3.55	3.96	$F = 8.96^{**}$
Depression (CES-D)	20.10	16.48	10.37	$F = 15.93^{***}$
Substance abuse (past 5 years)	1.46	1.10	.85	$F = 4.81^{**}$
Sexual behavior risk (past 6 months)	35.8%	37.4%	28.4%	$\chi 2 = 1.67$
Suicidal thoughts (past 6 mos.)	38.3%	22.9%	18.5%	$\chi 2 = 8.96^{*}$
Suicide attempts (lifetime)	56.8%	36.1%	30.9%	$\chi 2 = 12.57^{**}$

$^{*}p < .05$; $^{**}p < .01$; $^{***}p < .001$.

Table 2. Family Acceptance and Health Outcomes Controlling for Background Characteristics. OLS Regression, Standardized Estimates

	Self-esteem	Social support	General health	Depression	Substance abuse
Family acceptance	0.33***	0.44***	0.21***	−0.29***	−0.19**
Background characteristics:					
Bisexual	−0.07	0.11	0.11+	−0.10+	0.04
Other sexual identity (reference group: gay/lesbian)	−0.06	0.08	−0.10	−0.01	0.10
Female	0.17**	0.06*	0.02	−0.10	−0.19**
Transgender (reference group: male)	0.05	−0.13+	−0.22**	0.08	−0.04
White (reference group: Latino	−0.17*	−0.08	0.01	0.10	−0.01
Immigrant (reference group: U.S. born)	−0.07	−0.06	−0.04	0.10	−0.07
Parents' occupation status	0.08	0.20**	0.17**	−0.11+	−0.07
Childhood religious affiliation (reference group: no affiliation)	−0.03	0.15	−0.08	0.00	−0.04
Childhood family religiosity	−0.08	−0.09*	0.05	0.04	0.08
Adjusted R^2	0.16	0.30	0.17	0.14	0.06

+$p < .10$; *$p < .05$; **$p < .01$; ***$p < .001$.

Table 3. Family Acceptance and Young Adult Health Outcomes Controlling for Background Characteristics. Logistic Regression, Odds Ratios (95% Confidence Interval)

	Suicidal ideation (past 6 months)	Suicide attempts (ever)
Family acceptance	0.98 (0.95–0.99)*	0.97 (0.95–0.98)**
Background characteristics:		
Bisexual	1.12 (.44–2.81)	0.74 (0.31–1.78)
Other sexual identity (reference group: gay/lesbian)	1.06 (.42–2.63)	2.36 (0.99–5.58)+
Female	0.60 (0.32–1.10)+	0.52 (0.29–0.92)*
Transgender (reference group: male)	1.42 (0.48–4.22)	0.73 (0.25–2.14)
White (reference group: Latino)	1.25 (0.61–2.54)	1.39 (0.73–2.67)
Immigrant (reference group: U.S. born)	1.52 (0.69–3.33)	1.01 (1.01–2.19)
Parents' occupation status	0.97 (0.90–1.04)	0.91 (0.85–0.97)**
Childhood religious affiliation (reference group: no affiliation)	0.91 (0.38–2.14)	0.81 (0.37–1.77)
Childhood family religiosity	1.18 (0.83–1.70)	1.17 (0.83–1.66)

+$p < .10$; *$p < .05$; **$p < .01$; ***$p < .001$.

substance abuse. Transgender respondents reported lower social support and general health; however, there were no differences in their reports of self-esteem, depression, and substance abuse. Bisexuals reported slightly better general health and less depression. White respondents reported lower self-esteem than Latinos. Family socioeconomic status was associated with general health scores; it was also associated with higher social support and less depression.

It is noteworthy that family religious affiliation, although linked to lower family acceptance, was positively associated with young adult social support. Follow-up analyses showed that the association between childhood religious affiliation and social support was not significant; thus, childhood religious affiliation is positively linked to social support in young adulthood after accounting for family acceptance. Religious affiliation in adolescence is known to be a factor that promotes well-being; these results indicate that this association is consistent for LGBT young adults only after differences between low and high family acceptance are taken into account.

Logistic regression results for the two dichotomous health outcomes (suicidal ideation and attempts) are presented in Table 3; results are interpreted as odds ratios, for which a number greater than one is interpreted as higher odds of the risk outcome, and a number lower than one represents lower odds. Table 3 shows that family acceptance is associated with reduced odds of suicidal ideation and attempts. The odds

ratios are deceptively small (suicidal thoughts: 0.98; suicide attempts: 0.97) given the 50-point range of the measure of family acceptance. To illustrate this point, we calculated the odds ratios for suicidal ideation and attempts for those who report low or no family acceptance compared with medium or high. Participants who had low family acceptance as adolescents were more than three times as likely to report both suicidal ideation and suicide attempts compared with those who reported high levels of family acceptance. Consistent with the results for depression, females are less likely than males to report suicidal ideation or attempts. Finally, for suicide attempts, family socioeconomic status was protective, but identifying as "queer" rather than as lesbian, gay, or bisexual was a strong risk factor.

Discussion

Until now, most thinking about LGBT adolescents and families has focused on negative parent–adolescent relationships or family rejection; our study is unique in pointing out the lasting, dramatically protective influence of specific family accepting behaviors related to an adolescent's LGBT identity on the health of LGBT young adults. These results show clear associations even after accounting for individual and background characteristics.

First, based on a sample of self-identified LGBT young adults, our results indicate that family acceptance did not vary based on gender, sexual identity, or transgender identity. Specifically, it does not appear that families are more accepting of female than male LGBT adolescents, of bisexual than gay/lesbian adolescents, or of transgender compared with nontransgender adolescents. However, Latino, immigrant, religious, and low-socioeconomic status families appear to be less accepting, on average, of LGBT adolescents. It appears that it is not the sexual orientation or gender identity of the adolescents themselves but the characteristics of their families (their ethnicity, immigration and occupation status, and religious affiliation) that seem to make a difference in distinguishing between those that score high versus low on acceptance of their LGBT children. This stands in contrast to family rejection, which has been shown to be higher among males and Latinos (Ryan et al., 2009).

Second, we find that family acceptance in adolescence is associated with young adult positive health outcomes (self-esteem, social support, and general health) and is protective for negative health outcomes (depression, substance abuse, and suicidal ideation and attempts). The only exception to the pattern was for sexual risk behavior during the past 6 months, for which family acceptance had no clear association. A prior study has shown a link between family LGBT rejection and sexual risk behaviors with this sample (Ryan et al., 2009), with parental rejection of their LGBT adolescent being associated with greater sexual health risk in young adulthood. The lasting influence of accepting family comments, attitudes, behaviors, and interactions related to the adolescent's LGBT identity clearly applies to personal emotional and physical states. It may be that intimate and sexual relationships are more strongly influenced by proximal interpersonal factors such as peer relations or characteristics of intimate relationships. These findings deserve further exploration in future research.

Third, our results show that the influence of family acceptance persists, even after control for background characteristics. Further, we find associations between background characteristics and young adult mental health and physical health that warrant further investigation. Independent of levels of family acceptance, transgender young adults reported lower social support and general health. While these specific findings have not been previously reported to our knowledge, they are consistent with the limited existing research that identifies transgender adolescents as a group at high risk for compromised health (Garofalo, Deleon, Osmer, Doll, & Harper, 2006). Young adults who did not ascribe to "gay," "lesbian," or "bisexual" identities (those who self-identified as "queer") were more than twice as likely to report lifetime suicide attempts but not recent suicidal thoughts. Our results indicate that although they were not at risk in young adulthood, they reported higher rates of earlier suicide attempts. These may be adolescents who most struggle to find an authentic, personal sexual identity or who do not identify with "gay" and "lesbian" stereotypes, perceptions, or expectations. A lack of fit or identification with the LGB community may be an important factor in their earlier suicide attempts. We know of no existing research that examines the implications for mental health of alternative identities among sexual minority adolescents.

In the context of these novel findings, there are several limitations to our study. LGBT individuals are a hidden population; thus, we cannot claim that this sample is representative of the general population of LGBT individuals. However, in order to maximize the broadest inclusion in our sample, we mapped the universe of social, recreational and service organizations, bars, and clubs that serve LGBT young adults within 100 miles of our office. We contacted each community organization to notify each member or participant so all would have an equal chance of participating in our study; and we conducted venue-based recruitment at bars and clubs within our recruitment area. In addition, the study focused on LGBT non-Latino white and Latino young adults, the two largest ethnic groups in California. The study did not include persons from other ethnic groups because of funding constraints. Subsequent research should include greater ethnic diversity to assess potential cultural differences in family reactions to their children's LGBT identity. Finally, the study is retrospective; young adults provided information about experiences that happened during their teenage years which

allows the potential for recall bias in describing specific family reactions to their LGBT identity. To minimize this concern, we created measures that asked as objectively as possible whether or not a specific family behavior or response related to their LGBT identity actually occurred (e.g., did your parent or caregiver connect you with an LGBT adult role model?).

Others have argued for the need for studies that identify risk and protective factors that are unique to LGBT individuals (Russell, 2003). Given that positive parent–adolescent relationships are known to be a foundation for optimal development, it is ironic that attention to LGBT adolescent–parent relationships has almost exclusively focused on negativity. Our approach to directly measuring LGBT-specific behaviors that express family and caregiver acceptance during adolescence is an important step toward better understanding LGBT health, and offers the opportunity for focused prevention and intervention with diverse families that have LGBT children. Practice approaches and programs that specifically support families of LGBT children and adolescents may have great potential for preventing the well-documented LGBT health disparities.

Implications for Nursing Practice and Research

Nurses are uniquely positioned to provide assessment, education, and support to LGBT youth and families and to discuss the impact of family acceptance on their children's health and well-being. Family-oriented care is a cornerstone of nursing practice (e.g., Bomar, 2004; Hanson & Boyd, 1996; Wright & Leahey, 2000) and guides nursing intervention and research in multiple care settings.

Although the focus of the research and relationships between LGB youth (little has been published, to date, on transgender youth) and families has been on disruption, conflict, and negative interactions, family support and connectedness are protective factors for adolescents, in general, and have been shown to protect against suicidality in LGB youth (Eisenberg & Resnick, 2006), in particular. Nurses can incorporate this emerging empirical understanding of the impact of family response on LGBT children's well-being into individual practice and interactions with youth and their families in several ways:

Assessment

Nurses should routinely ask adolescents about their sexual orientation and gender identity to provide appropriate assessment and care. A clinical protocol sponsored by the Health Resources and Services Administration and developed by clinical care and practice experts on sexual minority youth has been published on mental health assessment and primary care (see Ryan & Futterman, 1997, 1998). (Download from http://familyproject.sfsu.edu)

Table 4. Supportive Behaviors That Help Families Promote Their LGBT Child's Well-Being

Talk with your child or foster child about their LGBT identity
Express affection when your child tells you or when you learn that your child is LGBT
Support your child's LGBT identity even though you may feel uncomfortable
Advocate for your child when he or she is mistreated because of their LGBT identity
Require that other family members respect your LGBT child
Bring your child to LGBT organizations or events
Connect your child with an LGBT adult role model to show them options for the future
Work to make your faith community supportive of LGBT members or find a supportive faith community that welcomes your family and LGBT child
Welcome your child's LGBT friends and partner to your home and to family events and activities
Support your child's gender expression
Believe your child can have a happy future as an LGBT adult

LGBT, lesbian, gay, bisexual, and transgender.
From: Supportive Families, Healthy Children: Helping Families with Lesbian, Gay, Bisexual & Transgender Children by Caitlin Ryan, 2009, Family Acceptance Project, San Francisco State University. Copyright 2009 by Caitlin Ryan. Reprinted with permission.

- Ask LGBT adolescents and youth who are questioning their sexual orientation or gender identity about how their family, caregivers, or foster family reacts to their identity.
- Provide supportive counseling, as needed, and connect youth with LGBT community resources and programs.

Parent/Family Education

Nurses should identify parents and caregivers, including foster parents and guardians, in need of education and guidance to help support their LGBT children.

- With the youth's consent, help families identify supportive behaviors that help protect against risk and help promote their LGBT child's well-being. Table 4 includes a list of some family behaviors included in this study that help promote well-being for LGBT youth.
- For LGBT youth who report negative family reactions, use the *FAP*risk assessment screener[1] (Ryan & Diaz, 2009) to identify the level of family rejection and related health risks in LGBT youth. Discuss findings from the Family

[1] (Download from http://familyproject.sfsu.edu/publications)

Acceptance Project (see Ryan, 2009b; Ryan et al., 2009) on how educating families of LGBT youth can help them understand the serious negative health impact of family rejection on the adolescent's health and mental health (including depression, suicide, illegal drug use, and risk for HIV). With the youth's consent and participation, contact the family to provide education, family counseling, and support.

Support for Youth and Family

Some adolescents can use the support of their health professional to come out to parents and caregivers. Nurses can offer to help the youth disclose their sexual orientation or gender identity to the parent/caregiver. This includes providing education on sexual orientation and gender identity, guidance to help parents and foster parents understand how to support their LGBT child, and counseling to help families reconcile values and beliefs that homosexuality is wrong with their love for their LGBT child. While it is important to offer this support, it is essential to respect the youth's preferences and decisions about where, how, and when they choose to disclose their LGBT identity to parents, caregivers, and other family members. For LGBT youth who report family rejection and are fearful of family involvement, individual counseling can help the adolescent deal with rejection, and referral to LGBT youth programs, including school diversity clubs, can provide access to peer support and positive LGBT adult role models.

Advocacy and Professional Education

Nurses can advocate in their agencies and institutions for the importance of providing family-related care for LGBT adolescents. This includes serving LGBT youth in the *context* of their family (typically LGBT adolescents are served alone, as if they were adults, and few providers routinely ask about family reactions to the youth's LGBT identity, gender expression, and behavior).

Early Intervention

Nurses (particularly in school settings) can identify children and adolescents in need of support, including those who are gender variant, who may be perceived to be gay and are harassed by peers, and who come out at younger ages and may be more vulnerable to negative reactions from family and peers. Researchers have observed that the average age of sexual attraction is about age 10 for heterosexual and homosexually identified youth (McClintock & Herdt, 1996), and this finding has been reported in subsequent studies of LGB adolescents (D'Augelli & Hershberger, 1993; Herdt & Boxer, 1993; Rosario et al., 1996).

Parents and many providers have limited information about sexual orientation and gender identity development in children and adolescents. Many parents see identifying as gay during childhood and adolescence as a "phase" or a reaction to outside influences. Others may see gender nonconforming behavior, especially in boys, as willful and disobedient. Their children experience parental denial and minimization of their identity as rejection that can negatively impact their relationship. Nurses can help parents and caregivers understand that sexual orientation and gender identity development are normative aspects of child development. They can work with young people and families to provide counseling, family therapy, and access to family peer support to help decrease family conflict and educate families about rejecting behaviors that are associated with significantly elevated risk for their LGBT children.

Strengths-Based Approach

The increased focus on strengths in nursing (e.g., Feeley & Gottlieb, 2000) provides an important framework for reinforcing supportive responses among families who seek to affirm their LGBT children and helping other families who see their children's LGBT identity as deficit based. A strengths-based approach helps families more readily identify with their competencies, skills, and resources—all of which can help motivate and empower parents, caregivers, and other family members to adopt supportive behaviors identified in this research that can help decrease their LGBT children's risk and promote their well-being.

Nursing has helped define the field of family-oriented care, and nurses work with families in all settings. However, surprisingly little literature in nursing journals has focused on care related to families of LGBT patients. These findings on the critical role of parents and caregivers in promoting the well-being and decreasing risk of their LGBT children warrant further investigation, intervention research, and specific training in nursing education, particularly for psychiatric nurses who work with patients whose families are struggling to adjust to their child's LGBT identity.

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BUILDING PARTNERSHIPS: CONVERSATIONS WITH LGBTQ YOUTH ABOUT MENTAL HEALTH NEEDS AND COMMUNITY STRENGTHS

UC DAVIS
CENTER FOR REDUCING HEALTH DISPARITIES

UCDAVIS
HEALTH SYSTEM

COMMUNITY ENGAGEMENT WITH LGBTQ YOUTH

The UC Davis Center for Reducing Health Disparities (CRHD) works on building relationships with communities, conducting research, and working with policy makers to improve the health of underserved groups in California. In 2006, the CRHD launched a project to reach out to communities and find out more about their ideas on mental health, the kinds of mental health concerns they have in their communities, and the types of programs that might help prevent mental illness from developing.

This brief report presents results from our initial community engagement meetings with Lesbian, Gay, Bisexual, Transgendered, and Questioning (LGBTQ) youth, including youth of color, in California. Their voices provide first-hand descriptions of the needs of this community and their struggles and accomplishments as members of a community excluded from full participation in society. Their experiences and insight provide invaluable guidance for developing Prevention and Early Intervention (PEI) programs and improving mental health services for this community.

THE MENTAL HEALTH SERVICES ACT

In November 2004, California voters passed Proposition 63, which on January 1, 2005 became state law entitled the Mental Health Services Act (MHSA). The purpose of the MHSA is to provide increased funding to support mental health programs for children, youth, adults, older adults, and families, especially for persons from communities who were not served or not effectively served in the past.

The ultimate goal of the MHSA is to create in California a culturally competent mental health care system that addresses prevention of mental illness, provides early intervention services for those in need, uses state-of-the-art treatment to promote recovery and wellness for persons with mental illness, and eliminates disparities in mental health care across socioeconomic and racial/ethnic groups.

THE MHSA AND COMMUNITIES

The MHSA has created the expectation of a comprehensive planning process within the public mental health system that includes California's most vulnerable populations: the ethnically diverse; the Lesbian, Gay, Bisexual, Transgendered, and Questioning community; the poor; the uninsured; and the geographically isolated. Ethnic and minority communities, clients, family members, community-based agencies, providers, and other stakeholders in the mental health system are encouraged to become key partners in the decision-making process so that the mental health system is successfully transformed to better serve all persons and all communities in the state.

To build a foundation for ongoing outreach and engagement with historically underserved communities, we reached out to develop relationships with LGBTQ youth, advocates, and LGBTQ community mental health care providers. The findings in this report are a summary of information obtained through focus groups held with LGBTQ youth, as well as interviews with key LGBTQ community providers.

We were living in Tennessee and you're like in seventh grade, you're not sexual or anything. But you want to hold your girlfriend's hand. ... We got complaints from parents about us. ... We were called dykes by teachers. ... My girlfriend actually ended up committing suicide three days before our seven-month anniversary. It was one of the days after we had been made fun of by the principals and they were talking to our parents about either separating us into different schools or having one of us be home-schooled or whatever, and her dad ended up beating her because she didn't want to leave. ... So she ended up killing herself.

LGBTQ Youth

I was kicked out when I was 15 and my parents ... I had recently come out and said that and there was already violence in my home, but it got worse after I came out. And he had thrown a [heavy object] at me and broke my shoulder blade and my collarbone. And I told the school and nothing really happened, like it was crazy. ... It was hard. I felt that it was because I had came out.

LGBTQ Youth

One woman, one girl in particular, who is in [our therapy] group, has struggled a lot with coming out at home. A lot of ... what I would consider verbal abuse from her mother and a lot of rejection from her mother, and then lead to cutting or thoughts of suicide or just self-injury on a variety of levels.

LGBTQ Community Provider

[Transgender youth are] not only ostracized but making a healthy transition into one's gender identity is very difficult, where you are constantly reminded on billboards, in the mall, of what a boy and girl should look like. ... For the youth, that plays a big role as far as their developmental stages and where they see themselves in society. All they see is that they don't belong, then we see ... self-destructive methods of dealing [with it].

LGBTQ Community Provider

It's mostly the ecstasy and crystal that gay people usually take. I had a lot of friends that actually do take a lot of crystal and they're very young. ... For them, there are always things like, "Well, nobody's there for me. Nobody cares about me." ... [So they take drugs] to make them feel better.

LGBTQ Youth

That is where we get most of our angst ... our depression during youth is having to be able to deal with those conflicts of feeling inadequate. And there is the drug issue .... And it is again some of them have been thrown out of their houses .... Drugs have always been a way for all different individuals who need to find a way out. The same with alcoholism.

LGBTQ Community Provider

WHAT CONDITIONS AFFECT MENTAL HEALTH IN THE COMMUNITY?

LGBTQ youth reported being harassed and bullied in their schools, homes, and neighborhoods on an almost-daily basis. Many youth shared that they had received death threats.

LGBTQ youth identified social factors as major causes of mental illness in their communities including challenging economic and physical living conditions. Rejection by their families often caused LGBTQ youth to leave home at an early age. After leaving home, they described a range of challenges including difficulty obtaining housing and employment. Participants reported that many in their community get involved in the sex trade industry as a way to obtain and maintain housing and food for themselves. Many youth experienced a range of mental health issues as a result of rejection from family including depression and suicidal and self-destructive thoughts and behaviors. Many said they felt as if "no one cares" for them, and suggested that this feeling leads to depression and drug and alcohol abuse.

LGBTQ youth also described how straight allies also got harassed and bullied, leading to further isolation of their community. Some LGBTQ youth felt rejected by religious communities and described the feelings of isolation due to the importance of religion in their lives.

LGBTQ youth of color discussed how, in addition to experiencing homophobia, they also had personal experiences with racism and discrimination. Youth of color felt they had fewer resources available to them, as there is a scarcity of programs specifically for LGTBQ youth of color and insufficient numbers of LGBTQ mentors and counselors of color.

With the counseling they have, they lack the experience and kind of the skills to work with queer youth because on a statewide level they are not trained to. … It is something [that] speaks to the conservatism of politics and wanting to keep things very neutral, very palatable when you are talking about issues of sexuality to any community.

LGBTQ Community Provider

I think those are big issues with mental health service providers and also even counselors really representing the young people that they are seeing, especially LGBTs of color. They often don't get to meet with a therapist who is a person of color … [or] a therapist who even had the racial justice analysis. … There are things going in your life that are huge and that are impacting your mental health in a big way, and [the therapist is] not able to address those things?

LGBTQ Community Provider

Isolation definitely, especially with our transgender community. The process they go from—we have female to male and male to female that we also work with at the LBGT center. And what is difficult because we are lumped together: lesbian, gay, bisexual, and transgender, it also makes it difficult because I can't really speak to the same length of a transgender experience, because that is not an experience I have. … And that is a population that needs to be served.

LGBTQ Community Provider

You have medical professionals really either being demeaning or they are moralizing, or just not listening. … I think even with service providers and trans and gender variant, there are things that happen like using incorrect pronouns. If somebody wants to go by "he," continually "sheing" them … it is really invaliding somebody's identity. Really saying, "Well, you are not old enough to make that decision." … So, again that feeling of worthlessness, of invalidation about who you are.

LGBTQ Community Provider

WHAT ARE THE COMMUNITY'S STRENGTHS AND ASSETS?

Sources of existing support for LGBTQ youth community included a system of peer youth counselors and mentorship. Connecting youths who need support with peers who have had similar experiences and resolved them was seen as tremendously effective and strengthening for the community.

Youth also mentioned the development of a counseling program that included anti-heterosexist analysis as well as an advocacy component. This was called by one respondent as "counseling with a political analysis perspective"—a program designed to create a space where youth think critically about gender arrangements and make links between sexism, heterosexism, racism, and other inequalities. The goal for youth is to not only become conscious of inequalities, but to make changes in their lives that will challenge or reduce inequality. By promoting solidarity and pride, this program helps build healthy relationships and a sense of community for individuals who often feel extremely isolated.

At my school in the Bay Area, we had a program called CHAC and it's a community healthy awareness council. And it was five different people, like three females and two males, and they would switch out throughout the week. They'd be there all day. It was free. I was like talk to me right now, and it would be great. ... They also had an outside-of-school place, so that I could go at seven o'clock at night if I needed to if something was happening with my family. ... And it was like counseling. ... They helped me through some tough times. I think that would be a great program to put into the high school because high school is tough.

LGBTQ Youth

I think that there should be more opportunities to people who grew up with ... having a mother treating them in a bad way. ... More outreach programs to encourage people to go to college, to do something with their life instead of being out there on the streets, whoring themselves, and having kids every couple months.

LGBTQ Youth.

It's actually, I think, really important having gay and lesbian counselors ... really good idea because sometimes I think some people maybe would talk to them. ... [But] if it's your parents that really need to go to counseling, you can only do so much.

LGBTQ Youth

Beyond educating our community, educating everybody else, too. I think that's hugely demoralizing, and people don't realize what effect that has on us and that keeps our right, our lack of rights chained, like our whole federal government is saying you're less because [you are homosexual].

LGBTQ Youth

Also diversity training that speaks to LGBT issues for teachers and really having that being infused into public curriculum. Because some of the worst treatment that students get are from teachers, not so much students. It is definitely how we speak about gender, having some sort of consciousness ....

LGBTQ Community Provider

It's the caring. ... It's basically the parents need to step up to the plate and take control, learn about what your kids are going through. Actually spend time with your kids, and actually ask them, how was your day? What's up? What's wrong?

LGBTQ Youth

There should be some type of service ... for parents of gay and lesbians. To be able to go, when they find out that their youth is queer. Have the type of support group for themselves to know that they might deal with difficulties of their youth being treated differently, to be able to answer some of the questions that the youth might have as gay youth, about life, about sex and whatnot.

LGBTQ Community Provider

Having a supportive network of services for the transgender community, I think that needs to be researched just as much as [services for homosexual youth]. I think that there are definitely different issues that they deal with.

LGBTQ Community Provider

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Forgotten Children

A Case for Action for Children and Youth with Disabilities in Foster Care

A Project of United Cerebral Palsy and Children's Rights, 2006

CHILDREN'S RIGHTS

UCP United Cerebral Palsy

Life without limits for people with disabilities™

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About United Cerebral Palsy

United Cerebral Palsy is one of the nation's leading organizations serving and advocating for the more than 54 million Americans with disabilities. Most UCP consumers are people with disabilities other than cerebral palsy. Through its nationwide network, United Cerebral Palsy offers services to individuals, families and communities such as job training and placement, physical therapy, individual and family support, early intervention, social and recreation programs, community living, state and local referrals, and instruction on how to use technology to perform everyday tasks. For more information, visit www.ucp.org or call (800) 872-5827.

About Children's Rights

Children's Rights is a national organization advocating on behalf of abused and neglected children in the U.S. Since 1995 we have used legal action and policy initiatives to protect children and create lasting improvements in foster care, adoption and child welfare. For more information, visit www.childrensrights.org or call (212) 683-2210.

Acknowledgements

The partnership between United Cerebral Palsy and Children's Rights would not be possible without the commitment of Loreen Arbus, a national Trustee of United Cerebral Palsy, who saw the need and cared enough to initiate and support this effort.

Children's Rights and United Cerebral Palsy also would like to thank the diverse group of United Cerebral Palsy affiliates who have added their voices to this collaboration, and to recognize Sara Munson at Children's Rights, the primary author of this comprehensive literature review.

A Case for Action

On any given day, there are more than half a million children and youth in foster care in the United States, and studies suggest that at least one-third have disabilities, ranging from minor developmental delays to significant mental and physical disabilities.[1] This population continues to increase as technology enables growing numbers of children to survive disabling medical conditions and as more children are being recognized and identified as having disabilities.[2] Evidence suggests, however, that the special needs of this population are not being met in foster care systems across the country, and that these children experience worse outcomes than other children in foster care.[3]

In 2004, two national organizations committed to improving the lives of vulnerable children, United Cerebral Palsy and Children's Rights formed an alliance to improve policy and practice for children and youth with disabilities in foster care. Through this partnership, United Cerebral Palsy and Children's Rights are identifying promising service delivery approaches for meeting the needs of this population and developing policy and legal advocacy strategies to address major systemic problems that negatively affect these children's safety, well-being and opportunity to grow up in permanent families. The joining of forces of the child welfare and disability service and advocacy communities at the national, state and local levels is a critical step in beginning to address these issues.[4]

This report provides a summary of the research and other available information regarding children and youth with disabilities in foster care. It documents the critical needs of the children and youth themselves and the status of the systems that serve them, detailing the range of issues that provide the foundation for the partnership between United Cerebral Palsy and Children's Rights.

The Kids

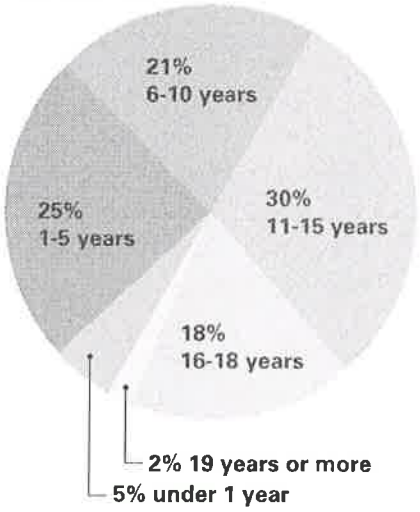
Of the more than 500,000 children and youth in foster care, almost one-third are under age five and one-fifth are over the age of 16. Almost half are placed with non-relative foster families, one-fourth live with relatives, and one-fifth are living in group homes or institutions. Forty percent have been in foster care for more than two years.[5] Many of these children and youth have disabilities.[6]

There are 119,000 children and youth in foster care who are waiting to be adopted. Their average age is eight; more than one-third are under the age of five, and more than one-third are over the age of 11. They have been in foster care an average of nearly four years.[7] The majority of these children and youth have disabilities.[8]

A Profile of Children in Foster Care

Age

Average Age = 10 years



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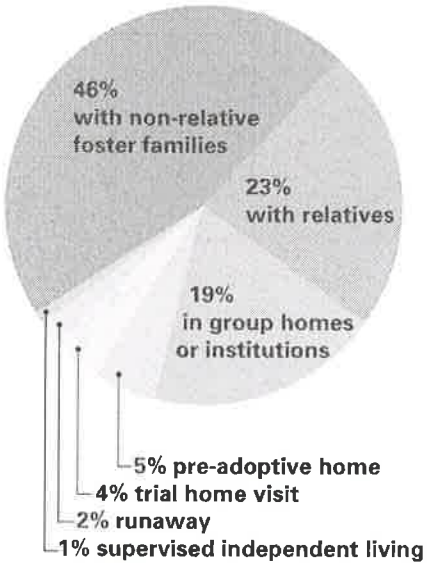
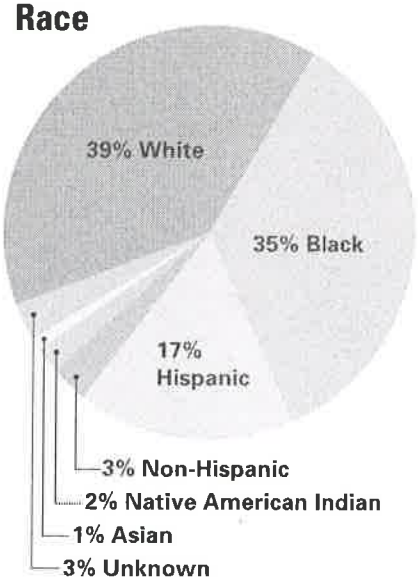


Race



Length of Time in Care

40% have been in foster care for more than 2 years

Gender

Slightly more males than females

Source: US Department of Health and Human Services, 2005

The Unmet Needs

A growing body of research has revealed that increasingly, children and youth in foster care have physical, mental health or developmental problems.[9]

Although the issues facing children and youth with disabilities in foster care have yet to come to the forefront of child welfare planning, service delivery or evaluation,[10] there is a developing body of literature that clearly highlights the critical need for this type of discussion and focus.[11]

Most of the children who enter foster care have been exposed to conditions that undermine their chances for healthy development.[12] Research indicates that children and youth in foster care are in worse health than those who are homeless or those living in the poorest sections of our inner cities.[13] They have a higher likelihood of chronic medical problems, lifelong psychiatric and behavioral issues, as well as permanent physical, cognitive and developmental disabilities than children in the general population.[14]

Whether they experience maltreatment that results in disabilities, or are victims of maltreatment because of their disabilities,[15] children who enter foster care with special needs, on average, already have experienced more than 14 different environmental, social, biological and psychological risk factors before coming into care.[16]

While there have not been systematic national studies of the prevalence of disability among children in foster care, individual studies in various states and localities have highlighted a range of potential challenges. These studies have found the following:

- **40% born low birth weight or premature;**[17]
- **80% prenatally exposed to substances;**[18]
- **30-80% with at least one chronic medical condition [e.g., asthma, HIV, TB];**[19]
- **30-50% with dental decay;**[20]
- **25% with three or more chronic health problems;**[21]
- **30-60% with developmental delays;**[22]
- **50-80% with mental and behavioral health problems;**[23]
- **20% fully handicapped;**[24]
- **30-40% receiving special education services.**[25]

Children and youth with these types of special needs experience disproportionately poorer foster care outcomes. When compared to children and youth without disabilities, those with disabilities in foster care:

- Are less safe, and more likely to be maltreated;[26]
- Are more likely to be on psychotropic medications;[27]
- Have poorer educational experiences and outcomes, including higher rates of school transfer, absenteeism, tardiness, grade retention, achieving poor grades, dropping-out, performing below grade level, receiving low state testing scores, exemption from state testing, suspension and expulsion, enrollment in vocational training, placement in more restrictive classrooms, and lower rates of doing homework, receiving help with schoolwork from caregivers, being enrolled in college preparatory courses, receiving a high school diploma, or participating in postsecondary education;[28]
- Are more likely to be institutionalized;[29]
- Experience more placement instability;[30]
- Have longer lengths of stay;[31]
- Have lower rates of achieving permanency, including lower probability of reunification with their birth families, guardianship with relatives or adoption,[32] and higher rates of re-entry into care;[33]
- Have fewer opportunities for positive adult functioning, including higher rates of homelessness, substance abuse, unemployment, receiving public assistance, criminal justice involvement, non-marital childbearing, being violently or sexually assaulted and having mental health problems following discharge from foster care.[34]

Systemic Challenges

Foster care is supposed to provide a safe haven for abused and neglected children.[35] Unfortunately, too many children in foster care experience further harm.[36] Children in foster care may not receive adequate health or mental health care or appropriate educational support. They may bounce from foster home to foster home or be placed inappropriately in institutional settings. Due to a range of systemic challenges, children with disabilities are at even greater risk for negative experiences in foster care and poor life outcomes.

The sections below describe various systemic issues in child welfare that affect children with disabilities.

Identifying the Population

Child protection investigators and foster care caseworkers are not typically provided with sufficient training, tools and support to ensure the identification and assessment of children and youth with disabilities.[37] This may result in underreporting, inappropriate placement decisions and inadequate provision of services for children and youth with disabilities in foster care.[38]

Federal, state and county data tracking systems have not accurately captured information regarding the disability status of children and youth in foster care.[39] Children's disabilities are not consistently evaluated and defined within and between systems, and services and outcomes are not monitored consistently or recorded at all in some states.[40]

Hence, it is difficult for frontline workers, advocates, researchers, policy makers and government officials to fully define this population, understand their unique needs and ensure tailored services and supports to adequately meet those needs.

Foster Parents

All children and youth in foster care need safe, committed caregivers who are able to meet their physical, emotional and social needs.[41]

In most communities, however, foster and adoptive parent recruitment, preparation, training and support do not focus on the specific needs of children and youth with disabilities.[42] Thus, foster and adoptive parents are routinely under-prepared for the challenges associated with caring for children and youth with disabilities. They may not have received training to help them effectively parent children and youth with different disabilities, or advocate for their special medical and educational needs. They often lack basic information about the special needs of the children who are placed in their homes, and are not provided with information regarding special programs and services that may be available in their area. More often than not, they are also under-supported, lacking access to respite care, in-home assistance and other specialized programs.[43]

These challenges increase the likelihood of frequent moves for children and youth with disabilities, decrease the possibility that foster parents will provide permanent adoptive homes for these children and increase rates of adoption disruption and dissolution.[44]

Health Care

All too frequently, children and youth with disabilities in foster care do not receive access to comprehensive assessments, immunizations and consistent medical, dental, mental health and other specialty care.[45]

In many instances, health care providers are not willing to accept Medicaid or to serve these at-risk youth, and children are placed on lengthy waiting lists for much-needed services.[46] In addition, services are frequently not located in the communities in which children are placed, resulting in increased use of costly emergency department visits to address non-emergent health care issues.[47]

Education

While studies have estimated that 30-40 percent of children and youth with disabilities in foster care may qualify for special education services, for a number of reasons, only 16 percent may actually receive the full array of services outlined in their Individualized Education Plans.[48]

Although children and youth with disabilities are entitled to special services and supports, they routinely are denied many of these accommodations because they lack consistent educational advocates. Despite increased attention to this issue, there continues to be a lack of clarity regarding the respective roles and responsibilities of caseworkers, foster parents and birth parents when working with school systems to meet the educational needs of these children and youth. All too frequently, birth parents are not included in educational planning activities; foster parents do not understand the importance of their role; and caseworkers do not have the time to participate in regular meetings.[49]

In addition, children and youth with disabilities in foster care may not receive timely testing and accommodations due to their frequent placement changes.[50] Research indicates that school placements routinely are delayed 2-4 weeks due to problems in the transfer of the student's educational records.[51] Once records are received, students with disabilities in foster care frequently do not receive credit for prior work, given different requirements among different schools.[52] Hence, students with disabilities in foster care often find themselves placed in markedly different settings [e.g., regular versus special education, self-contained versus integrated, etc.] simply due to a move from one school to another.

Transition to Adulthood

Youth with disabilities transitioning from foster care to adulthood frequently do not receive critical services and supports to ensure their safety, stability and well-being. They typically lack coordinated transition plans and do not have access to further education and training opportunities. They may receive little help finding jobs and have few dependable mentors. They are likely to receive little or no assistance finding housing, arranging for their health and mental health care or establishing themselves in their communities.[53]

Fragmented Systems and Lack of Information

These challenges are further exacerbated by a general lack of information-sharing, collaboration and communication among child welfare and the many systems that can serve and support children and youth with disabilities in foster care, including the health care, court, early intervention, education, disability and mental health systems.[54] These gaps can result in poor health and well-being outcomes for non-disabled children in foster care and have the potential to be catastrophic for children and youth with disabilities in foster care.[55]

Promising Approaches

The literature highlights a range of approaches and recommendations, summarized below, for addressing some of these longstanding challenges. Currently, however, many of these strategies have not been fully implemented, adequately funded or universalized among all foster care systems.

The United Cerebral Palsy and Children's Rights collaboration seeks to share this existing information, and to build upon these innovations in order to develop a more effective and comprehensive approach to improving the lives of children with disabilities in foster care.

Strategies for improving services for children and youth with disabilities in foster care include:

- ***Adopt Health Care Standards***
  - –Direct all agencies to adopt and meet standards for health care for children and youth in foster care that reflect those put forth by the Child Welfare League of America (1988), the American Academy of Pediatrics (1994, re-affirmed in 2002), and the American Academy of Child and Adolescent Psychiatry (2001);[56]

- ***Ensure Timely and Comprehensive Evaluations***
  - –Ensure that an initial medical screening of all children and youth entering foster care occurs within the first 24 hours;[57]
  - –Require a comprehensive assessment within 30 days for all children and youth entering foster care, focusing on physical [including medical, dental, vision, hearing], behavioral, emotional, cognitive, relational, educational and other environmental domains;[58]

- ***Manage Records More Effectively***
  - –Universalize the medical home model for all children and youth in foster care, whereby dedicated Foster Care Clinics, staffed by pediatric health care professionals who understand the effect of foster care on children and youth, provide initial health screening, comprehensive medical and dental assessment, developmental and mental health evaluation, and ongoing primary care and monitoring of health status for all children and youth in foster care;[59]
  - –Implement and utilize education/medical passports to ensure the documentation and exchange of information among caregivers, providers and decision-makers;[60]
  - –Establish health care management professionals or teams at foster care agencies, with a broad mandate to gather children's health care information, assure appropriate medical consents, coordinate access and approval for health care services, educate staff, other professionals and caregivers and ensure the integration of medical plans into safety and permanency plans;[61]

- ***Increase Specialized Services***
  - –Develop mechanisms to recruit, train and reimburse "preferred" health care professionals for serving children and youth in foster care, as well as offer incentives to providers to encourage acceptance of foster care clients;[62]
  - –Institute mandatory referral to Early Intervention for all children in foster care under age three;[63]
  - –Increase the range of specialized, therapeutic, medical or treatment foster care programs that provide children and youth with disabilities with a team of specially trained foster parents, respite caregivers, medical professionals and social workers;[64]
  - –Generate awareness and strengthen targeted recruitment efforts to highlight the need for foster and adoptive families willing to care for children and youth with disabilities;[65]
  - –Design integrated support and service systems for transitioning youth to reflect the specific needs and experiences of youth with disabilities;[66]

- ***Improve Training Programs***
  - –Create specialized training programs for investigators, caseworkers and other child welfare professionals to ensure the identification and documentation of disabilities;[67]
  - –Expand current models of foster parent training to address caring for children and youth with disabilities, including identifying and understanding different disabilities, locating and accessing appropriate providers, and developing skills in medical, disability rights and educational advocacy;[68]
  - –Organize comprehensive cross-systems training to ensure information-sharing and collaboration between child welfare, education, health care, court and other systems;[69]

- ***Collect and Assess Data***
  - –Infuse disability status and evaluation in all child protection risk assessments;[70]
  - –Mandate data collection, tracking and reporting regarding disability status, services and outcomes for all children and youth in foster care.[71]

Conclusion

This review of available literature and research indicates that there has not been nearly enough attention paid to the specific issues facing children and youth with disabilities in foster care, even though the risk factors facing this population are monumental. Their health care is often compromised, and their educational experiences are frequently damaging. Their opportunities for placement with permanent families and lifelong connections with caring, committed adults are severely lacking. Their community experiences often are defined by isolation and frequent relocation. And when it comes time to move to an adult life with more independence, there may be little or no help available to them during this crucial transition.

Without intervention and assistance at all levels of the system and without the development of innovative partnerships to address these longstanding issues, these barriers will remain.

Children's Rights and United Cerebral Palsy are dedicated to continuing our efforts to improve policy and practice for children and youth with disabilities in foster care.

ENDNOTES

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About Isabelle's Kids

Isabelle's Kids, a national initiative of United Cerebral Palsy, endeavors to empower children and youth with disabilities to live without limits. Named in honor of UCP co-founder Isabelle Goldenson, Isabelle's Kids addresses the countless challenges faced by children and youth with disabilities, including school, friends, play and growing up with self-confidence. United Cerebral Palsy, through its national network of affiliates, encourages, supports and mentors a new generation of leaders with disabilities to contribute to their communities and achieve their dreams. For more information, visit www.ucp.org/isabelleskids.

OUR HEALTH MATTERS

MENTAL HEALTH, RISK, AND RESILIENCE AMONG LGBTQ YOUTH OF COLOR WHO LIVE, WORK, OR PLAY IN BOSTON

THE FENWAY INSTITUTE

OUR HEALTH MATTERS:

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Kerith Conron, Johannes Wilson, Sean Cahill, Jessica Flaherty, Mio Tamanaha, and Judith Bradford

GLASS

BOSTON ALLIANCE OF GAY LESBIAN BISEXUAL TRANSGENDER YOUTH BAGLY

OUR HEALTH MATTERS

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EXECUTIVE SUMMARY

Throughout the United States of America, lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQ) youth experience high rates of victimization, suicidality, substance abuse, homelessness, and HIV infection compared to heterosexual youth. Among LGBTQ youth, the risks that contribute to health disparity conditions disproportionately affect youth of color in Greater Boston. Many are mistreated at home and school. Some have access to supportive programs, while others lack knowledge or awareness of a small number of programs designed to provide needed support. In 2012, The Fenway Institute received a research grant from the National Institute for Minority Health and Health Disparities (NIMHD) to study these concerns among LGBTQ youth of color in Greater Boston.

A partnership of The Fenway Institute, BAGLY Inc., and Boston GLASS was formed to gather information about the health concerns of LGBTQ youth of color and strategies to improve their health. With guidance from youth and adult community advisory boards, the research partnership developed and implemented a survey to explore these concerns within Greater Boston. Between February and August 2014, over 300 youth 13 to 25 years of age completed the survey, with a final sample of 294 LGBTQ youth of color. Most (55%) participants were recruited during regular programming at community-based LGBTQ youth programs or from Youth Pride (40%).

KEY FINDINGS

- Over forty percent of youth reported symptoms of depression and/or anxiety and nearly one in five youth attempted suicide within the prior 12 months.
- Half of the sample reported binge-drinking and half reported marijuana use in the past 30 days. More than one in 10 youth reported any lifetime methamphetamine use.
- Child maltreatment, discrimination, and food insecurity were prevalent and are correlated with poor mental health and substance misuse.
- Racial-ethnic pride, LGBTQ pride, and hope for the future were prevalent and are protective factors.
- About three-quarters of the sample had attended one or more LGBTQ youth programs in the prior 30 days and reported having opportunities to develop leadership skills and/or to make a positive difference in the community. However, just over half reported having paid jobs or internships.

RECOMMENDATIONS

- Address "upstream" factors at the root of health disparities that affect LGBTQ youth of color -- including racism, poverty, LGBTQ stigma, discrimination, victimization, and minority stress -- and include youth as active partners in developing strategies to improve the health and social conditions of their lives.
- Provide paid opportunities for LGBTQ youth of color to engage in program development and delivery, research, and policy analysis and advocacy, in conjunction with support and on-going training to enable sustained success and continued growth.
- Ensure that culturally-competent and affirming mental health and substance use prevention and treatment services are available to all youth who need them.
- Support collaborative, participatory approaches to research that value science and practice, as well as adult and youth partnerships.
- Monitor the health of LGBTQ youth of color in high school and beyond by including questions on assigned sex at birth, gender identity, and sexual orientation in all surveillance systems and over-sampling racial-ethnic and sexual and gender minorities.

INTRODUCTION

As noted by the Institute of Medicine in its landmark 2011 report, The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding, evidence of health disparities that disfavor lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQ) youth is quickly mounting. However, appropriate interventions are lacking. LGBTQ youth have high rates of victimization, suicidality, substance abuse, homelessness, and HIV infection compared to heterosexual youth. Among LGBTQ youth, the risks that contribute to health disparity conditions disproportionately affect youth of color; LGBTQ youth of color are exposed to LGBTQ-related stressors (LGBTQ-related violence, family rejection, discrimination), as well as racial-ethnic minority stressors (race-related discrimination, community violence) and overrepresentation in low-income families and low opportunity neighborhoods.

The community survey that generated the findings summarized in this report was a product of a community-based participatory research (CBPR) project designed to address the lack of prior scientific efforts to develop evidence-based interventions to reduce health disparities that impact this highly marginalized population--a critical barrier in the field. Our three-year NIMHD-funded CBPR project entailed prioritizing a health priority condition and developing a pilot intervention to address it. During a review of local epidemiological data with the project's two community advisory boards, or CABs (representing youth-serving organizations and youth themselves), grossly elevated rates of suicidality among LGB youth of color surveyed in Massachusetts high schools emerged as a significant concern. (Youth of color refers to black, Latino/a, Asian Pacific Islander, American Indian, and multiracial youth.)

Our CABs were also concerned about high rates of HIV infection among young gay and bisexual men and transgender women of color who have sex with men; however, because most public health resources directed toward LGBTQ youth of color focus on sexual risk, the need to address mental health emerged as a clear priority. The CABs also felt that mental health was an upstream factor driving sexual risk, as well as many other health behaviors of concern (e.g., smoking, substance abuse), and that prioritizing mental health would most benefit LGBTQ youth of color and result in cost-effective positive effects across multiple domains of health. Gaps in local (as well as state and national) data about the mental health status of LGBTQ youth of color, as well as associated risk and protective factors, were noted by our CABs as a barrier to selecting a priority mental health outcome and determining how to address it. In order to address these gaps, the project team and CABs developed a community survey that was informed by Minority Stress Theory and prioritized Positive Youth Development constructs.

METHODS

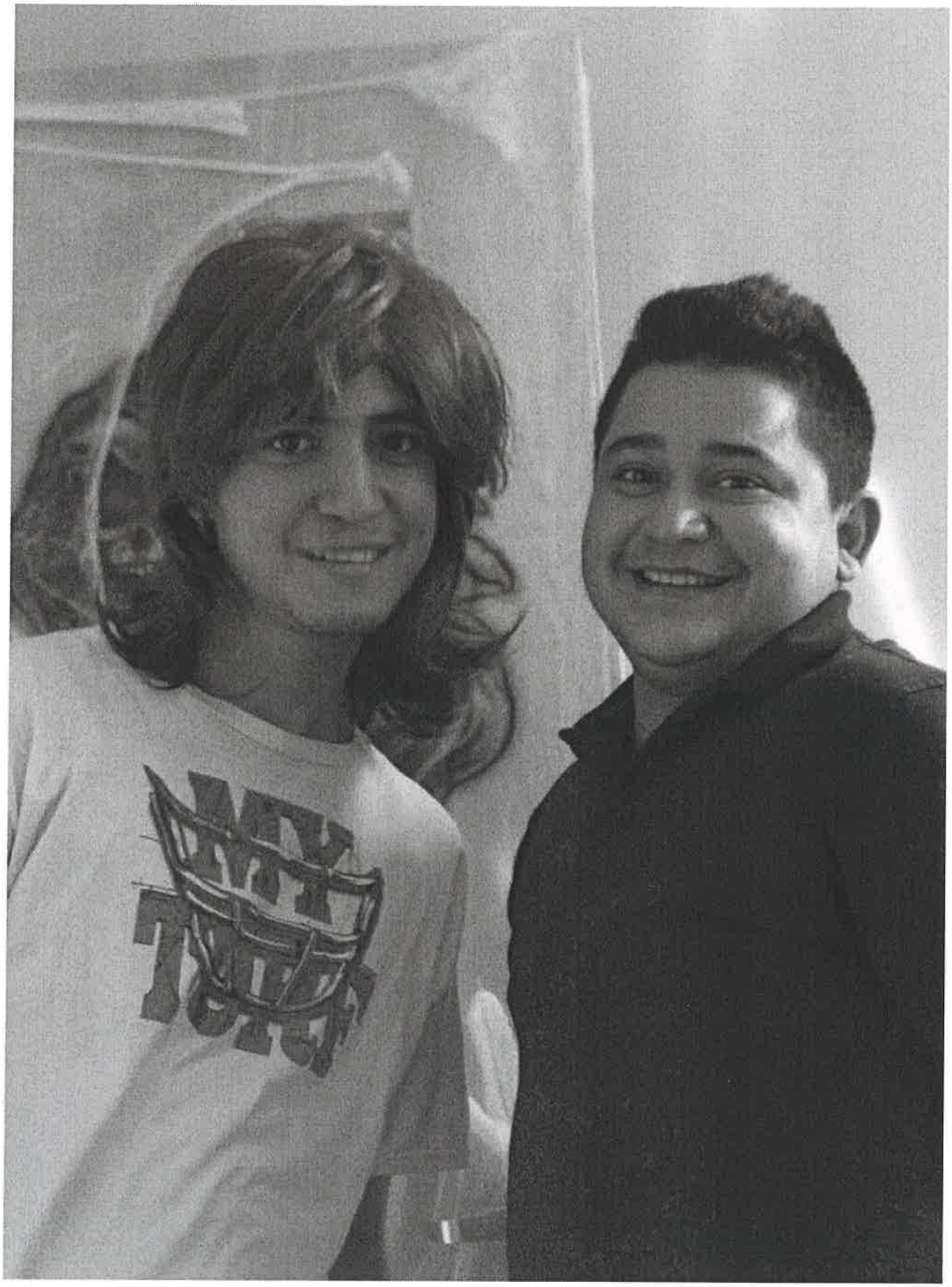
A cross-sectional survey was conducted between February and August 2014 to address local data gaps about LGBTQ youth of color, specifically, gaps in knowledge about transgender youth, 19-25 year olds, Asian and Pacific Islander (API) youth, and out of school youth—groups of youth whose needs are not captured by the high-school-based Boston Youth Risk Behavior Surveillance Survey due to their relatively small numbers or other factors, like not being of high school age. Our community survey was anonymous and included self-report measures of mental health and substance use, minority stressors, Positive Youth Development constructs, and demographic and socioeconomic characteristics. Measures with good psychometric properties or items from health surveillance surveys were used when possible. The survey was pilot tested with LGBTQ youth and young adults of color and revised in response to feedback obtained.

Our survey recruitment plan utilized a combination of venue-based recruitment and respondent driven sampling, as these methods have been shown to be effective in recruiting hard-to-reach populations. Recruitment also took place at large gatherings organized by our partner organizations such as a large annual youth dance, the annual Massachusetts Youth Pride festival, and events organized to attract specific groups of youth (e.g., API youth, cisgender young women of color). We partnered with organizations on our CAB, as well as other prominent organizations that serve LGBTQ youth of color to spread awareness about our survey in the community, and engaged Youth CAB members in this work as field assistants. Youth CAB members were trained in research ethics basics and our survey protocol in order to prepare them for helping with recruitment.

The survey was distributed by project staff and youth field assistants and took approximately 20 to 30 minutes to complete. Participants received a $20 gift card and resource list upon completing the survey. Waivers of written assent/consent and parental consent were obtained from the Fenway Health Institutional Review Board which provided oversight for this project.

Over 300 youth ages 13 to 25 completed the survey. Most participants were recruited during regular programming at community-based LGBTQ youth programs (55%) or from Youth Pride (40%). The remainder was recruited from events organized to attract specific groups of youth to community-based youth programs (4%) or through respondent-driven sampling (1%). Our final sample is 294 LGBTQ youth of color after excluding youth who did not meet eligibility criteria (i.e., heterosexual and cisgender youth, as well as white, non-Hispanic youth). The analysis was conducted by the project team. Missing data were less than 10% per survey item unless otherwise noted.

In keeping with our community-based participatory research model, we held two presentation and feedback sessions with LGBTQ youth of color. The purpose of these sessions was to solicit youth comments on our survey findings as well as recommendations for how the findings could be translated into action. Youth comments and recommendations are integrated throughout this report and are highlighted in large pink text.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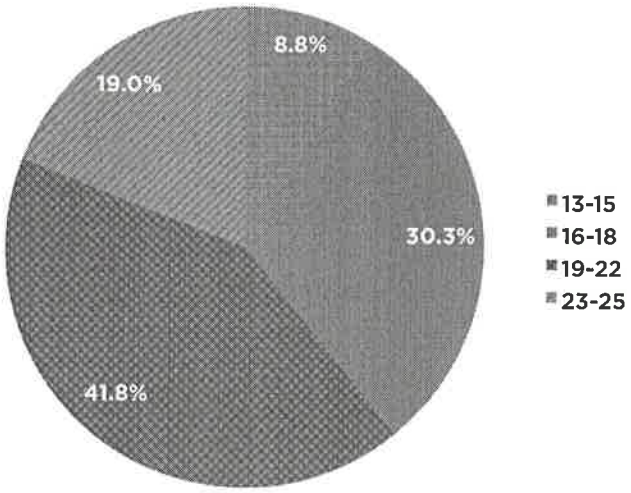
FINDINGS

DEMOGRAPHIC CHARACTERISTICS

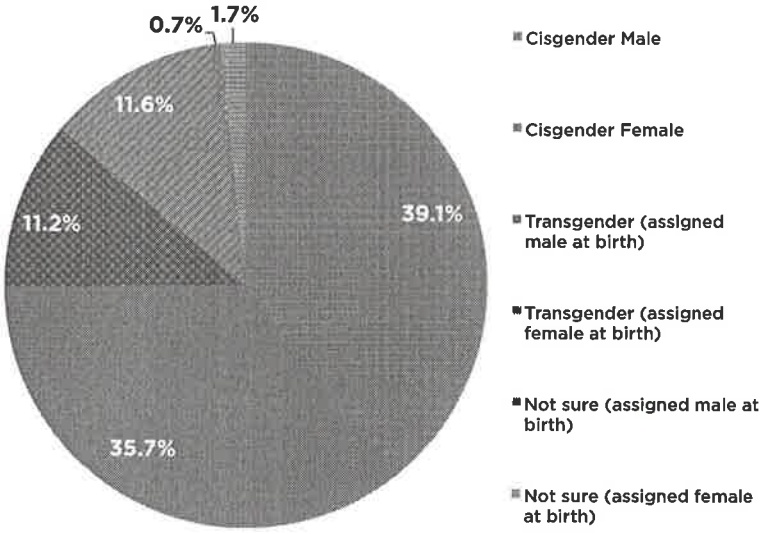
- The majority of youth reported a Boston residence, while 43.1% lived outside of Boston. Youth from every Boston neighborhood were included in our sample; one in five participants lived in Dorchester.
- Nearly two-fifths (39.1%) of participants were 13-18 years of age while the remainder (60.9%) were 19 to 25.

Age



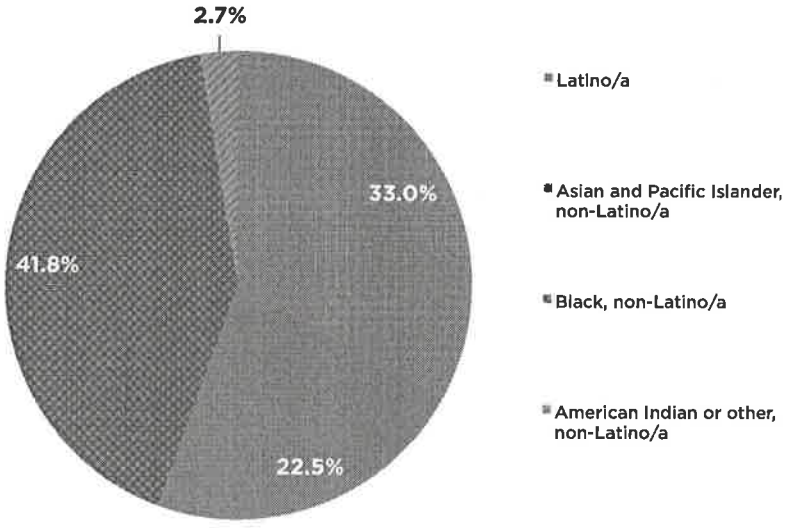
- About half (51.0%) of youth reported male sex assigned at birth and 49.0% reported female sex assigned at birth. A total of 25.2% of participants reported a current gender identity that was not fully concordant with their assigned sex at birth, including a few who were uncertain of their gender identity – together, these youth were considered transgender.

Sex & Gender Identity



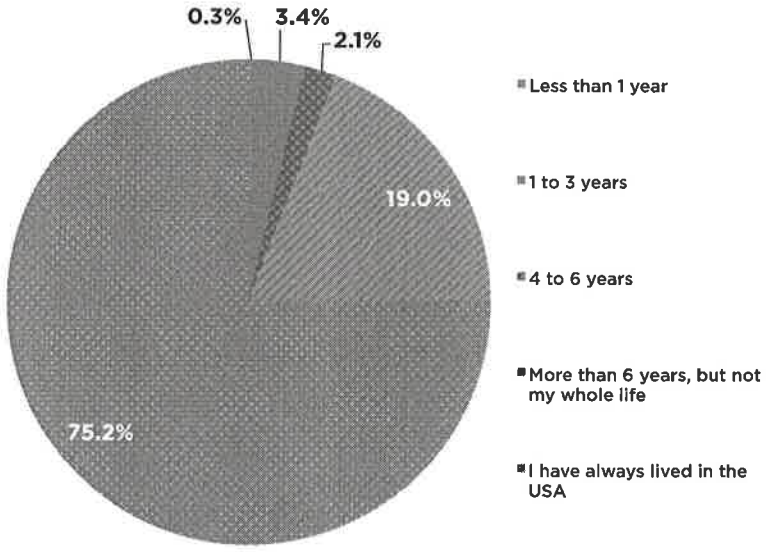
- A third (33.0%) of youth identified as Latino/a or Hispanic. Among the nonHispanic youth, 22.5% were Asian, Native Hawaiian or Pacific Islander, 41.8% were black, and the remainder (2.7%) was American Indian or other.

Race/Ethnicity



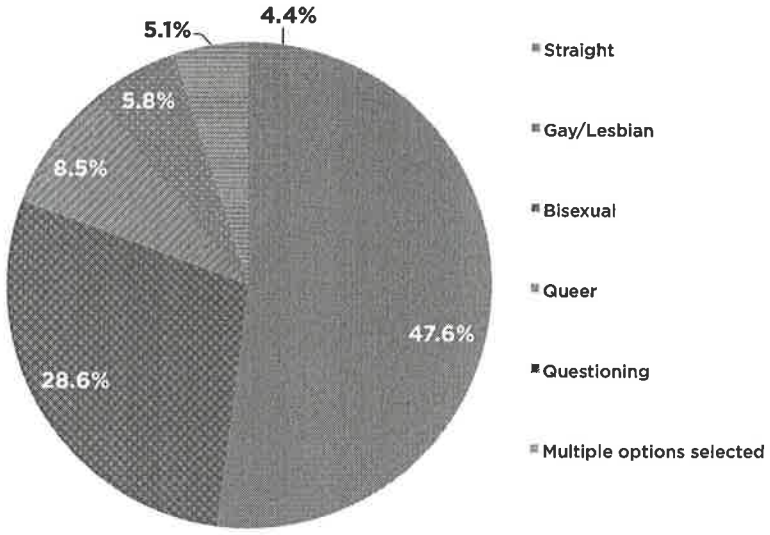
- The majority (75.2%) of participants indicated that they have always lived in the U.S., while a sizable minority reported having lived elsewhere (19.0% lived in the U.S. for over 6 years and 4.9% lived in the U.S. for 6 years or fewer.)

Length of Time Lived in the U.S.



- Nearly half (47.6%) of the sample identified as gay or lesbian, about a third (28.6%) were bisexual-identified. Youth who identified as queer, questioning, or heterosexual/straight comprised 8.5%, 5.8%, and 4.4% of the sample, respectively. Five percent of youth in our sample selected multiple options for sexual orientation.

Sexual Orientation



SOCIOECONOMIC STATUS

- Approximately one third (34.6%) of youth were in middle or high school when they completed the survey. The remainder of our sample was diverse in terms of current educational status. A sizable minority was in college part- (7.0%) or full-time (15.7%) or had graduated high school (14%). Some youth had completed either an associate's (2.1%) or bachelor's degree (7%).
- Over one in ten (13.7%) participants could be considered "out of school" youth in that they had dropped out of middle or high school, completed a terminal GED, or were engaged in a GED program.
- Over half of youth were engaged in paid work, one third (32.7%) was unemployed and some (10.5%) were volunteering or working as unpaid interns.
- Few (1.0%) youth reported work in the street economy (drug sales or sex work); however, 15.7% reported exchanging sex for a place to sleep, money, food, drugs or other resources in the prior 3 months.
- Just over half of participants (51.1%) reported sleeping at home with parents/guardians or relatives in the past 30 days, while about one-fourth (27.5%) reported living in a place that they rent or in campus housing. A sizable minority (15.5%) reported an unstable housing arrangement (multiple places, a friend's place, shelter, car or park) and 6.0% reported sleeping someplace else.
- Youth varied considerably in terms of their level of financial dependence on parents/guardians. Over a quarter (27.5%) were completely independent of parents/guardians while nearly a third (30.6%) were mostly or completely dependent.
- Many (52.6%) youth reported current receipt of public benefits/governmental assistance, including MassHealth insurance, food stamps (SNAP), public housing, Section 8 or rent vouchers, or Supplemental Security Income (SSI). According to participants, a comparable proportion (53.9%) of parents/guardians also utilized public benefits/governmental assistance.
- More than two out of every five youth in the sample reported food insecurity in the prior 12 months, with 30.9% reporting cutting the size of meals or skipping meals because there wasn't enough money for food either some months or almost every month.

"When youth in general turn 18, they get pushed out of home and are not given what they need to survive. I live in a shelter. There are a dozen youth living there. There should be a separate list for housing for youth. Lots of LGBTQ youth living are in shelters because their parents don't accept them."

Youth expressed a general sense of frustration with job requirements. One said,

"You need experience to get a job,
but you need a job to get experience."

A young transgender woman shared an experience trying to get a job,

> "I applied for a job at the supermarket and the guy said we'll hire you, but you need to cut your hair."

Neighborhood gentrification and rising housing costs were also discussed during feedback sessions. One youth told us that a Bay Village school she went to was closed and eventually converted to luxury apartments, with 2 bedroom units being offered for $7,000/per month.

Youth felt that an increased minimum wage was necessary to help struggling LGBTQ youth survive. One youth commented,

> "Rents in Boston are too high. This is unfair—Boston is one of the biggest cities with the lowest minimum wage you can have. You have to work up to $9 an hour...."

The socioeconomic status of younger youth (ages 13 to 18) and older youth (19 to 25) was expected to vary. Thus, socioeconomic status indicators were examined separately by age. As shown in the table below, younger LGBTQ youth of color were more likely to be in-school, unemployed, living at home with a parent/caregiver, and financially dependent on parents/caregivers. Older youth (ages 19 to 25) were more likely to be working full-time, in college, to live independently, and to be more financially independent of parents/caregivers. Food insecurity and sex-exchange was more common among older youth; however, they were less likely to report their own use of public benefits/governmental assistance than younger youth.

SOCIOECONOMIC STATUS OF OUR HEALTH MATTERS COMMUNITY SURVEY PARTICIPANTS BY AGE

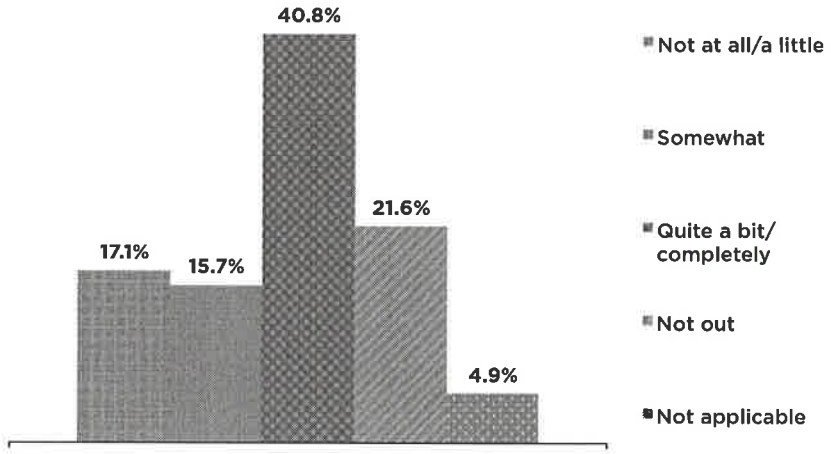
	Full sample (N=294)		13-18 years old (n=115)		19-25 years old (n=179)		Chi-square p-value*
	n	%	n	%	n	%	
Educational Status							p<0.0001
In middle or high school	99	34.6	87	77.7	12	6.9	
Dropped out of middle or high school	14	4.9	4	3.6	10	5.8	
Graduated high school	40	14.0	7	6.3	33	19.0	
Completed GED	17	6.0	4	3.6	13	7.5	
In a GED program	8	2.8	0	0	8	4.6	
In a vocational training program	5	1.8	1	0.9	4	2.3	
In college part time	20	7.0	1	0.9	19	10.9	
In college full time	45	15.7	7	6.3	38	21.9	
Dropped out of college	12	4.2	1	0.9	11	6.3	
Completed Associate's degree	6	2.1	0	0	6	3.5	
Completed Bachelor's degree	20	7.0	0	0	20	11.5	
Work Status							
Full time (> 30 hours/week)	62	21.1	9	7.8	53	29.6	p<0.001
Part time (20-29 hours/week)	38	12.9	7	6.1	31	17.3	P<0.01
Part time (10-19 hours/week)	30	10.2	8	7.0	22	12.3	p=0.140
Part time (<10 hours/week)	26	8.8	10	8.7	16	9.0	p=0.94
Unemployed	96	32.7	56	48.7	40	22.4	p<0.001
Street economy, drug sales	2	0.7	0	0	2	1.1	p=0.26
Street economy, sex work	1	0.3	0	0	1	0.6	p=0.42
Volunteering/interning, unpaid	31	10.5	16	13.9	15	8.4	p=0.13
Other	16	5.44	10	8.7	6	3.4	p<0.05
Sex Work in Past 3 Months	45	15.7	9	8.1	36	20.6	p<0.01
Housing							p<.0001
Home with caregiver or parent	145	51.1	80	72.7	65	37.4	
Own place	78	27.5	9	8.2	69	39.7	
Unstable/with friends	44	15.5	12	10.9	32	18.4	
Other	17	6.0	9	8.2	8	4.6	
Financial Dependence							p<0.0001
Complete independence	78	27.5	15	13.6	63	36.2	
Partly to 50% dependent	119	41.9	35	31.8	84	48.3	
Mostly/completely dependent	87	30.6	60	54.6	27	15.5	
Receipt of Public Benefit/Government Assistance	150	52.6	69	62.1	81	46.6	p=0.01
Food Insecurity	88	30.9	26	23.4	62	35.6	p=0.03

* If the Chi-Square p-value is less than 0.05, then one can consider the proportions or proportion of the socioeconomic status indicator to differ across 13-18 and 19-25 year old youth.

FAMILY ACCEPTANCE AND PARENT/CAREGIVER-PERPETRATED ABUSE

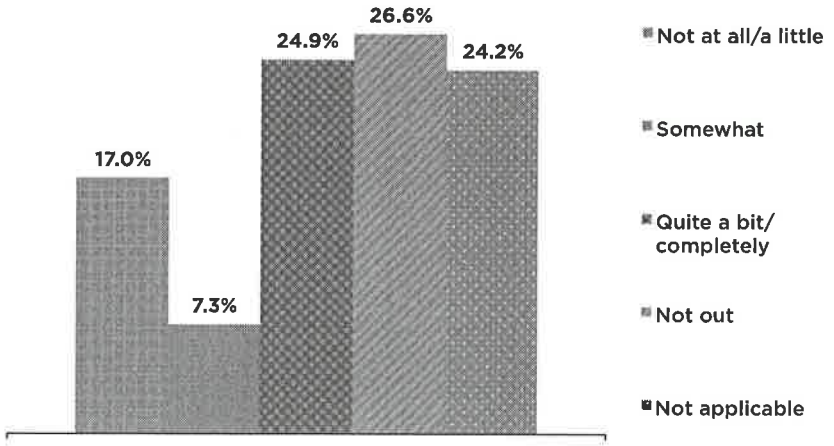
- Participants were asked to report how accepting of them as a LGBTQ person their mother (or main person who raised them) and father (or other parent) was currently. While a sizable minority of mothers (40.8%) was perceived as quite a bit or completely accepting, almost one in five (17.1%) youth reported that their mother was not at all or only a little accepting of them as a LGBTQ person and 21.6% were not out to their mothers.

Current Maternal Acceptance



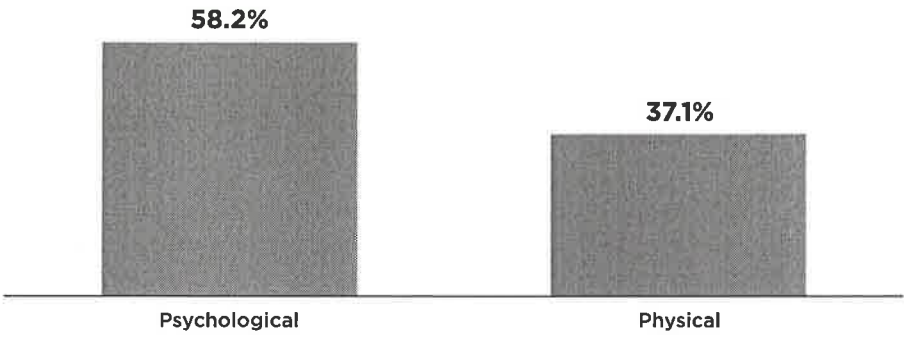
- One quarter (24.9%) of youth reported that their father was quite a bit or completely accepting of them as a LGBTQ person; 17.0% reported low acceptance and 26.6% were not out to their fathers. One quarter of youth (24.2%) reported that they had always had just one parent or that their father was deceased.

Current Paternal Acceptance



- More than half (58.2%) of the sample reported psychological abuse (e.g. being put down, humiliated or intimidated) by parents or another adult living in their home "sometimes," "often," or "very often" during their first 18 years of life.
- Over a third (37.1%) of participants reported experiencing some form of physical abuse (e.g. being pushed or hit) by parents or another adult living in their home "sometimes," "often," or "very often" during their first 18 years of life.

Parent/Caregiver Perpetrated Abuse Through age 18 (More Often Than Once or Twice)



One youth stated that she expected the number of youth who experienced some form of psychological or physical abuse to be much higher than what was found in our survey. She noted that youth experience multiple forms of abuse including some that were not measured in our survey, such as financial abuse and sexual abuse, and that many youth who are experiencing abuse do not realize it.

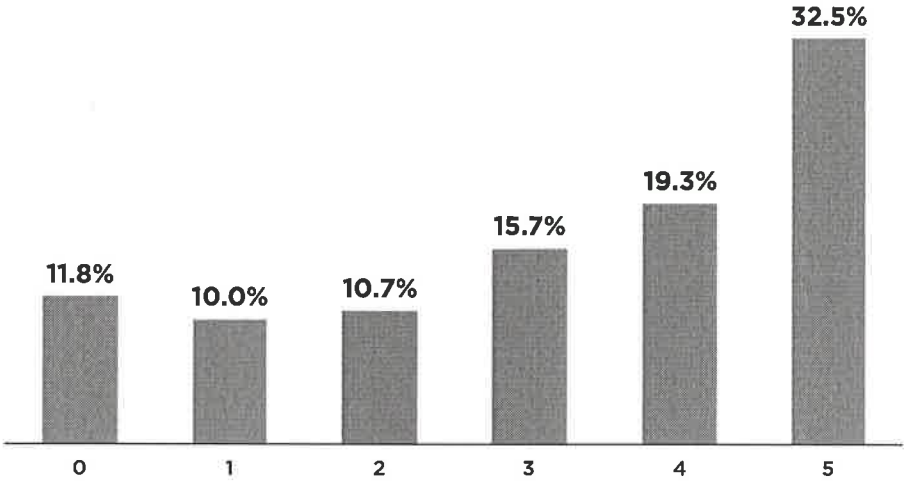
Many youth, including youth who have been rejected by their families, spoke about the importance of "chosen families" as sources of emotional and material support -- including housing. As one youth stated,

"Ask us about our families of choice, because some of us don't have relationships with our families of origin."

DISCRIMINATION, INTERNALIZED STIGMA, AND PRIDE

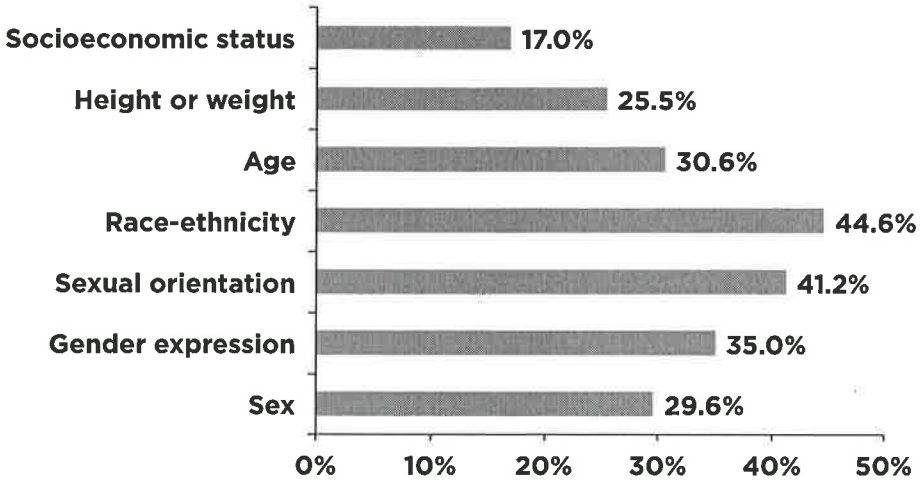
- Participants were asked to report the frequency with which they experienced five specific types of everyday discrimination during the prior 12 months, such as being treated with less courtesy or respect or being treated as if they were not as smart as others. About a third (32.5%) of participants reported experiencing 5 or more types of everyday discrimination and only 11.8% reported no experience of everyday discrimination in the prior 12 months.

Number of Types of Everyday Discrimination

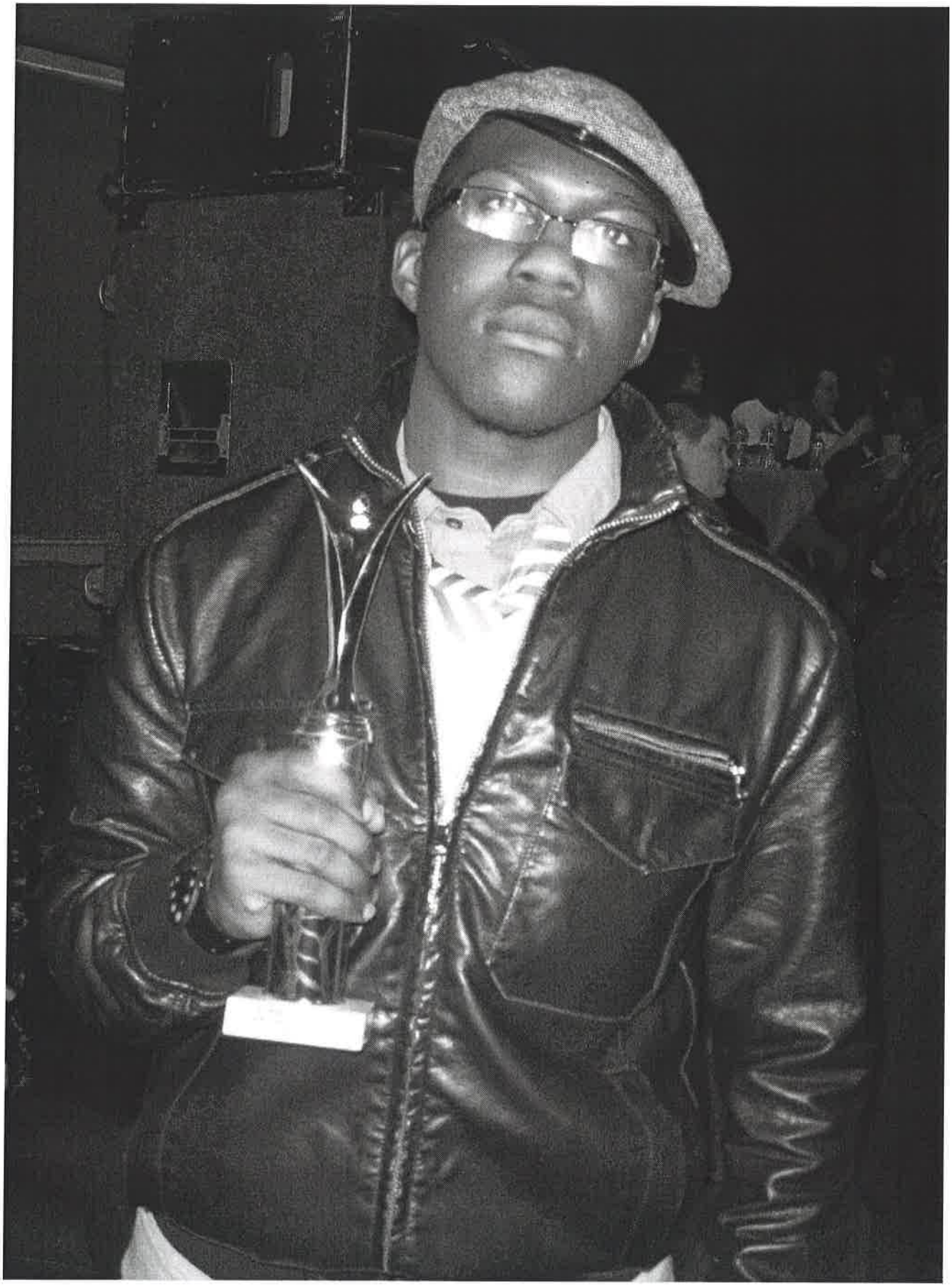


- Among participants who reported discrimination, the most commonly reported reason for these experiences was race/ethnicity (44.6%), followed by sexual orientation (41.2%), gender expression (35.0%), and age (30.6%).

Main Reasons for Discrimination



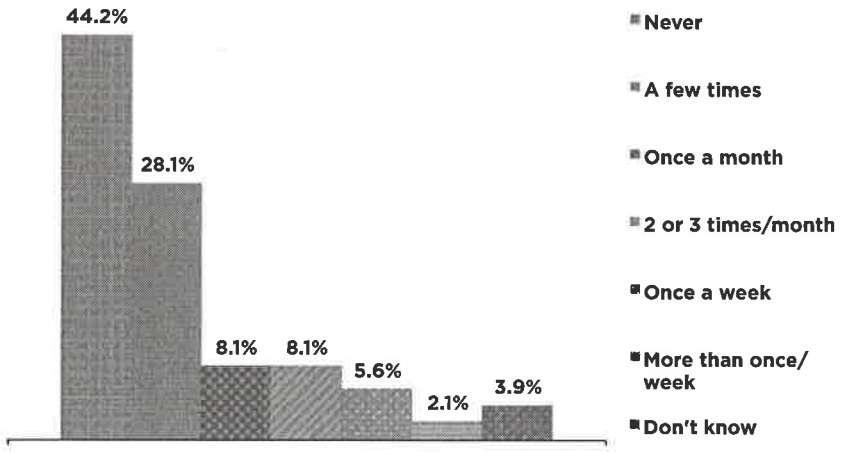
- Racial/ethnic pride was high in our sample; 84.0% of participants indicated that, on average, they somewhat or strongly agreed with statements reflecting attachment, belonging, and commitment to their racial/ethnic group (e.g., "I have a strong sense of belonging to my own ethnic group, I feel good about my cultural or ethnic background.") In contrast, 16.0% of youth somewhat or strongly disagreed, on average, with these types of statements and may be experiencing internalized racism.
- Levels of LGBTQ pride were also high in our sample; 82.0% of participants indicated that, on average, they sometimes or often felt good about being LGBTQ and felt a strong sense of belonging to a LGBTQ community. In contrast, 18.0% of youth never or rarely, on average, reported experiencing these feelings and may be experiencing internalized LGBTQ stigma.



RELIGIOSITY/SPIRITUALITY

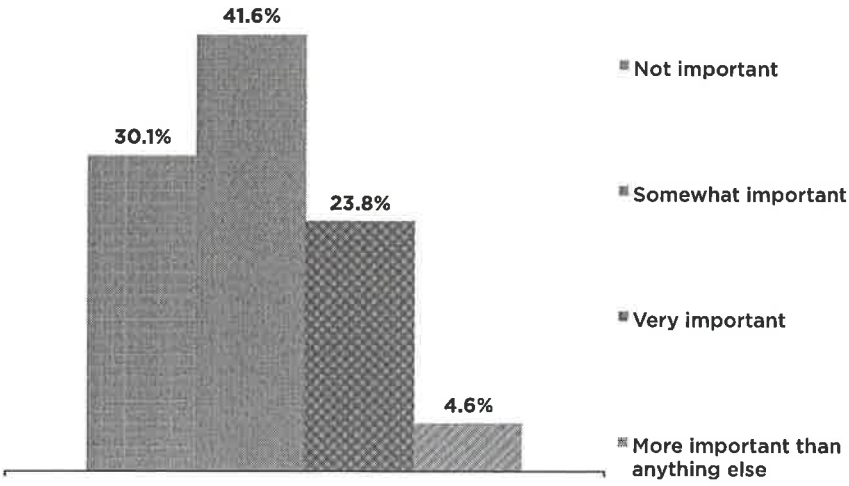
- When asked how often they had attended church, synagogue, temple, mosque or religious services within the prior 12 months, 44.2% of youth reported that they never attended, 28.1% reported that they had attended a few times, and one-quarter (23.9%) reported attendance at least once a month.

Religious Service Attendance (12 Months)



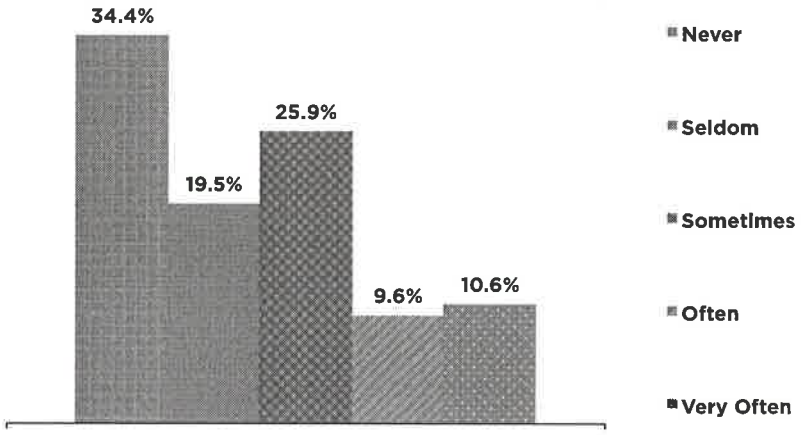
- The importance of their religious faith varied among youth; 30.1% of youth reported that their religious faith was not important to them, yet for more than one in four youth, religious faith was quite important – 23.8% reported that it was very important and 4.6% reported that it was more important than anything else.

Importance of Religious Faith



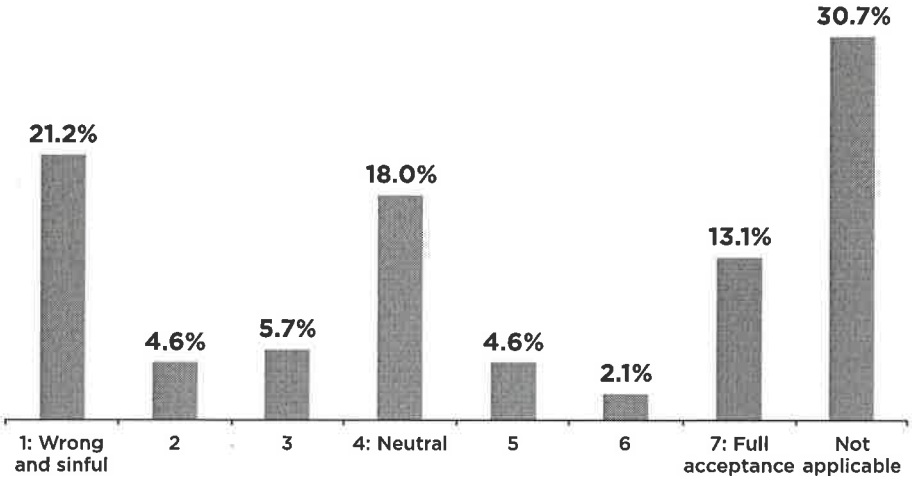
- Over half (53.9%) of participants reported that they never or seldom turned to religious or spiritual beliefs for help when they had personal problems or problems at school or work, while 25.9% sometimes did, and one in five (20.2%) often or very often drew upon religious or spiritual beliefs for help with problems.

Frequency of Religious Beliefs to Cope



- Youth also reported considerable heterogeneity in how their church/religion views homosexuality, with one in five (21.2%) indicating that their church/religion views homosexuality as wrong and sinful, 18.0% as neutral, and 13.1% reporting full acceptance. More broadly, 31.5% reported negative views (less than neutral view), 19.8% reported positive views on homosexuality (greater than neutral view), and 30.7% indicated that the church/religion's views were not applicable to them because they do not have a church/religion. Youth responded similarly regarding their parent/guardian's church's view of homosexuality.

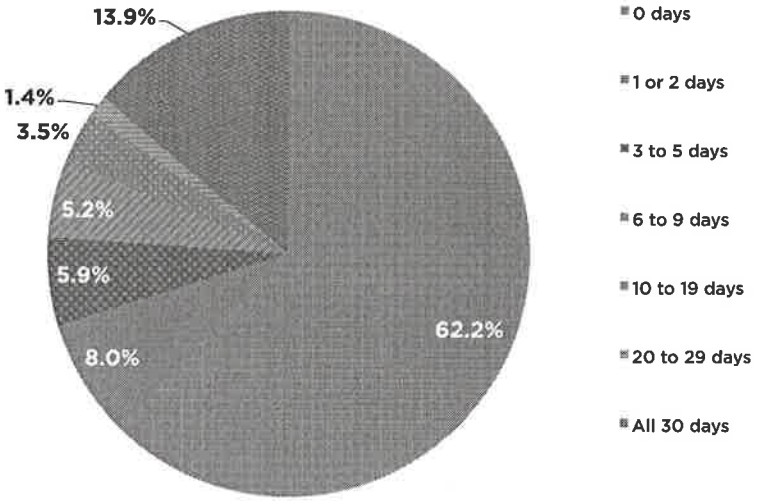
Church/ Religion's View of Homosexuality



SUBSTANCE USE

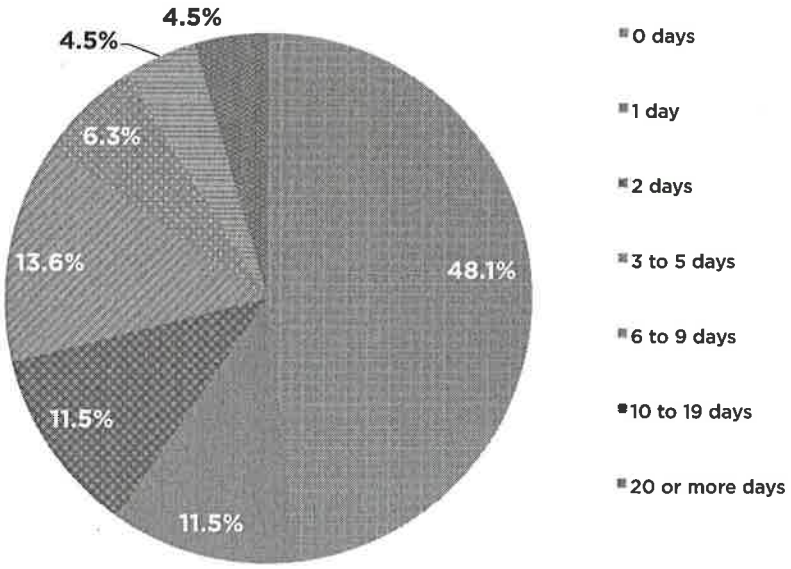
- A sizable minority (37.9%) of participants reported smoking cigarettes within the prior 30 days, with 13.9% reporting daily cigarette consumption. However, many (62.2%) youth had not smoked at all, especially younger youth. Four out of five 13 to 18 year olds had not smoked cigarettes in the prior 30 days.

Cigarette Smoking, Past 30 Days



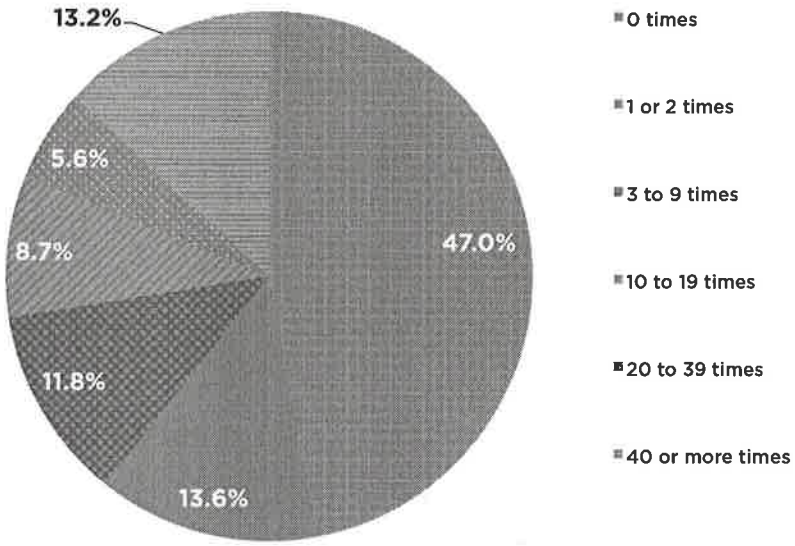
- About half (51.9%) of the sample reported binge drinking (consuming 5 or more drinks within a couple of hours) in the prior 30 days, with 9.0% reporting having 5 or more drinks in a row on ten or more days in the past month. Among 13 to 18 year olds, two out of five reported any 30-day binge drinking.

5 or More Drinks of Alcohol in a Row, Past 30 Days



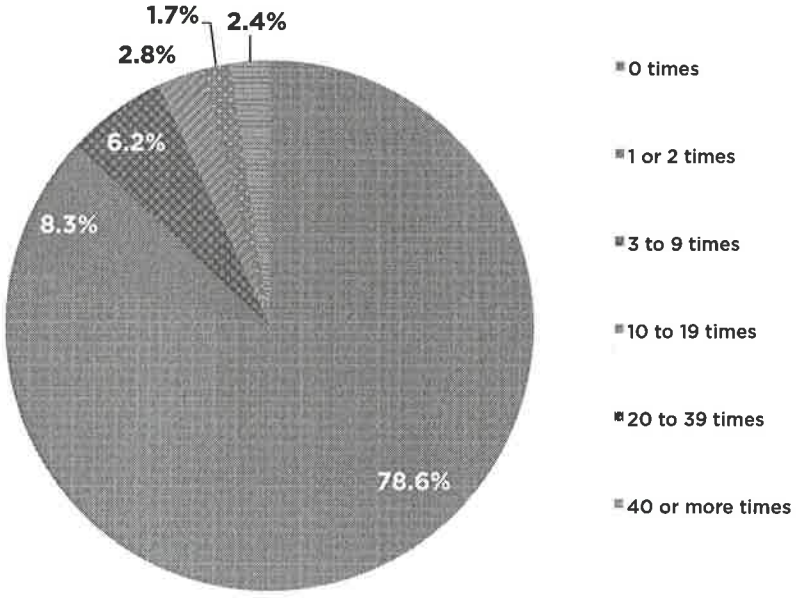
- Marijuana use was also common; about half (53.0%) of the sample reported 30 day use, with 18.8% reporting marijuana use 20 or more times in the prior 30 days. Among 13 to 18 year olds, two out of five reported any 30-day marijuana use.

Marijuana Use, Past 30 Days



- Misuse of drugs including "benzos, percs, OCY, Ritalin, Adderall, and hormones" in the prior 30 days that were not prescribed to the respondent was reported by 21.4% of the sample, with 13.1% of participants reporting use more than once or twice.

Prescription Drug Misuse, Past 30 Days



- With regard to other controlled substances, 18.5% of participants reported any lifetime MDMA (ecstasy) use, 19.2% reported any lifetime cocaine use, 10.1% reported any lifetime heroin use and 13.6% reported having previously used methamphetamine at some point in their life. Use was significantly lower among 13 to 18 year old youth than older youth.

Youth expressed interest in alternative forms of behavioral health and substance abuse treatment that promote healing within community. One youth felt that the ideal substance abuse treatment would incorporate "**community-based healing, without stigma, working in groups,**" and another stated

"I'd like to see some alternative or holistic approaches to mental health... reiki, acupuncture, mindfulness..."

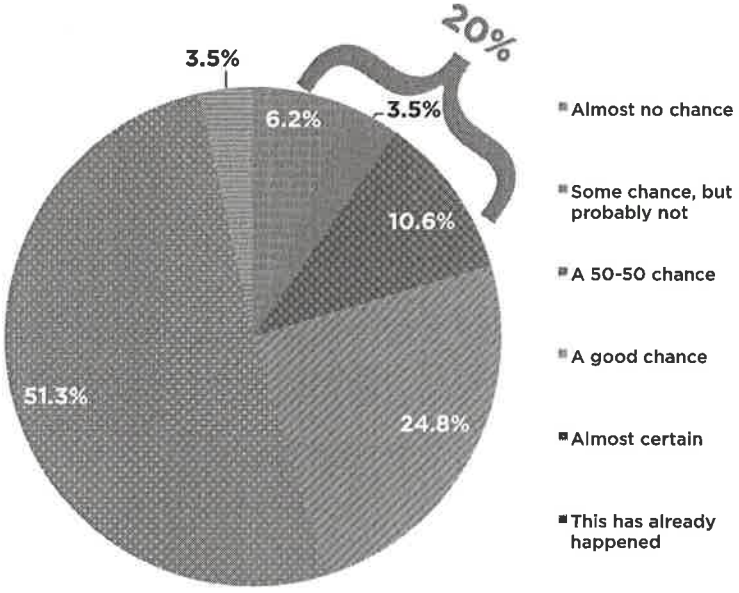
Youth also expressed a desire for decreased reliance on extreme measures for mental health treatment such as hospitalization, in favor of the holistic community-based approaches.

One youth stated a desire for an LGBTQ-specific shelter for people experiencing substance use disorders. This could help create more inclusive and affirming spaces for LGBTQ youth of color with substance use disorders, especially those also experiencing homelessness, to cope with and recover from their problematic substance use.

HOPE FOR THE FUTURE

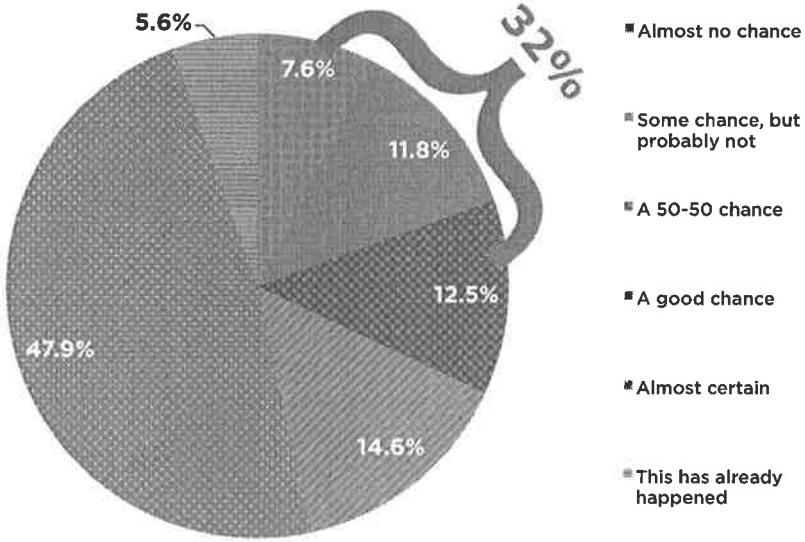
- Among youth who reported that they had not yet completed high school or a GED (n=113), half (51.3%) of youth felt "almost certain" that they would graduate high school or complete their GED by age 30; however, one in five (20.3%) youth reported their expectations about completing a high school/GED as no more than "a 50-50 chance."

I Will Graduate High School/Get My GED by Age 30



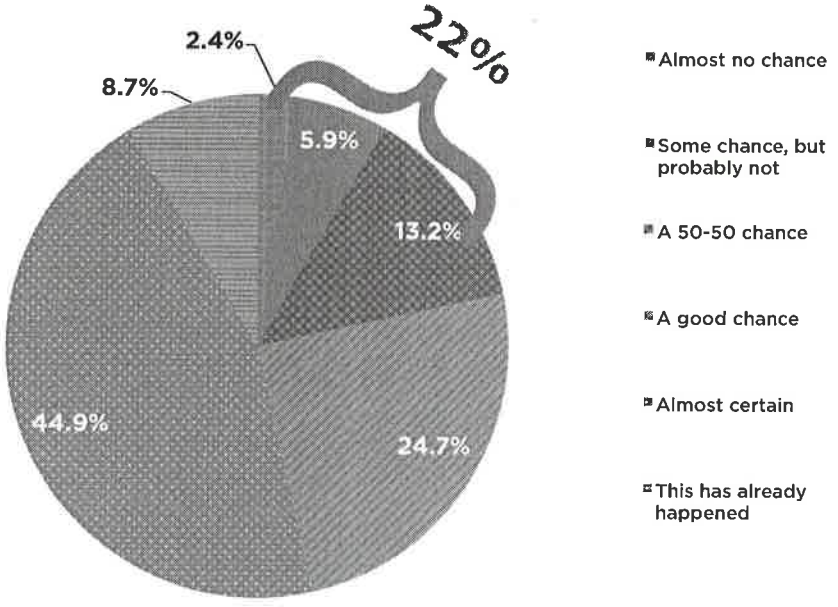
- Among youth who reported that they had completed high school or a GED (n=144), about half (47.9%) felt "almost certain" that they would graduate college by age 30; however, a third (31.9%) of youth reported no more than "a 50-50 chance" of graduating college by age 30.

I Will Graduate College by Age 30



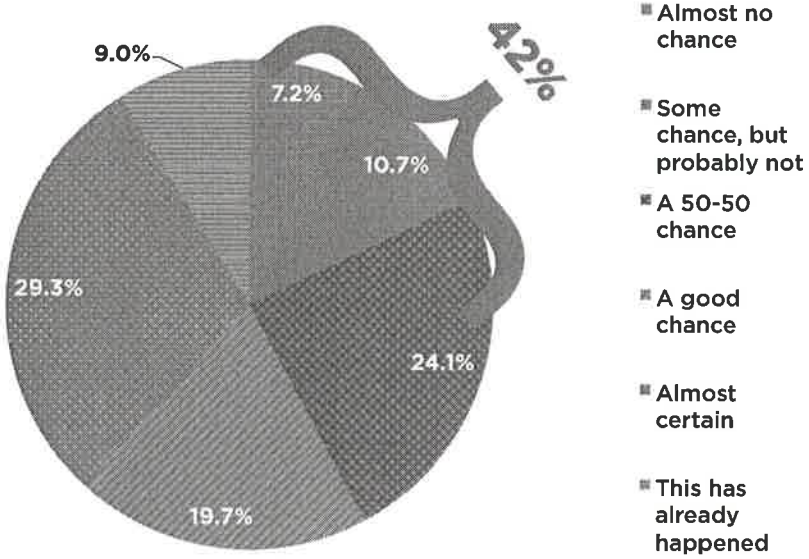
- In the full sample, just over half (53.6%) of participants felt "almost certain" that they would have a good job by age 30, or that this had already happened; however, one in five (21.5%) youth felt that there was no more than a "50-50 chance" of having a good job by age 30.

I Will Have a Good Job by Age 30



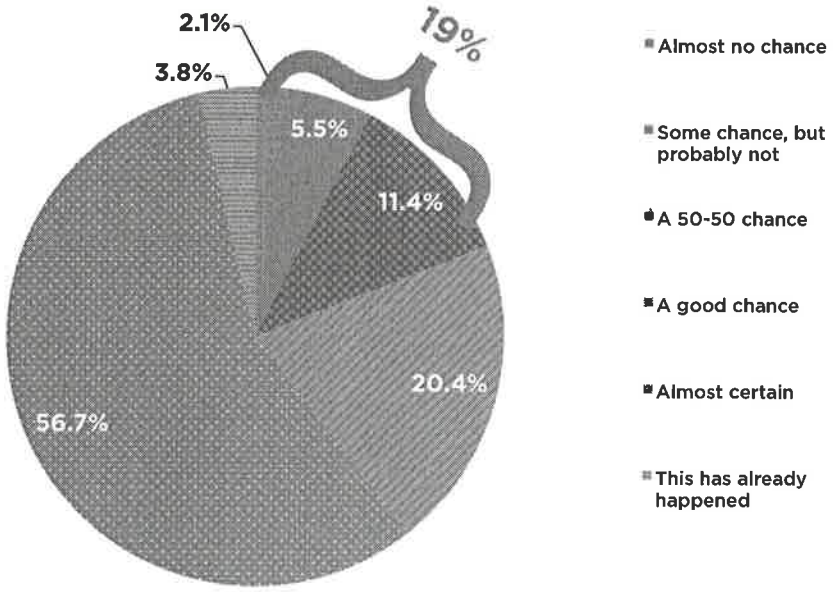
- Thirty-eight percent of our participants felt "almost certain" that they would have a loving partner or spouse by age 30, or that this had already been accomplished. A comparable proportion (42.0%) felt that there was no more than a "50-50 chance" of having a loving partner or spouse by age 30.

I Will Have a Loving Partner / Spouse by Age 30



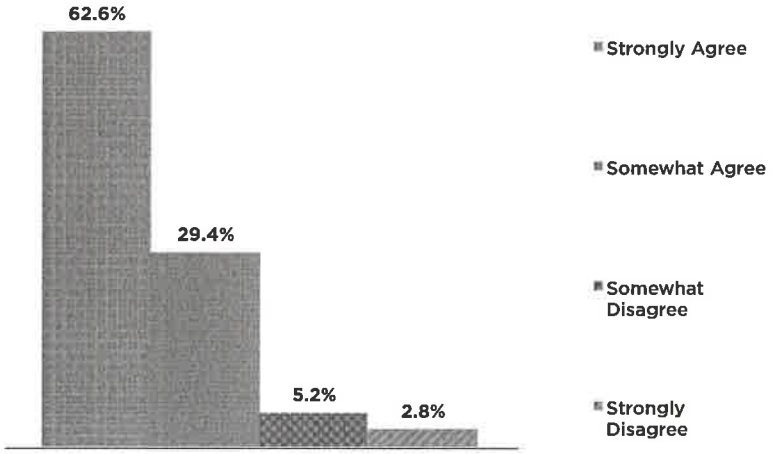
- More than half (56.7%) of youth were "almost certain" that they would live to age 30; however, 19.0% felt that their chances of living until age 30 were no more than "50-50."

I Will Live to Age 30



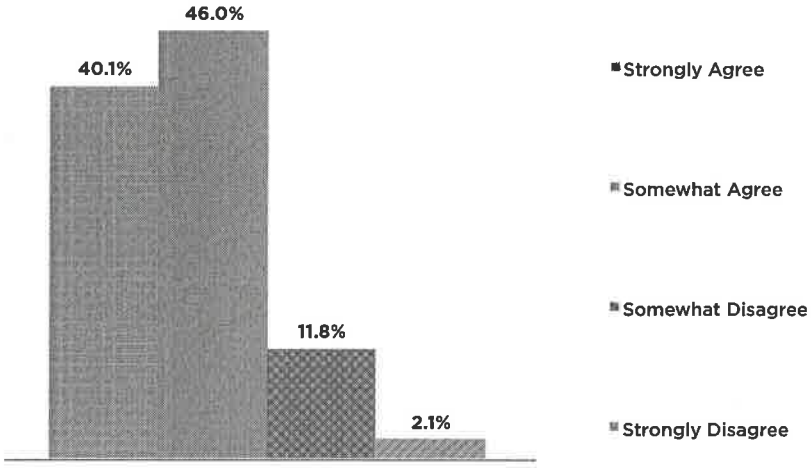
- The majority of participants indicated that their life has purpose, with 62.6% of the sample reporting that they "strongly agree" and 29.4% of the sample reporting that they "somewhat agree" that their life has purpose.

My Life Has Purpose



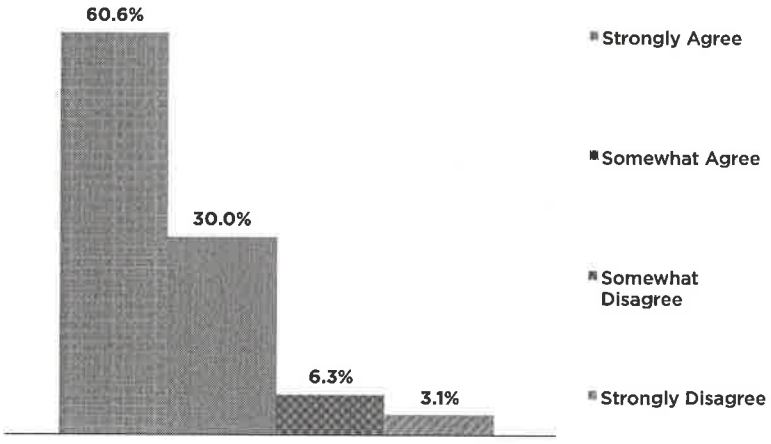
- Youth were somewhat less likely, however, to agree that they had control over the things that happen in their life, with 40.1% of the sample reporting that they "strongly agree" and 46.0% of the sample reporting that they "somewhat agree" that they have control over the things that happen in their lives.

I Have Control Over Things That Happen In My Life



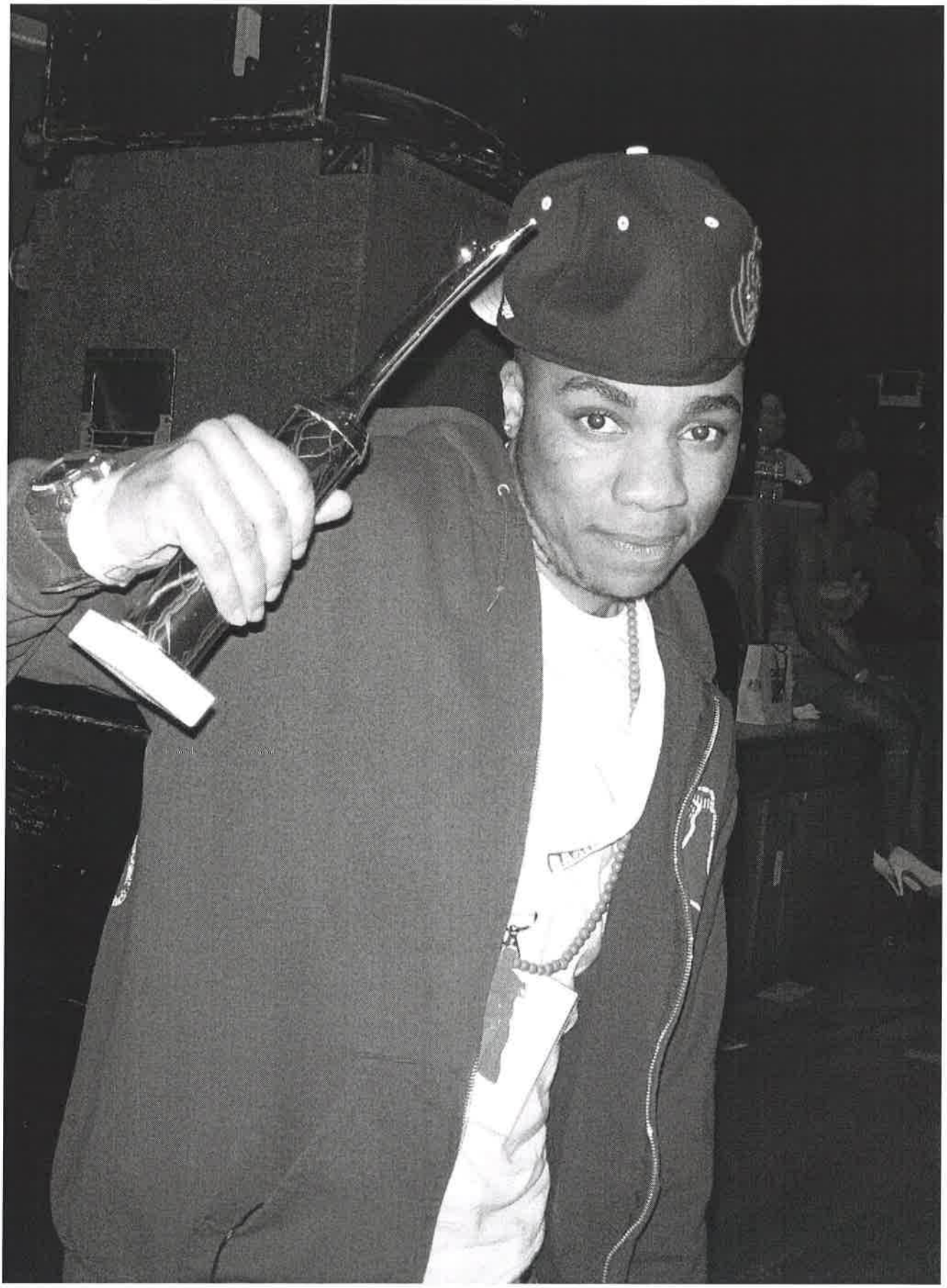
- Most youth strongly (60.6%) or somewhat (30.0%) agree that they are looking forward to the future.

I Am Looking Forward to The Future



One youth's comment illustrated the ways in which youth demonstrate resilience in the presence of adversity:

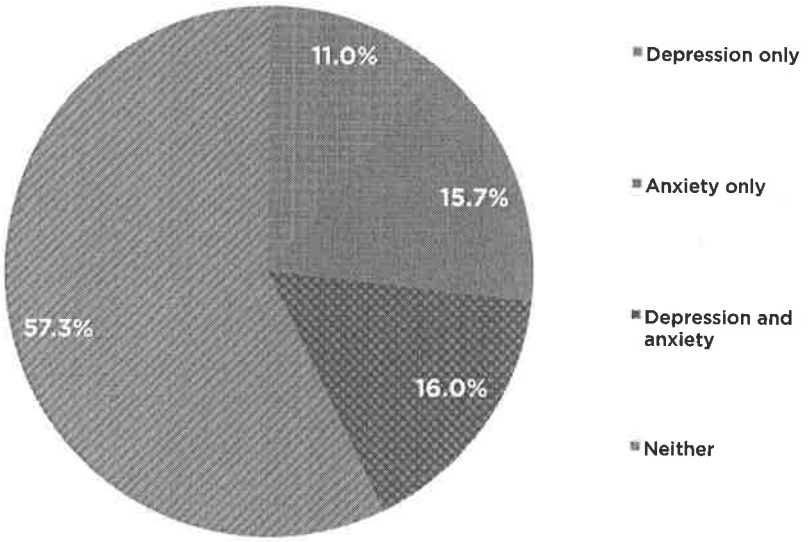
> "I think people hold multiple feelings at one time. Like you can hold both being depressed and anxious, but also having hope for the future."



MENTAL HEALTH AND CORRELATES OF MENTAL HEALTH

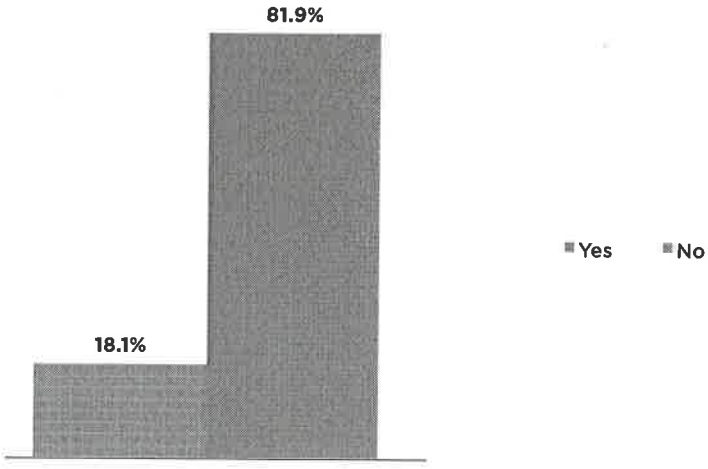
- Nearly half of youth endorsed symptoms of probable clinical depression and/or anxiety; 11.0% endorsed symptoms of depression alone, anxiety alone (15.7%), or concurrent depression and anxiety (16.0%). Eleven percent of youth reported symptoms of depression at moderately severe to severe levels, and 9.3% of youth reported symptoms of anxiety at a severe level.

Depression and Anxiety



- Many other youth reported mild symptoms of depression (28.8%) or anxiety (33.3%).
- Almost one of five (18.1%) participants reported trying to kill themselves during the prior 12 months. Missing responses on the 12-month suicide attempt item totaled 11.5%.

Suicide Attempt (12 months)



Many youth felt that society views them as bearing responsibility for their own mental health concerns. One said,

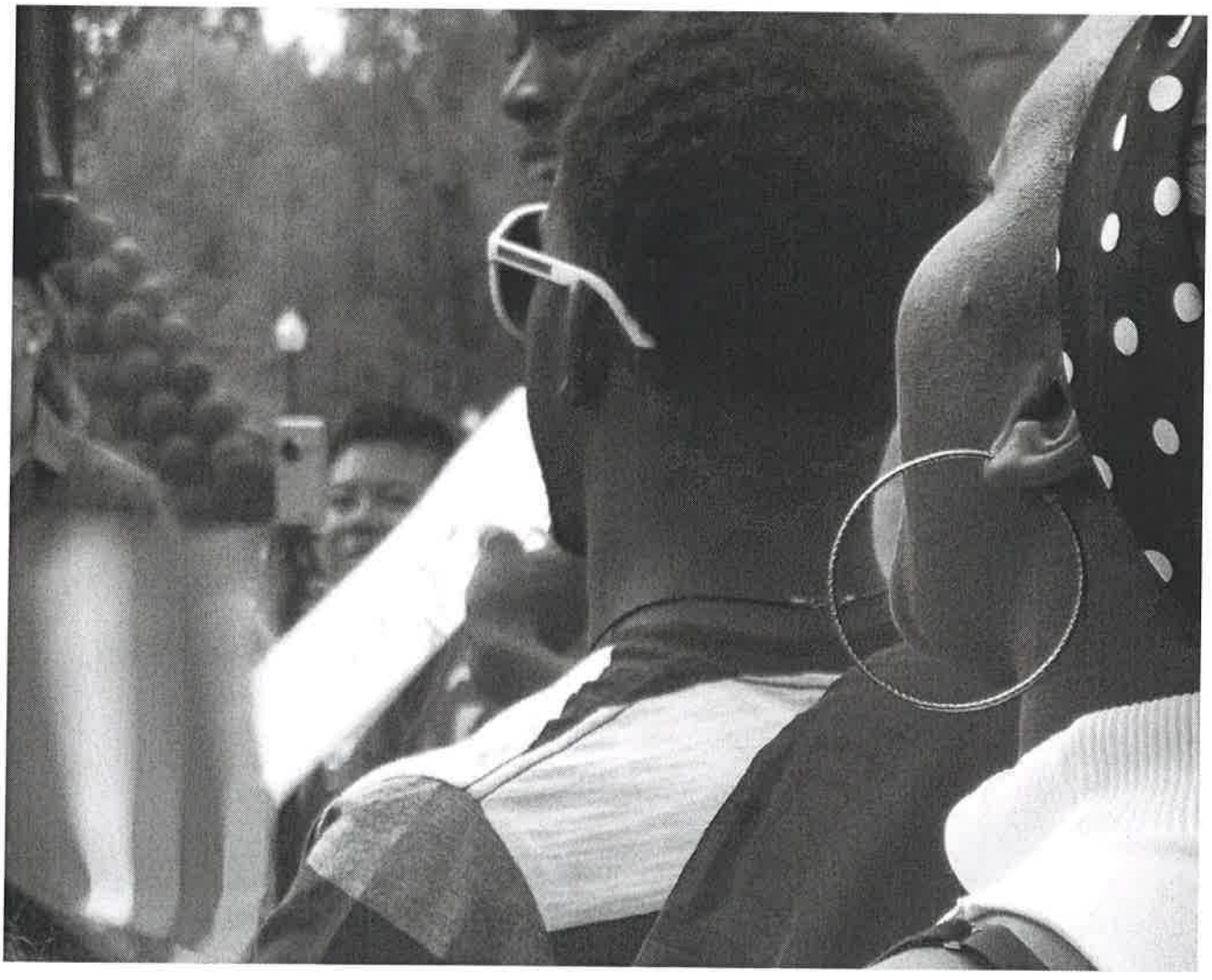
> **"We are suffering from anxiety, stress—then they blame us. They say, 'Well, it's your fault.'"**

Youth encouraged a perspective that instead focuses on the ways in which social determinants impact mental health and systemic barriers to mental health care access for LGBTQ youth of color.

When asked to draw connections between the findings of our survey, youth stated that food insecurity, homelessness, and mental health issues were all related to family acceptance and experiences of discrimination.

According to one youth,

"Some people are depressed for many different reasons... no food, nowhere to take showers, no friends. There must be something going on in their life that makes them turn to drugs. Dig into why people turn to drugs. Like, it's easier for me to get through the day when I'm high because it makes it easier to manage my anger at people and situations."



In order to identify correlates of mental health that might serve as intervention levers, risk and protective factors that were associated with depression, anxiety, or any suicide attempt were included in age-adjusted logistic regression models (results shown below). Findings from the regression analyses are as follows:

- Child abuse prior to age 18 and food insecurity were associated with increased risk of depression, anxiety, and any suicide attempt in the prior 12 months.
- Everyday discrimination was marginally associated with depression and anxiety, while housing instability was marginally associated with increased risk of a suicide attempt in the prior 12 months. (Marginally significant findings are those that are likely to be statistically significant in a larger sample.)
- LGBTQ pride was associated with reduced risk of depression and anxiety, and racial-ethnic pride was marginally associated with reduced risk for anxiety.
- Living elsewhere (not with caregivers/relatives or in one's own place) was marginally associated with increased risk for a suicide attempt in the prior 12 months.

AGE-ADJUSTED ODDS OF POOR MENTAL HEALTH AMONG LGBTQ YOUTH OF COLOR ASSOCIATED WITH MINORITY STRESSORS, LIVING CONDITIONS, AND PRIDE

	Depression N=265		Anxiety N=269		Any 12-month Suicide Attempt N=250	
	OR*	95% CI	OR	95% CI	OR	95% CI
Any frequent psychological or physical child abuse	2.6	1.4, 4.8	3.0	1.6, 5.8	3.5	1.5, 8.3
12-month everyday discrimination	1.1	1.0, 1.4	1.1	0.9, 1.3	NA	
12-month food insecurity (> some months vs. < 2 months)	2.2	1.3, 4.0	1.9	1.1, 3.4	2.6	1.3, 5.5
LGBTQ pride	0.9	0.8, 0.99			0.9	0.7, 0.98
Racial/ethnic pride			0.7	0.4, 1.1		
Housing in own place vs. home with a caregiver/relative					0.5	0.2, 1.5
Housing elsewhere vs. home with a caregiver/ relative					2.0	0.9, 4.4

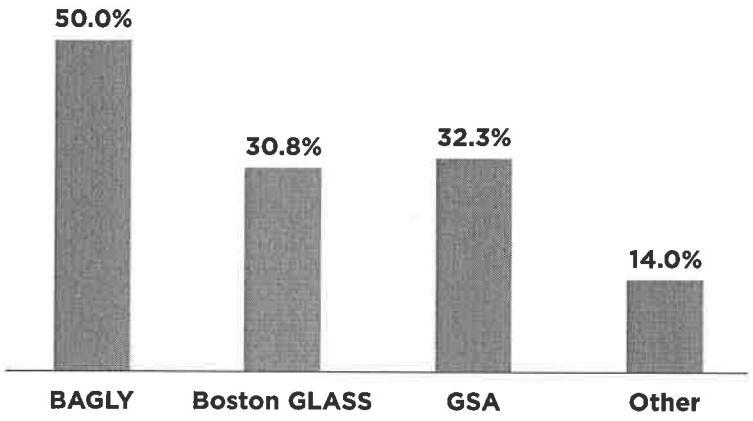
Odds ratio (OR), 95% confidence interval (CI). When the 95% confidence interval covers or includes 1.0, the odds ratio is not statistically significant at $p<0.05$.

Variables that were not associated with any of the three mental health outcomes were: sex/gender identity group, race-ethnicity, maternal acceptance, and religion as a source of coping.

CONNECTION TO LGBTQ YOUTH PROGRAMS AND OPPORTUNITIES FOR DEVELOPMENT

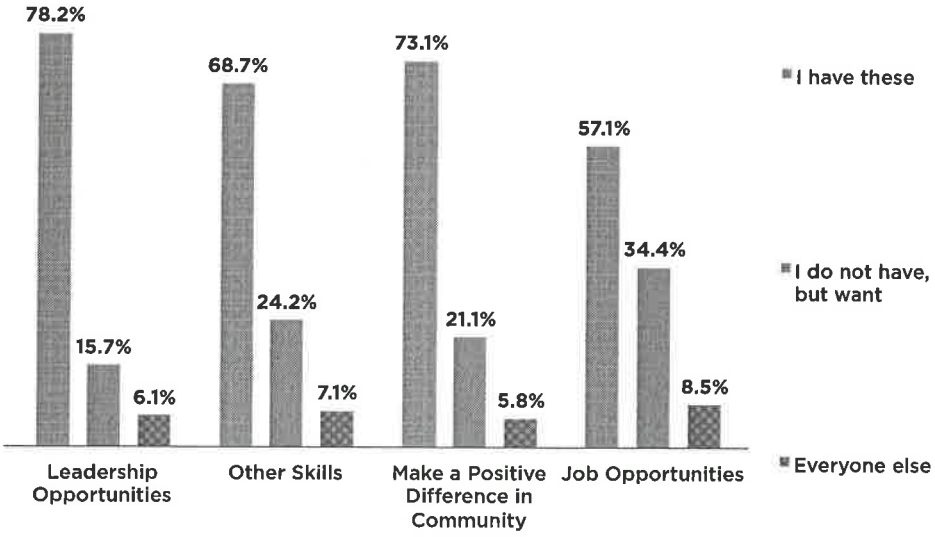
- Most (72.5%) of the sample reported attending one or more LGBTQ youth programs in the prior 30 days. Specifically, 50.0% reported having been to BAGLY, 30.8% went to Boston GLASS, 32.3% had been to a Gay-Straight-Alliance (GSA), and 14.0% had been to one of more of the following: Hispanic Black Gay Coalition, Youth on Fire, NAGLY, or SHAGLY.
- Almost one in four (22.9%) youth reported being connected to the House and Ball Community either as a current or past member of a House.

Attend LGBTQ Youth Programs



- Many (59.9%) youth reported having a mentor (defined as an adult who is not a parent/guardian and offers support and guidance), some (19.1%) indicated that they would like a mentor, and the remainder (21.1%) did not have or want a mentor.

Development Opportunities



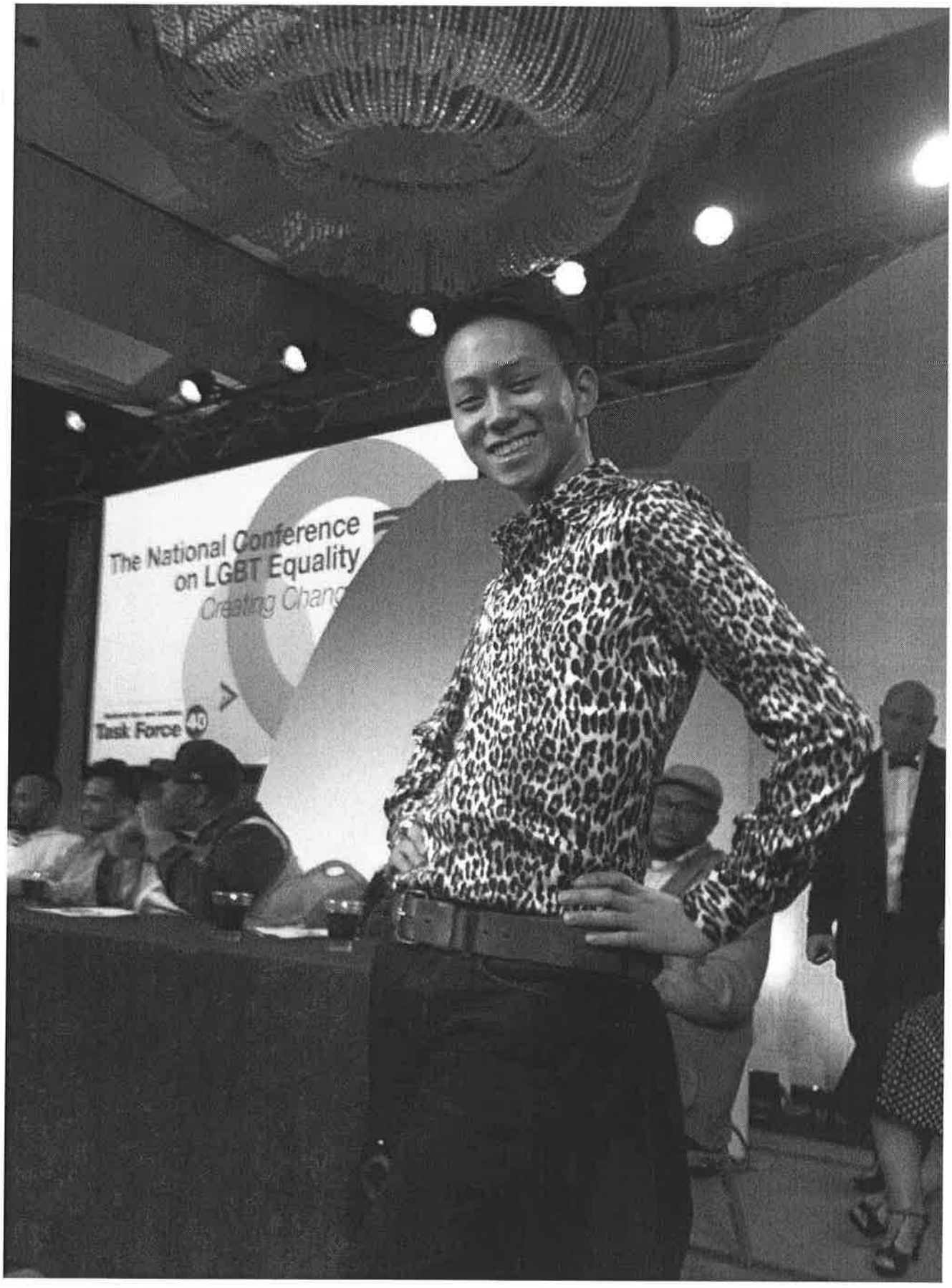
- Many participants reported having opportunities to develop leadership skills (78.2%), to develop other new skills (68.7%), and to make a positive difference in the community (73.1%); however, fewer (57.1%) reported having paid jobs or internships. Interest in development opportunities among those who reported that they did not currently have them was high, and was the highest for paid jobs and internships.

Youth expressed a desire for LGBTQ organizations to create more spaces for youth to interact with adults, and for older youth to interact with one another. One person said that there should be "**more spaces for queer young people 25-30,**" noting that many youth serving programs have age limits of 23 to 25, and that LGBTQ youth of color may be especially in need of continued support even beyond that age range.

Another youth agreed, stating that there should be "**multiple age groups and intergenerational space,**" noting the benefits that LGBTQ youth of color could obtain from mentoring relationships with older LGBTQ people of color, who they may not currently have many accessible spaces to build relationships with. Intergenerational programs might address "**the loss of history and intergenerational dialogues.**"

"We need to recover QTPOC [queer and transgender people of color] history,"

said another youth.


The National Conference
on LGBT Equality
Task Force

CONCLUSIONS AND RECOMMENDATIONS

Our three overarching conclusions (in bold) and the recommendations that follow are based on careful reflection upon our study findings by the research team and through discussion with LGBTQ youth of color in the Boston area.

- **Many LGBTQ youth of color in this sample demonstrated considerable resilience given their exposure to multiple forms of discrimination, violence, and socioeconomic adversity; however, a significant proportion are in need of mental health treatment and other forms of support.**
  - Increase access to caring LGBTQ behavioral health care providers of color and culturally-competent substance use prevention and treatment services, including residential or in-patient programs that accommodate transgender youth according to their gender identity.
  - Expand outreach to LGBTQ youth of color who are not connected to organizations that specifically serve these groups. Such programs can be important sources of support and behavioral health care, as well as serving as a gateway to other services.
- **Findings highlight the importance of addressing the social context affecting LGBTQ youth of color -- interpersonal, social, and community circumstances (e.g., racial discrimination, poverty, violence, LGBTQ stigma, family acceptance or rejection, school, church) -- and intersectionality (understanding and addressing the impact of racism and other stigma and socioeconomic factors, as well as understanding and promoting racial/ethnic and LGBTQ pride.)**
  - Address "upstream" factors at the root of health disparities that affect LGBTQ youth of color --- including racism, poverty, LGBTQ stigma, discrimination, victimization, family rejection, and minority stress that increase vulnerability to poor mental health, substance use, and other health problems.
  - Engage youth as partners in developing strategies to improve the health and social conditions of their lives and to support youth leadership.

At our feedback sessions, youth indicated a strong desire to be involved in supporting their peers. As one youth put it,

"Show people it's OK to accept and be accepted. Show people 'I know what you're going through,' so people don't feel so alone."

  - Provide paid opportunities for LGBTQ youth of color to participate in program development, delivery, research, policy analysis and advocacy, in conjunction with support and on-going training, to enable sustained success and continued growth.
  - Increase access to low-cost and free housing, particularly for 19- to 25-year- old LGBTQ youth of color and provide supports to sustain housing.
  - Increase access to scholarships and programs that waive tuition and fees to enable access to higher education for LGBTQ youth of color.
  - Promote family acceptance of LGBTQ youth with communities of color, including immigrant communities; provide LGBTQ-affirming refugee and immigrant services to adults, some of whom may be parents of a LGBTQ youth, and youth themselves.
  - Reduce poverty, racism, adultism, and anti-LGBTQ prejudice through social activism, norm change campaigns, and community engagement efforts that include increasing livable wages and affordable housing, reducing LGBTQ stigma, supporting policing and criminal justice reform, and promote inclusion and shared decision-making power.

- **The community-based participatory research process through which our survey was conducted enabled us to fill gaps in the health surveillance landscape by collecting information on health, as well as salient risk and protective factors, from nearly 300 LGBTQ youth of color in a short period of time.**
  - Conduct research to understand and improve the health of LGBTQ youth of color in collaboration with community partners and engage youth in processes from survey design through interpretation of results and the formulation of recommendations.
  - Embrace a participatory and collaborative approach to the generation of solutions to identified problems; partner with organizations working closely with LGBTQ youth of color, share resources, and foster leadership of LGBTQ people of color.

As one youth remarked,

"It's hard to participate in dominant group led and white capped organizations. We don't see ourselves reflected in the organizations we are going to."

  - Improve heath surveillance systems to provide critical data about the health of LGBTQ youth of color in high school and through the age of 25.
    - Include questions on assigned sex at birth, gender identity, sexual orientation, and socioeconomic status in all surveillance systems.
    - Over-sample racial-ethnic and sexual and gender minority groups.
    - Produce reports or briefs making findings accessible to the public.

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