

Recommendations to the
Pennsylvania Department of Public Welfare's
Office of Mental Health and Substance Abuse Services
From the LGBTQI Workgroup

**Issues of Access to and Inclusion in
Behavioral Health Services
for**

**Lesbian, Gay, Bisexual, Transgender,
Questioning and Intersex Consumers**



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Executive Summary: Three Goals for our Commonwealth

The Pennsylvania Department of Public Welfare (DPW) and its Office of Mental Health and Substance Abuse Services (OMHSAS) have recognized the behavioral health disparities between the lesbian, gay, bisexual, transgender, questioning, and intersex (LGBTQIⁱ) population and the larger population they serve.ⁱⁱ As such, the Deputy Secretary of OMHSAS invited representatives of the LGBTQI consumer communities and their advocates to form a workgroup that would make recommendations to DPW/OMHSAS on how to ensure that OMHSAS, county mental health programs, behavioral health managed care organizations (BHMCOs), and mental health provider agencies can improve access to, and quality of treatment and care for, LGBTQI consumers.

The Workgroup formed to address issues of access to and inclusion in behavioral health services for LGBTQI consumers was convened in December 2008, and included LGBTQI consumers, family members, advocates, county representatives, BHMCOs, OMHSAS staff and academics. The Workgroup met for six months to develop recommendations that would benefit consumers seeking or being referred to behavioral health services throughout the Commonwealth by insuring quality care unimpeded by differences of sexual orientation, gender identity and gender expression. The Workgroup's process and product were inspired by a similar local project already underway in Philadelphia. Energized by the leadership and vision of Joan Erney, Deputy Secretary for the Office of Mental Health and Substance Abuse Services, the Workgroup produced the recommendations outlined in this document.

To address these disparities in behavioral health care, and to reduce disparities in behavioral health outcomes, the Workgroup calls on the Office of Mental Health and Substance Abuse Services (OMHSAS) to commit to achieving **three goals**:

Goals of the LGBTQI initiative

- A. To protect LGBTQI consumers from discrimination and mistreatment
- B. To ensure that OMHSAS and contracted providers provide culturally affirmative environments of care for LGBTQI consumers
- C. To ensure clinically competent behavioral health care for LGBTQI consumers

The Workgroup recommends that the DPW and OMHSAS commit the staff and financial resources necessary to achieve these goals through the timely implementation of all of the recommendations in this document, beginning with the following **five priority actions**:

Priority Actions	
To address Goal A:	1. By 2010, adopt: <ul style="list-style-type: none">▪ a Non-Discrimination Policy that includes sexual orientation, gender identity and gender expression, covering staff and all people receiving services; and▪ a policy clarifying that OMHSAS does not endorse or pay for so-called conversion therapy.
To address Goal B:	2. By 2010, develop training to encourage culturally affirmative environments of care for LGBTQI consumers and family members, and fully roll out by 2012.
To address Goal C:	3. By 2010, adopt an Appropriate Services Policy which defines competency criteria for providers of services to LGBTQI consumers and which incorporates Peer Support Specialists in their care.
To support actions 1-3:	4. In 2009, designate an OMHSAS staff person as a point-of-contact to facilitate the implementation of these recommendations. 5. By 2011, put data collection in place at every stage of consumer care, at the state, county/Managed Care Organization (MCO) and provider levels, to measure current population served, needs and outcomes.

The DPW and OMHSAS have committed to pursuing their mission by providing “quality services and supports” that, among other principles, “recognize, respect and accommodate differences as they relate to culture/ethnicity/race, religion, gender identity and sexual orientation.”ⁱⁱⁱ In line with this mission, the Workgroup is eager to support OMHSAS in the implementation of these recommendations.

A Few Words on Language

In this document, the acronym “LGBTQI” is used to identify all of the populations targeted by these recommendations – consumers across the spectra of gender identity, gender expression, and sexual orientation. “LGBTQI” is currently a widely-accepted identifier which explicitly and affirmatively includes people who identify as lesbian, gay, bisexual, transgender, questioning and intersex, and is intended to communicate inclusiveness as well as within-group differences.

Please see Appendix B for a glossary.

Context for these Recommendations

The Workgroup presents these recommendations against the backdrop of heightened public attention to LGBTQI rights and hate crimes in many state capitals and in the federal government.

Even as the incidence of other hate crimes decreased in 2007, those based on bias against people’s sexual orientation increased by 6%, with 1,265 incidents reported.^{iv} Pennsylvania’s own hate crimes law has protected against crimes based on sexual orientation or gender identity since 2002, yet in 2007, 46 such incidents were reported.^v Attempted-suicide rates of up to forty percent have been reported for lesbian, gay and bisexual young people, compared to about ten percent for heterosexual youth,^{vi} and an average of one or more transgender people are murdered in the U.S. each month.^{vii} These and other manifestations of intolerance and indifference persist and affect millions of American lives.

Prejudice and discrimination against LGBTQI people are well-documented and widely known. The physical and behavioral health of LGBTQI consumers can be affected by prejudice, discrimination, phobia and other negative behaviors and attitudes exhibited by the public at large. A consumer’s physical and behavioral health challenges can be compounded when these negative behaviors and attitudes are perpetuated by those responsible for representing and implementing public health programs and behavioral health treatment. In addition, members of these populations, whether in urban, suburban, or rural areas of Pennsylvania, frequently cannot find providers of care for their mental health or substance-related issues who are skilled at incorporating the clinical concerns particular to LGBTQI people.

Prejudice and policy have limited both the will and the funding for research on health disparities, and many LGBTQI consumers do not disclose these identities to their providers out of fear, further complicating data collection efforts. But existing research has shown, for example, that men who have sex primarily with other men have greater incidences of major depression, anxiety attacks and bipolar disorder than non-gay men; women who have sex primarily with other women have higher rates of drug and alcohol abuse; and transgender people have access to fewer psychological health services than do members of the general population.^{viii}

Researchers have described the negative effects of homophobia, transphobia, discrimination and violence on LGBTQI people as “minority stress.” The chronic stress of being stigmatized, we have learned, results in negative mental health outcomes.^{ix}

Within the LGBTQI population, several sub-groups are at higher risk for behavioral health concerns. LGBTQI individuals of any age who are in the process of “coming out”^x to themselves, their families and their communities are at especially high risk for suicide, drug and alcohol abuse, depression and physical abuse.^{xi} Gay youth are at much greater risk for suicide attempts, physical victimization and substance abuse.^{xii} Individuals located in rural communities may also be at higher risk due to increased isolation and the absence of affirmative behavioral health resources; however, little is known about this population in PA due to lack of data. LGBTQI parents and other family members, elders,^{xiii} immigrants, and people with HIV/AIDS and other physical disabilities^{xiv} face uniquely complex sets of challenges.

While lesbian, gay and bisexual people are identified as such by their sexual, affectional or social preferences, transgender people identify as transgender based on their own sense of their own gender. Yet transgender and intersex people are targeted for particularly brutal harassment and assault by others who are affronted or terrified by gender differences. Transgender people may be particularly affected by “societal and internalized transphobia, violence, discrimination, family problems, isolation, lack of educational and job opportunities, lack of access to health care, and consumers’ low self-esteem. Many transgender people have had negative experiences with providers of health care, and they may be distrustful of providers.”^{xv}

LGBTQI people of color and LGBTQI women face the compounded life challenges of discrimination and disempowerment based on perceived race and gender, mixed in with their own LGBTQI identity and presentation. These challenges are further complicated among low-income people, who comprise much of the consumer population in the OMHSAS system.

In many cases, even the self-identification of an LGBTQI person as lesbian, gay, bisexual, or transgender is challenged or denied by the very mental health care provider entrusted to support the person, in the name of “repairing” or “converting” the person to a “normal” condition.

These gaps and challenges have historically been invisible. LGBTQI people have sometimes been excluded from the Surgeon General’s report on mental health, from the National Strategy for Suicide Prevention, from the report to the U.S. Congress on the “Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorders,” as well as from state and local mental health and substance abuse plans.^{xvi}

While social prejudice and discrimination create stress that increases risk for some LGBTQI individuals and groups, this population has also demonstrated significant resiliency and resourcefulness. The LGBTQI community has struggled, and in many cases succeeded, in responding to these needs over time by providing community members with affirmative resources and with “counseling from someone who was not trying to change them or who did not label them as crazy because they were gay.”^{xvii} The general community of behavioral healthcare providers, too, has in many instances developed sensitive mental health and substance-related care tailored to the needs of LGBTQI people.

Laws in several Pennsylvania municipalities protect certain rights of lesbian, gay, bisexual and transgender people. There is currently no Commonwealth law protecting individuals from discrimination based on their sexual orientation, gender identity, or gender expression. The recommendations in this document set out to cast a wider net across the Commonwealth to ensure support for all LGBTQI people with respect to their mental health and/or substance-related needs, should they seek access to treatment and care through OMHSAS, county mental health programs, BHMCOs, or mental health provider agencies.

Detailed Recommendations

The Workgroup presents these recommendations for OMHSAS' consideration and potential implementation to ensure that consumers from LGBTQI communities receive fair, equal, welcoming and competent treatment by skilled practitioners as they seek access to or are referred to the Department's behavioral health services. The highest-priority recommendations, as listed in the Executive Summary, are highlighted.

Goal A: Protection from Discrimination and Harassment

Ensure that consumers requesting access to treatment and care through OMHSAS, county mental health programs, BHMCOs, or mental health provider agencies are guaranteed protection from discrimination and harassment based on actual or perceived sexual orientation, gender identity or gender expression.

Recommended Actions:

1. Adopt a **Non-Discrimination Policy** that includes sexual orientation, gender identity, and gender expression, covering staff and all people receiving services.
 - Require that the non-discrimination **policy be made available** to all people providing and receiving services, and to all employees.
2. Adopt a **policy clarifying that OMHSAS does not endorse or pay for so-called conversion therapy**.^{xviii xix xx}
 - Clarify to all providers **the dangers of conversion or “reparative” therapy** for LGBTQI people stating that OMHSAS does not provide it, but supports only those therapies that affirm the identities of LGBTQI people and respect their right to self-determination.^{xxi}

3. **Amend language** in current and future OMHSAS policy, regulations, training materials and contracts to ensure protection from discrimination based on sexual orientation, gender identity and gender expression.
 - In existing OMHSAS training documents, include language and components about **non-discrimination and affirmative** of LGBTQI people and their families.
 - Add requirements regarding the inclusion of sexual orientation, gender identity and gender expression in the non-discrimination language of **every new or renewing BHMCO contract**.
4. Establish mechanisms for consumers, families, providers and staff to **report violations** of the non-discrimination and anti-conversion therapy policies. Provide for systematic follow-up of any alleged violations and a continuous feedback loop by which data regarding violations are reported.
 - **Inform consumers** of their right to report discrimination. Ensure that all consumer handbooks published or supplied by MCOs include this information.

Goal B: A Culturally Affirmative Environment

Ensure that OMHSAS, its field and executive administration, counties and BHMCOs, as well as contracted providers, have the appropriate cultural awareness, knowledge and skill to create a welcoming environment for behavioral health consumers of every sexual orientation, gender identity and gender expression.

Recommended Actions:

1. Develop **training** to encourage culturally affirmative environments of care for LGBTQI consumers and family members.
 - **Design and implement** a set of appropriate trainings in cultural competency in working with LGBTQI populations for OMHSAS field and executive office administration and new hires, OMHSAS advisory groups, counties, BHMCOs and contracted providers. Include training on discriminatory language, attitudes and behaviors towards LGBTQI individuals and related behavioral health consequences, along with additional topics listed in Appendix C.
 - **Coordinate with the Drexel University Partners Reaching to Improve Multi-cultural Effectiveness (PRIME)** program to discover ways to increase the impact of both.
 - Identify and provide more intensive training for **a point person in each OMHSAS field office** and bureau.
 - **Include as trainers LGBTQI people** and family members.
 - **Facilitate the inclusion of workshops** on LGBTQI cultural competency by volunteer LGBTQI Workgroup members at conferences, including the Pennsylvania Mental Health Consumers Association (PMHCA), the Pennsylvania Association of Psychosocial Rehabilitation Services (PAPSRS), the Pennsylvania Association of Rehabilitation Facilities (PARF), the Pennsylvania Community Providers Association (PCPA), the Mental Health and Mental Retardation Administrators Association and the Pennsylvania Psychological Association.
 - **Make educational materials available** to schools, universities and other public institutions.

2. **Provide models** and support for contracted providers to develop policies of inclusion and non-discrimination.
3. Build OMHSAS' existing cultural competency initiatives by developing and implementing a **certification process in cultural competency** which defines practices that will support attitude and culture change such that people of every sexual orientation, gender identity, gender expression, and HIV/AIDS status, as well as people of every racial and ethnic identity, gender, age, religion and national origin are treated in a welcoming and affirming manner when requesting services or being employed by these entities. With regard to sexual orientation, gender identity and gender expression, tie certification to required trainings as well as practice standards based on the models of the Philadelphia Report,^{xxii} the National Association of Social Workers, the American Counseling Association and the American Psychological Association.
 - Encourage MCOs to offer **enhanced rates** to compensate providers who demonstrate cultural competency.
4. Ensure that **all OMHSAS practices** consider LGBTQI needs
 - **Wherever “cultures” are mentioned** in documentation, include LGBTQI as a population. Take action to prevent and reduce homophobia, heterosexism and transphobia by including language on sexual orientation and gender identity on intake forms and other appropriate documents.
 - **Disseminate brochures**, including NAMI's brochure, and other marketing related to LGBTQI issues through the MH/MR and Addiction Services systems.
 - Include LGBTQI members and content on **consumer satisfaction surveys** and on consumer satisfaction teams.
 - Include **LGBTQI representation** on OMHSAS advisory boards, committees and workgroups.

Goal C: Ensure Competent Care

Ensure that clinically competent providers, care and resources are available and accessible to serve the particular behavioral health needs of Pennsylvanians of every sexual orientation, gender identity and gender expression, in every geographic location.

Recommended Actions:

1. Adopt an **Appropriate Services Policy** which defines competency criteria for providers of services to LGBTQI consumers and actively incorporates peer support in their care.
2. Put in place clinical resources to **ensure quality services** for everyone regardless of sexual orientation, gender identity and gender expression.
 - Conduct a **needs assessment** by county to determine the existing capacity, gaps and needs in provider networks. Develop an action plan to build a network of clinically competent providers in every region. Base the assessment and action plan on the standards outlined in the GLBT Health Access Project's Massachusetts Report.^{xxiii}
 - Conduct **listening forums** to gain a more comprehensive understanding of the needs of LGBTQI consumers and their families in the diverse regions of Pennsylvania.
 - Require all state-funded BHMCOs to offer consumers **access to providers trained in serving this population**.
 - Ensure that all contracted providers have the knowledge and **resources needed to make appropriate referrals** of LGBTQI consumers and family members to appropriate and clinically competent agencies, therapists, self-help groups and other community resources. Include on the DPW website a **list of additional LGBTQI-related resources** (schools, community groups, youth-serving agencies, etc.).
 - Assure access to appropriate clinical resources in a timely manner regardless of geography, language or hearing impairment, employing the use of appropriate technology to **reach underserved populations**.
 - Develop written resources and training for MCOs and providers to support the integration of **peer support** and other natural support systems to complete the circle of quality behavioral health care. (See next item.)

3. Develop a **training program for contracted providers** in the clinical competencies needed to serve this population. Base the program on “practice-based evidence” (i.e. the field-proven successes of area agencies already engaged in this work) and evidence-based practices when available.
4. Develop and implement a **certification process in clinical competency** in working with LGBTQI consumers.
 - Develop an **instrument to measure qualifications** for clinical competency, based on the Philadelphia Recommendations.
5. Develop clinical resources specifically targeted to **LGBTQI youth** and the children of LGBTQI families, including youth peer support systems.
6. Develop clinical resources for **prevention** of behavioral health problems specific to the LGBTQI consumer population.
 - Develop resources, specifically for LGBTQI consumers that promote healthy life choices and help develop resiliency.
 - Develop resources to aid providers in promoting affirmative, inclusive, non-heteronormative care.
7. Expand the OMHSAS statewide suicide prevention strategy to include a **suicide intervention plan** specific to the needs of LGBTQI youth and adults.

Additional Recommended Actions to support Goals A, B and C

1. Designate an OMHSAS staff person as a **point-of-contact** to coordinate communication among those who will implement these recommendations.
 - The point-of-contact works closely with the OMHSAS Field Office, and **builds partnerships as appropriate with local** governments and community organizations, to enhance implementation across the Commonwealth.
 - **Coordinate all of the training components** recommended under Goals A, B and C.
2. Put **data collection** in place at the state, county/MCO and provider levels, to measure current population served, needs and outcomes.
 - **Modify intake, data collection and reporting systems** to count, and analyze data trends for, this population in order to identify possible health disparities, gaps in service, and successes in service provision, and to support appropriate resource allocation. Give due attention in the design of these systems to the needs of many LGBTQI consumers for anonymity.
 - Incorporate into data analysis **prevalence data** which are not predicated on the assumption that LGBTQI people will indeed self-identify on intake forms or interviews.
 - Collaborate with business partners and BHMCOs to develop a **consistent set of data elements** to capture across entry points.
 - Use CCR, POMS and/or PROMISE to **collect and track data**.
 - **Provide adequate training before the initiation of data collection** in order to ensure that intakes are conducted sensitively and consistently.
 - **Change existing forms** (applications for services, any forms asking about marital status, etc.) to include sexual orientation and gender identity.^{xxiv} Review forms for additional reflections of heterosexism.
 - Recommend to The Secretary of Public Welfare that the inclusion of culturally sensitive data questions on sexual orientation, gender identity and family status be introduced **DPW-wide** into the CIS.^{xxv}
 - Develop a **pilot data collection program**.

3. Monitor, measure and **evaluate outcomes** of the implementation of these recommendations.
 - **Collect baseline data** at the outset in order to be able to properly measure outcomes later.
 - Based on baseline data, **establish measurable outcomes** for all actions recommended in this document.
4. Ensure that implementation of these recommendations is based on solid scientific and/or clinical evidence that supports its effectiveness with LGBTQI people.
5. Include **LGBTQI consumer and family voices** in any training or implementation of these recommendations so that the integrity and spirit of these recommendations reflect the behavioral health needs of LGBTQI communities across the Commonwealth.
6. Advocate where possible among other state service systems for policies and practices that end discrimination, bring about cultural competency, and provide appropriate services for LGBTQI people. In particular, **coordinate with the Drug and Alcohol system** to address the needs of LGBTQI people with mental health and drug and alcohol challenges.

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Appendix A: A Vision for Inclusion

The Workgroup envisioned a positive, welcoming, inclusive approach for OMHSAS, responsive to the needs of LGBTQI people in need, and based on the following principles:

- This approach is **realistic**, such that while it is comprehensive, it is done with mindfulness about what can realistically be accomplished at each stage, given budgets, logistical constraints, and the pace of cultural and political change.
- Support for people across the range of sexual orientations and gender identities is spun in **a positive light**, moving beyond the language and practice of “tolerance” to welcoming and affirmation. Sexual orientation is not treated as pathology, but as a normal variant of sexual behavior. Similarly, the focus is not limited to pathology and problem-solving, but extends to wellness.
- Care is **recovery- and resiliency-** oriented. OMHSAS’ approach to serving these populations is **holistic**, taking into consideration people’s physical and spiritual needs, community contexts, and all aspects of a person’s life.
- LGBTQI **communities at elevated risk** – transitioning and homeless youth, adults and youth in the process of coming out, transgender adults and youth, people of color, older adults facing unique challenges, and people with HIV/AIDS – are priorities in the system.
- The **voices of LGBTQI persons in recovery** and the voices of resilient **LGBTQI youth** are included in all training.
- The needs of LGBTQI **consumers and their families** are taken into account, however consumers define their families.
- The need for **culture change** at OMHSAS and in the field is taken seriously. Culture change goes deep enough, where possible, that it challenges beliefs each administrator or provider has developed beneath the surface, regardless of one’s good intentions and well-meaning affect.
- These practices are incorporated at **all the major points of entry into the system**, including crisis services. In addition, OMHSAS does outreach to **other state service systems** (e.g. child and youth welfare, justice, substance-related issues, etc.) which affect the behavioral health care of individuals in this population, advocating that they adopt parallel sets of policies and practices in support of LGBTQI Pennsylvanians.
- These recommendations give **strength and support to those working** in the administration or provider systems who are already committed allies to LGBTQI people and their behavioral health needs.
- These practices are **sustainable**, such that funding is allocated and available to ensure culturally- and clinically-competent practices across all counties in all the areas described above.
- Outcomes of these practices are **measured and documented** to facilitate effectiveness and obtaining grant funding.

Appendix B: Glossary

While there are no absolutely agreed upon definitions to describe members of these communities, terms and expressions used in this document are intended to be understood according to the following definitions:^{xxvi}

Ally: A non-LGBTQI person who supports and stands up for the rights of LGBTQI people, though LGBTQI people can be allies, such as a *lesbian* who is an ally to a *transgender* person.

Bisexual: A person who identifies as being attracted relationally and sexually to men as well as women.

Coming Out: The process of acknowledging one's *sexual orientation* and/or *gender identity* to oneself or to other people. For most LGBTQI people this is a life-long process.

Conversion therapy or reparative therapy: Clinical treatment with the purpose of changing a person's *sexual orientation*. This type of treatment assumes that any sexual or affectional preferences other than *heterosexual* ones are pathological.

Gay: A man who identifies primarily as being attracted relationally and sexually to other men. Although it can be used for any sex (e.g. gay man, gay woman, gay person), "*lesbian*" or other terms are used more frequently for women who are attracted to women.

Gender Expression: The manner in which a person outwardly expresses their *gender identity*.

Gender Identity: A person's inner sense of self as male, female, somewhere in between, or something else altogether. Most people develop a gender identity that corresponds to their biological sex, but some do not.

Genderqueer: A person who identifies as living outside the traditional gender construct of male body and gender, and female body and gender.

Heteronormative, Heteronormativity: The general practice in our culture of assuming that heterosexuality and traditional gender identities are the norm.

Heterosexism: The attitude that *heterosexuality* is the only valid or acceptable *sexual orientation*. Heterosexism "resembles racism or sexism and denies, ignores, denigrates, or stigmatizes non-heterosexual forms of emotional and affectional expression, sexual behavior, or community."^{xxvii} Heterosexism "can affect LGBT people by causing internalized homophobia, shame, and a negative self-concept (Neisen, 1990, 1993)."^{xxviii}

Heterosexual or Straight: A person who identifies primarily as being attracted relationally and sexually to people whose gender identity is different from theirs – specifically, a woman who identifies as being attracted to men, or a man who identifies as being attracted to women.

Homophobia: The fear of *lesbian, gay, bisexual* and *queer* people or what they do. Homophobia in the hands of the dominant or more powerful in society results in *heterosexism*.

Homosexual: A clinical term for people who are sexually attracted to members of the same sex. Some *gay* men and *lesbians* find this term offensive, as it has been used in the past to pathologize people.

Intersex: A term used for “a variety of conditions in which a person is born with a reproductive or sexual anatomy that doesn’t seem to fit the typical definitions of female or male.”^{xxix} Intersex people may have various combinations of genitalia, reproductive organs, secondary sex characteristics and combinations of sex chromosomes. These conditions occur in approximately 1 out of 2000 births. At birth or more preferably later in physical and mental development, intersex people may undergo surgery to make their genitalia conform to the conventions of the gender binary (i.e. either male or female). Many intersex people struggle with issues of shame and secrecy. Some struggle with the implications of surgery or gender assignment earlier in life, which may not match their gender identity and/or may have caused them permanent physical damage.

Lesbian: A woman who identifies primarily as being attracted relationally and sexually to other women.

LGBTQI Communities: Because of the ways the larger society has regarded people of these descriptions, the organizations, religious institutions, advocacy groups and other more or less formal community associations which they form have become key components of their recovery supports. As such, in considering the behavioral health issues affecting LGBTQI people, it is necessary to be mindful of these community organizations and connections. However, LGBTQI individuals may or may not associate with these communities.

Queer: An umbrella term used by some LGBTQI people to refer to themselves, and to reflect an ongoing stance of non-restriction toward one’s *sexual orientation, one’s gender identity and/or one’s gender expression*. In the past, this term has been considered offensive and some LGBTQI people still consider it so, but others embrace it as liberating and reflective of an identity as outside the *sexual orientation or gender identity* norms.

Questioning: A person who is unsure about their *sexual orientation* and/or *gender identity*, or chooses at a given time to hold off in defining their *sexual orientation* and/or *gender identity*.

Reparative Therapy: See *conversion therapy*

Sexual orientation: Where a person stands in relation to the sexes or genders of sexual and affectional partners – for example, an orientation to dating people of the same sex or gender, different sex or gender, or any sex or gender. How a person “learns to acknowledge, accept, and then act on a sexual orientation that is different from that of the majority is shaped by cultural, religious, societal and familial factors.”^{xxx} Gay, lesbian and bisexual people are no longer considered by the mainstream medical and psychological communities to be disordered or ill because of their same-sex attractions.

Transgender: A person who lives either full or part time in a gender role other than the gender assigned to them at birth. This may include *transsexuals*, cross dressers, drag queens, drag kings, *genderqueer* people and *intersex* people. Some transgender people undergo surgeries or take hormones to change the sex characteristics of their bodies, and others do not. The medical and psychological communities continue to view the behavior of such people as psychopathological. Many are diagnosed as having a gender identity disorder.^{xxxi} Other transgender people express themselves in the traditional role assigned them at birth, but do not identify themselves with the traditional gender-binary language of male and female.

Transphobia: Transphobia is the set of “irrational or persistent fears or non-acceptance towards people whose gender identity or expression differs from the gender they were assigned at birth. ...As with many fears, transphobia can be based on ignorance and irrationality. The discrimination and harassment that follows can be accidental or deliberate, subtle or obvious.”^{xxxii}

Transsexual: A person who undergoes gender confirmation surgery, changing from woman to man or man to woman. As many *transgender* people do not undergo surgery and/or hormone treatment, the term “*transgender*” is now used as a more inclusive description of trans-people regardless of physical sex characteristics.

Two-Spirit: A person who identifies with the Native American tradition of characterizing certain members of the community as having the spirit of male and female genders.

Appendix C: Recommended Training Content

The following is a sampling of content that would be included in trainings. It would be customized based on the purpose and setting of the training.

Basic Awareness:

- Defining the target populations (LGBTQI)
- Orientation to key words and appropriate language

Self-Awareness:

- Identify stigmas and prejudices in one's own approach
- Tools to address these prejudices

Identity Development & Coming Out:

- Coming out process for LGBTQI people, their families and friends
- Transitioning for transgender individuals and their families
- Sensitivity related to openness and confidentiality
- Self-acceptance, empathy, acceptance, affirmation and self-awareness
- Intersections of multiple identities
- Internalized homophobia, heterosexism and transphobia

Health & Wellness:

- Safety and risk
- Suicide and attempted suicide
- Physical health
- HIV/AIDS and other sexually-transmitted infections
- Substance-related and other co-occurring issues
- Healthy sexuality
- Violence within LGBTQI relationships
- Relationship counseling

Experiences of LGBTQI Individuals and Families:

- Race, class and their intersections with LGBTQI issues
- LGBTQI parenting
- Child development, support and harassment in education systems
- Homelessness, particularly among youth
- Adoption of gender-variant young people
- Roles of family members and caregivers of LGBTQI consumers
- Trends in sexuality and behavior across living generations
- Personal stories

Culture/Society:

- Role of the dominant culture in perpetuating systems of oppression against those outside, or challenging that culture
- Effect of cultural differences on identity formation
- Homophobia, Biphobia, Transphobia and Heterosexism
- Consciousness-raising on subtle discrimination speech in the workplace
- LGBTQI people in the military
- Religion and spirituality

Practice Skills Development:

- LGBTQI-inclusive policy changes and impact on practice
- Best practices for treatment and care of clinical behavioral-health issues of particular concern to the LGBTQI communities
- Awareness and skills for relating competently with transgender people, including appropriate practice for asking about preferred pronouns
- Challenge of conversion or "reparative" therapy
- Working with trauma associated with pathologizing sexuality and gender identity

Appendix D: Data Collection Recommendations

Based on research and consultation with Randy Sell, PhD at Drexel University, the Workgroup recommends that OMHSAS include in its intake forms and interview specific questions related to sexual orientation and gender identity.

Marriage: The Workgroup recommends that where asked, “marital status” be re-titled “family status,” and that the option of “partnered” or “in a domestic partner relationship” be added to forms or processes. “Parenting status” can be added, with the options of “parent,” “step-parent,” “co-parent,” “foster parent,” and “other.”

Sexual Orientation: Questions on sexual orientation can be drawn from a variety of sources, including those cited in Appendix E. The Workgroup recommends the addition of the following to intake forms and processes:

Sexual Orientation: I consider myself:

- Attracted to the opposite sex, or “straight”
- Gay or lesbian
- Bisexual
- Other: _____

Gender Identity: Questions on gender identity are less well-developed. The Workgroup recommends that instead of asking about “sex,” forms and processes include the following language:

Gender:

- Male
- Female
- Gender Variant
 - Transgender – Male to Female
 - Transgender – Female to Male
 - Intersex
 - Other

Appendix E: Sources and Resources

This document has drawn on the following sources, which in turn may serve OMHSAS as resources as it pursues implementation of the recommendations herein:

Healthy People 2010: Companion Document for Lesbian, Gay, Bisexual, and Transgender (LGBT) Health
http://www.glma.org/data/n_0001/resources/live/HealthyCompanionDoc3.pdf

Looking Ahead: Health Issues Affecting LGBTQ Communities: Resource List and Bios
Cosponsored by GIH and FLGI
January 24, 2008
http://www.gih.org/usr_doc/Resource_List.doc

Guidelines for Care of Gay, Lesbian, Bisexual, and Transgender Patients
Gay and Lesbian Medical Association
http://www.glma.org/data/n_0001/resources/live/Welcoming%20Environment.pdf

Teaching Transgender
National Center for Transgender Equality
http://nctequality.org/Resources/NCTE_Teaching_Transgender.pdf

The Trevor Project
Suicide prevention helpline for lesbian, gay, bisexual, transgender and questioning youth
<http://www.thetrevorproject.org/info.aspx>

The Workgroup has begun to collect additional resources for LGBTQI consumers, which can be made available to care providers.

ENDNOTES

ⁱ See Appendix B for a full glossary of terms used in this document.

ⁱⁱ These disparities are fully documented in Gay and Lesbian Medical Association and LGBT health experts, "Healthy People 2010 Companion Document for Lesbian, Gay, Bisexual, and Transgender (LGBT) Health." San Francisco, CA: Gay and Lesbian Medical Association, 2001.

ⁱⁱⁱ From OMHSAS Guiding Principles.

^{iv} "FBI Report: Anti-Gay Crimes Up." USA Today, 10/18/08.

^v "Anti-Lesbian, Gay, Bisexual and Transgender Violence in 2007." National Coalition of Anti-Violence Programs, 2008. As reported by Equality Advocates Pennsylvania, p. 48.

^{vi} "Massachusetts Department of Public Health, as reported in "Massachusetts Study Shows High Suicide Rate for Gay Teens." Boston Globe, 2/28/01.

^{vii} Website of National Center for Transgender Equality, http://www.nctequality.org/Issues/issues_hate_crimes.html

^{viii} Gay and Lesbian Medical Association and LGBT health experts, Op. Cit., pp. 212-214.

^{ix} Meyer, I. H., "Minority stress and mental health in gay men." Journal of Health Social Behavior, 1995.

^x See glossary in Appendix B.

^{xi} Gay and Lesbian Medical Association and LGBT health experts, Op. Cit.

^{xii} Quinn, Sandra Crouse, Principal Investigator, "Voices for a New Tomorrow: An Assessment of the Lesbian, Gay, Bisexual and Transgender Community of Allegheny County," Persad Center, Inc., 2003, p. 160.

^{xiii} Grossman, Arnold, Anthony R. D'Augelli, and Timothy S. O'Connell, "Being Lesbian, Gay, Bisexual, and Sixty or Older in North America." Psychological Perspectives on Lesbian, Gay, and Bisexual Experiences, 2nd Ed., Linda D. Garnets and Douglas C. Kimmel, Editors. New York, Columbia University Press. Chapter 23, pp. 629-645.

^{xiv} Hunt, Brandon, Connie Matthews, Amy S. Milson, and Julie Lammel, "Lesbians with physical disabilities: A qualitative study of their experiences with counselors." Journal of Counseling and Development, 2006. Pp. 163-173.

^{xv} U.S. Dept. of Health and Human Services, Substance Abuse and Mental Health Services Administration Center for Substance Abuse Treatments, "A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals," www.samhsa.gov page xix.

^{xvi} Davis, Mark A., "Reducing Stigma and Discrimination among People who are Lesbian, Gay, Bisexual, and Transgender," Presentation to U.S. Dept. of Health and Human Services, Substance Abuse and Mental Health Services, Center for Mental Health Services, March 12, 2008.

^{xvii} Website of Persad Center, counseling center in Pittsburgh serving the gay, lesbian, bisexual and transgender community. www.persadcenter.org

^{xviii} See in particular the American Psychological Association 2009 Policy Statement on "Transgender, Gender Identity, and Gender Expression Non-Discrimination."

^{xix} Whitman, Joy S., Harriet L. Glossoff, Michael M. Kocet, and Villa Tarvydas, American Counseling Association, "Ethical Issues Related to Conversion or Reparative Therapy." <http://www.counseling.org/Publications/CounselingTodayArticles.aspx?AGuid=4b4ac742-9a58-4086-bcff-96e925cc3599>

^{xx} American Psychological Association, "What about therapy intended to change sexual orientation from gay to straight?"

<http://www.apa.org/topics/orientation.html#whatabout>

^{xxi} *ibid.*

^{xxii} Department of Behavioral Health/Mental Retardation Services, "The State of Behavioral Health services for Lesbian, Gay, Bisexual and Transgender Persons in Philadelphia," 2007.

^{xxiii} JRI Health, GLBT Health Access Project, “Community Standards of Practice for Provision of Quality Health Care Services for Gay, Lesbian, Bisexual and Transgendered Clients.”

^{xxiv} See Appendix D for culturally sensitive questions on family status, sexual orientation and gender identity.

^{xxv} See Appendix D.

^{xxvi} Many of the definitions not otherwise footnoted are adapted from GLSEN/Gay, Lesbian, and Straight Education Network, <http://www.glsen.org/cgi-bin/iowa/all/library/record/2335.html?state=media>

^{xxvii} U.S. Dept. of Health and Human Services, Op. Cit., page xiv.

^{xxviii} Ibid., page xv.

^{xxix} Website of Intersex Society of North America, http://www.isna.org/faq/what_is_intersex

^{xxx} U.S. Dept. of Health and Human Services, Op. Cit., page xiv.

^{xxxi} U.S. Dept. of Health and Human Services, Op. Cit., page xix.

^{xxxii} Department of Education, Tasmania, Australia <http://www.education.tas.gov.au/school/health/inclusive/antidiscrimination/gender/what-is-transphobia>