

**Making the Invisible Visible:
LGBTQI2S Mental Health Consumers of Alameda
County**

Alameda County Behavioral Health Care Services

Innovations Grants

Consultation for Mental Health Analysis and Demographic Profile

Findings and Recommendations

Conducted by

Health and Human Resource Education Center

March 12, 2012

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Executive summary

In June of 2011 Alameda County’s Behavioral Health Cares Services (BHCS) issued a call for an assessment of the mental health services needs of low-income LGBTQI2S residents and an analysis of the demographics of targeted LGBTQI2S populations. The assessment is part of BHCS’s implementation of the Mental Health Services Act (Prop 63) and it’s Innovations Grant Program and has presented an opportunity to shape services with input from LGBTQI2S communities. The Health and Human Resource Education Center (HHREC), a 25 year Alameda County based non-profit agency responded to this call. We present the results of two months of inquiry in this report, *Making the Invisible Visible: A Community Assessment of Alameda County Low-income LGBTQI2S Residents*.

The story behind *Making the Invisible Visible* is the limited, almost absent data – demographic or even anecdotal—that captures the realities of LGBTQI2S populations. It has to be noted this scarcity of data is not unique to Alameda County. LGBTQI2S persons remain invisible in national and state population studies. While the US Census questionnaire included same-sex couples in 2000 and 2010, individual lesbians, gay men and bisexuals are not counted. The California Health Interview Survey (CHIS) includes self-reported sexual orientation in 2001 and 2009, the data has limitations that allow us to see only a portion of the lesbian, gay and bisexual populations. Neither the US Census, the American Community Survey, nor CHIS include questions allow for self-identification by people who are intersex, transgender or two-spirit to identify themselves as other than male or female.

In spite of limitations, these and select other national and state surveys now provide data for limited analysis of lesbian, gay and bisexual populations. According to the Williams Institute at UCLA, 4.2% of Alameda County’s population is lesbian, gay or bisexual,¹ and at least 0.3% is transgender.²

Historically the Bay Area has been a place of refuge for LGBTQI2S people. For years neighboring San Francisco has been a hub for LGBTQI2S community and the center of Bay Area LGBTQI2S activism and culture. Alameda County has been a refuge to LGBTQI2S people

¹ Gates & Ramos 2008d.

² Gates 2011.

seeking more diversity and refuge from San Francisco's high cost of living. Alameda County has the largest number of African American same-sex couples in the state of California. Berkeley, Oakland and Albany are among the US cities with the highest percentage of lesbian couples, and 22% of all same-sex couples in the county are raising children.³ Alameda County is home to the first mental health center in the country whose founding mission is to serve LGBTQI2S communities. Nevertheless, as low-income mental health consumers reported to us, there are still not sufficient resources to meet their behavioral health needs and many Alameda County LGBTQI2S persons seek community and/or services held in San Francisco.

Making the Invisible Visible focuses primarily on low-income LGBTQI2S and our recommendations reflect the needs of this population. A demographic profile of LGBTQI2S people living at or below the 200% poverty line is constructed by drawing on a range of population data. Focus groups and individual interviews with LGBTQI2S mental health consumers, and interviews with select behavioral health service providers inform this report with rich lived testimony. An extensive review of current literature on the mental health needs of LGBTQI2S populations was conducted. The report gathered information on four target groups:

1. Transitional Age Youth (16-24)
2. Adults (18-59)
3. Older Adults (60 and over)
4. Parents and Family members of LGBTQI2S persons

A network of LGBTQI2S focused mental health services providers does exist in Alameda County. The Pride Committee, composed of mental health service providers serving and advocating for LGBTQI2S mental health consumers, was the source for both service provider interviews and outreach to consumers. Consistent in these interviews was the need for more culturally responsive training for staff at every level to better serve the county's diverse LGBTQI2S constituencies. Providers and consumers alike expressed a desire for more clinicians and services providers to have training for that addresses the specific realities of low-income LGBTQI2S people and includes specific tools for understanding and addressing heterosexism, homophobia and transphobia within the racial and ethnic diversity of Alameda County.

³ LGBT Family Collaborative 2007.

Making the Invisible Visible recognizes that the letters “LGBTQI2S” encompass a range of communities composed of individuals of every sexual orientation and gender identity; a glossary in this report shares the distinction that exist for each individual “letter” and terms used in self-identification by LGBTQI2S people. In reviewing the literature on LGBTQI2S mental health we utilized an intersectional approach: looking at research that reflects the intersection of identities that involve all aspects of low-income LGBTQI2S Alameda County residents’ lives and mental health status. This intersection is particularly key when it comes to gender inequity – whether for lesbians who continue to face the economic inequities and sexism that is shared by all women, or for transgender individuals who likewise encounter gender discrimination in all areas of their lives irregardless of sexual orientation. The intersections of race/ethnicity and class with gender and sexual minority status become even more pronounced with the changing demographics and economic uncertainties in Alameda County. Nuances of identity are also revealed in the acceptance or rejection of the use of the word Queer.

Findings, Conclusions and Recommendations

An extensive review of the literature informs the composite demographic profiles of LGBTQI2S mental health consumers, and salient issues in the research on LGBTQI2S mental health inform the report’s conclusions and recommendations. Focus Group quotations in *Making the Invisible Visible* are almost verbatim and represent a hefty portion of the report. They are only edited to protect participants’ anonymity. This decision was made to give adequate space to the authentic stories that research has yet to fully address. We hope it will help the readers of this report understand the breath of LGBTQI2S mental health concerns, and the need to expand the mental health system’s view that LGBTQI2S issues are narrowly limited to “coming out” or “coping” with gender identity or sexual orientation.

The report’s recommendations are organized around the four-targeted groups. For the purpose of this Executive Summary we are listing recommendations that will have system wide impact and will ultimately better serve low-income LGBTQI2S persons in need of mental health services.

BHCS Systemic Recommendations

1. At all levels LGBTQI2S consumers and their family members must be given the opportunity if they choose to make themselves visible. This includes intake forms and

any attempts to assess utilization rates of BHCS services. Protocols and trainings must be developed to insure providers know how to implement this data collection in a respectful manner.

2. A re-examination of what it means for behavioral health organizations to be culturally responsive in terms of provider engagement skill sets, revised clinical approaches that understand the cognitive dissonance experienced by LGBTQI2S people who experience denied realities on a daily basis.
3. Development of LGBTQI2S networks of care within the broader Alameda County health care system.
4. Development a strategic plan to acquire federal, state, and public funding to expand the provision and accessibility of LGBTQI2S services throughout the County of Alameda.

Recommendations to serve the mental health needs of low-income LGBTQI2S people

1. Increase the capacity of existing LGBTQI2S focused mental health agencies to serve the diverse needs of low-income LGBTQI2S people.
2. Establish a minimum standard of cultural competency for providers that is responsive to the diversity of low-income LGBTQI2S and recognizes the impact of social oppressions on the mental health of LGBTQI2S individuals.
3. Create easier access throughout the county for mental health prevention and intervention services for low-income LGBTQI2S as opposed to the often-used crisis response.
4. Provide training to Access therapists and BHCS contracted organizations that will increase the opportunity for low-income LGBTQI2S to receive culturally competent and responsive mental health services.
5. Increase the number of diverse geographically located low-income LGBTQI2S support groups throughout the county.
6. Develop mind body spirit mental wellness approaches that include nutrition, wellness, fitness and holistic therapies as alternatives to medication.
7. Create collaborations and programs within the mental health system, similar in models to PFLAG and school based Gay-Straight Alliances.
8. Create service systems designed to respond to the cultural and linguistic needs of low-income LGBTQI2S racial and ethnic minorities.

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Introduction

This report draws on available demographic data from a range of sources in a first attempt to provide an initial composite description of one diverse segment of Alameda County—low-income LGBTQI2S mental health consumers. This composite is also informed by seven LGBTQI2S community focus groups and interviews with LGBTQI2S mental health consumers and behavioral health service providers to LGBTQI2S mental health consumer populations.

While there are no studies for Alameda County that include all lesbian, gay, bisexual, transgender, intersex or two-spirit populations, we are able to draw on existing research on other intersecting segments of low-income adults to provide an initial assessment of the mental health needs of LGBTQI2S target populations. We utilize research on low-income populations, transitional aged youth, seniors and lesbian and gay families, for example, that draw on recent statewide data such as the California Health Interview Survey that minimally includes sexual orientation (counting lesbians, gay men and bisexuals), and target population studies that take advantage of the US Census count of same-sex couples to further expand what we know about some aspects of LGBTQI2S populations.

Just as challenging as a lack of demographic data is a complete absence in the literature of the voices of LGBTQI2S low-income mental health consumers themselves in describing their experiences with the behavioral health system and their mental health needs. HHREC conducted 7 focus groups of LGBTQI2S mental health consumers in Alameda County. We present the thoughts and opinions that came out of these focus groups as an introduction into the world of LGBTQI2S mental health consumers. The purpose of the focus groups was not to obtain statistically measured data, but to hear individual LGBTQI2S mental health consumer stories that have the weight of the lived experience of a portion of a population that has been invisible for too long.

Alameda County is home to a million and a half people and is known for its diversity. Our population is actually a multitude of populations of different ethnic groups and cultures and races, who speak tens of languages and observe many different religious traditions. Alameda

County is known for its openness toward lesbian, bisexual, gay and transgender populations—Oakland has the largest population of lesbian couples of any US city, and in November Alameda County elected the nation’s first transgender judge. Nevertheless, we have a long way to go in bringing down the walls of exclusion that take the form of discrimination and stigma towards LGBTQI2S citizens. Mental health consumers, too, are a historically stigmatized population. Confronting these intersectional exclusions is an on-going struggle for the rights of all citizens to full mental health, and full participation in our county and society.

Mental health, sexual orientation and gender

The history of mental health treatment of gay, lesbian, bisexual, and transgender (GLBT) populations is an uneasy one. In the 1950s and 60s, many psychiatrists believed that homosexuality (as well as bisexuality) was a mental disorder. Gay men and lesbians were often subjected to treatment against their will, including forced hospitalizations, aversion therapy, and electroshock therapy.⁴

In 1973 the American Psychiatric Association (APA) removed the term homosexuality from the DSM-II⁵ classification of mental disorders. In theory, this meant that LGBTQI2S individuals seeking mental health support for issues other than their sexuality could now do so.⁶ The DSM classification change opened the door to shifts in thinking about gender orientation, although in 1973 the gender-related umbrella term *transgender* was not yet in use. The 38 years since the historical landmark DSM classification change have seen many shifts in social attitudes, legal status, and unevenly, mental health service provision for LGBTQI2S populations. That Alameda County recognizes these populations as underserved is itself a reflection of this history for equal rights.

The DSM change was a result of a social forces pushing for change – gay activists and lesbian, gay, bisexual and transgender mental health consumers who rejected the pathologizing of their identities as well as lesbian, gay, bisexual and transgender practitioners and allies within the APA—all within the context of a the social movements and struggles that marked the end of the

⁴ National Alliance on Mental Illness 2007.

⁵ The second edition of the *Diagnostic and Statistical Manual of Mental Disorders*

⁶ The change in the DSM-II did not end the pathologizing of sexual orientation of course, nor did it begin to address issues related to gender identity.

last century. One direct effect of this activism and the DSM change on Alameda County was the establishment of the Pacific Center. The Pacific Center, founded in Berkeley in 1973, was the first LGBT mental health services center in the country. It continues to play a unique role in Alameda County providing mental health services to LGBTQI2S communities.

While there are still disparities in access and services, and stigma and discrimination still exist, Alameda County's behavioral health professionals and mental health consumers have the capacity to continue pushing for, and creating, changes that will ensure the mental health needs of all members of our society are met.

The demographic data in this report is based on the results of the work of researchers and policy-makers studying and writing about lesbian, gay, bisexual and transgender populations in the US as well as demographic research on "other populations" (seniors, transition age youth, women, immigrants, etc) that include people who are lesbian, gay, bisexual, transgender, intersex and two-spirit. These researchers utilized population data obtained in the past ten years from three primary sources: US Census reports, the American Community Survey, and the California Health Interview Survey, and/or data obtained from smaller population samples and focus groups. Wherever possible we have attempted to cross-reference reports that drew on the same data streams. Where that was not possible we note the source. We also looked first to studies done on Alameda County, the Bay Area, and California, and secondarily to studies done on segments of LGBTQI2S populations.

Focus Groups and Interviews

Giving life and depth to the composite picture based on demographic reports and statistics are the voices of the low-income mental health consumer focus groups. These are the voices of people whose reality continues to be unstudied and unheard. HHREC held nine focus groups in Alameda County. We issued a call for participants via an email flyer that was distributed by Alameda County Pride Committee. Focus group participants received a small cash incentive of \$30 and meals were provided. The flyer was also sent to Alameda County behavioral health care providers in county agencies and community based agencies. Phone and email outreach was done via individual providers who directly serve specific LGBTQI2S populations including the

Pacific Center, Lavender Seniors, and Our Space. Focus group participants and interviewees volunteered in response to the flyer, and through word of mouth from providers and peers.

Provider Interviews

Behavioral health care providers have a unique opportunity to observe low-income mental health consumers. Phone interviews were conducted with 14 behavioral healthcare providers from agencies and community based organizations serving lesbian, gay, bisexual, transgender, questioning, intersex and two-spirit populations. They are also all members of the Alameda County Behavioral Health Care Services' Pride Committee.

Terminology

This report focuses on three sub-categories of lesbian, gay, bisexual, transgender, questioning, intersex and two-spirit populations: **transition age youth** from 16 to 20 years of age (TAY), **adults** ages 18 to 59, and **older adults** ages 60 and above. A focus group was also conducted with parents of LGBTQI2S low-income mental health consumers.

The exclusion of LGBTQI2S people from public life and public discourse means that as a citizenry we do not yet have a common understanding of the people who make up the term LGBTQI2S. Creating mental health services that are culturally responsive begins with knowing who our consumer population is. Below we share what the individual letters mean and other terms that are used in self-identification. However, it should be noted that some language can be fluid and some terminology is still contested, based on trends and social norms within LGBTQI2S populations.

Terminology

LGBTQI2S – what the letters mean

Lesbian, gay, and *bisexual* are terms that describe sexual orientation. Sexual orientation is different from **biological sex** – the anatomical, physiological and genetic characteristics associated with being male or female; **gender identity** – having to do with one’s psychological sense of being male or female; and **social gender role** – the role defined by cultural norms for “feminine” or “masculine” behavior. *Questioning* refers to the state of uncertainty about or exploration of one’s sexual orientation, gender identity, or both. *Transgender* is a term that describes gender identity. *Intersex* describes an individual’s biological sex characteristics. *Two-spirit* refers to gender roles in modern Native American and other indigenous societies, although in common usage some people may use the term interchangeably with terms for sexual orientation.

Lesbian – a woman who is romantically, sexually and emotionally attracted primarily to other women. *Lesbian* refers to sexual orientation.

Gay – a gay man is a man who is romantically, sexually and emotionally attracted to men. *Gay* refers to sexual orientation. While *gay* is an adjective that can be applied to all genders who experience same-sex attraction, it is also used to refer specifically to gay men and that is how it is used in this report.

Bisexual – an adjective describing people are romantically, sexually and emotionally attracted to both men and women. It is also commonly used as a noun, as in “I’m a bisexual”, shortened by common usage from *a bisexual person*. *Bisexual* refers to sexual orientation.

Questioning – a term most often used by or about young people who are questioning their sexual orientation, and more recently, their gender assignment or identity. In this report we will use *questioning* exclusively in our reference to transitional aged youth self-identification and literature about needs and best practices.

Transgender – an umbrella term that describes *gender identity* or *gender expression* (the way a person communicates gender identity to others – behavior, personal hair or clothing style, body characteristics). *Transgender* includes *transsexuals* – people whose gender identity is different from the sex they were assigned at birth. Some transsexuals may alter or wish to alter their bodies through surgery and hormones (called *transitioning*), including *MTF* (male-to-female transsexual), *FTM* (female-to-male transsexual). *Cross-dressers* are people who wear clothing traditionally worn by another gender in their culture. *Drag king* refers to women who dress as men for entertainment at clubs, bars or social events, *drag queen* generally refers to men who dress as women for the purpose of entertaining others at social events or clubs. *Transgender* is not a sexual orientation – transgender people may be heterosexual, lesbian, gay, bisexual or asexual. (APA 2008b)

Intersex – a term referring to 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 (ambiguous genitals), also known as *intersex* conditions. Some people with intersex conditions prefer the term *disorders of sex development (DSD)* persons, and some people feel both terms are stigmatizing. For now the common usage is *intersex*. People with intersex conditions are often subjected to medical intervention as infants and children, with doctors making decisions about their sex and gender assignment. Intersex people, their parents, and doctors may have different opinions about the need for surgery to change the appearance of ambiguous genitals, and what age it should be performed. *Intersex* people may identify as female, male, or define their gender differently. *Intersex* conditions have nothing to do with sexual orientation – *intersex* people may be heterosexual, lesbian, bisexual, or gay. (APA 2006)

Many people confuse transgender and transsexual people with people with intersex conditions because they see two groups of people who would like to choose their own gender identity and sometimes those choices require hormonal treatments and/or surgery. ... In spite of these similarities, these two groups should not be and cannot be thought of as one. The truth is that the vast majority of people with intersex conditions identify as male or female rather than transgender or transsexual. Thus, where all people

*who identify as transgender or transsexual experience problems with their gender identity, only a small portion of intersex people experience these problems.*⁷

Two-spirit – a term used by, and to describe, Native American / Aboriginal / Indigenous people who assume cross -, or multiple gender roles, attributes, dress and attitudes for personal, spiritual, cultural, ceremonial or social reasons. These roles are defined by each cultural group and can be fluid over a person’s lifetime. In this report *two-spirit* is used only in reference to Native peoples of North America and other indigenous peoples (i.e. Pacific Islanders) who self-identify as such.

Other terms

Cis-gender – the opposite of transgender, someone who is cis-gender has a gender identity that agrees with their societally recognized sex. Many transgender people prefer "cis-gender" to "biological", "genetic", or "real" male or female because of the implications of those words. Using the term "biological female" or "genetic female" to describe cis-gendered individuals excludes transgendered men, who also fit that description.

Queer – Originally a derogatory epithet aimed at gay men considered “effeminate”, *queer* was later extended in the US lexicon of hate speech to anyone perceived as homosexual or gender non-conforming. In the 1990s LGBT activists re-appropriated *queer* and a younger generation of LGBTQI2S people have embraced and popularized the term. However, not all LGBTQI2S people identify as *queer* – for many it is still an offensive reminder of hate and exclusion, for others it is too “political”.

Genderqueer – someone who rejects stereotypical and binary gender roles and lives outside of expected gender norms.

Female-to-Male (FTM) – describes the trajectory of a person who is changing or has changed their body and lived gender role from a birth-assigned female to an affirmed male. Also, trans male, trans man, or transman.

⁷ Intersex Society of North America.

Male-to-Female (MTF) – describes the trajectory of a person who is changing or has changed their body and lived gender role from a birth-assigned male to an affirmed female. Also, trans woman or transwoman.

Trans – shorthand term for a variety of transgender identities. Also, trans people or transpeople. Not a noun: a person is not "a trans"; they may be a trans person.

Straight – a heterosexual person irregardless of gender.

MSM – a man who has sex with men.

WSW – a woman who has sex with women.

Femme – a feminine-identified woman whose primary intimate relationships are with other women. May also refer to a feminine identified man or other gender.

Butch – a masculine-identified woman whose primary intimate relationships are with other women. May also refer to a masculine-identified man or other gender.

Stud – a masculine-identified woman whose primary intimate relationships are with other women.

Aggressive – a masculine-identified woman whose primary intimate relationships are with other women.

Boi – a young or youthful masculine-identified lesbian or bisexual woman; a young or youthful transgender man (FTM); a younger gay or bisexual man.

Racial and ethnic terminology

For the purposes of this report we utilized the racial and ethnic classifications consistent with most of our data sources, as follow:

African American, Black – Terms used interchangeably to refer to people of African descent who are not also counted as Latino /Hispanic.

American Indian/Alaska Native – umbrella term that includes all indigenous tribes and nations now occupied by the United States. Source terminology and abbreviations may include AI (American Indian), AIAN (American Indian/Alaska Native), Native American, Native and indigenous. When referring to populations in Canada the terms First Nations and aboriginal peoples are also used.

Asian/Pacific Islander – Many sources follow usage originally established by the US Census and use the term *Asian/Pacific Islander (API)* as an umbrella term for any one from or descended from Asia, Southeast Asia, the Indian subcontinent and the Pacific Islands. The Office of Management and Budget later separated “Asian/Pacific Islander” into “Asian” and “Native Hawaiian and other Pacific Islander”.

Multiracial – Also *mixed race*. Terms used to describe people of mixed racial ancestry.

White – term used to refer to anyone of European descent who is not also counted as Latino / Hispanic.

Demographics - Alameda County LGBTQI2S populations

LGBTQI2S is an umbrella term that encompasses a wide range of populations who are identified by sexual orientation, gender identification, or sexual anatomy.

How many lesbians live in Alameda County? How many youth are transgender? Where do gay seniors live? These are not easily answered questions. According to one of the foremost researchers of LGBT populations,

Assessing the demographic characteristics of the gay, lesbian, bisexual, and transgender population can be a daunting challenge, in part because sexual orientation and gender identification are not easily measured constructs, data are relatively rare, and the glbtq population can be reluctant to identify themselves as such in surveys...

Further, few data sources that can be generalized to the population include questions about sexual orientation, behavior, or attraction; and even fewer ask questions about gender identification.⁸

The 2000 US Census included for the first time same-sex unmarried couples – not individuals – which nevertheless has provided an initial data source for social science and policy researchers looking at lesbian, gay and bisexual populations. Numerous other population surveys, such as the California Health Interview Survey [CHIS], have begun to count some segments of lesbian, gay and bisexual populations. While these data sets are woefully incomplete – particularly in assessing the numbers of people of color, transgender and intersex people, and other minority groups – gradually researchers are developing a picture of some segments of the many LGBTQI2S populations. This report utilizes the various demographic and scholarly inquiries on lesbian, gay, bisexual and transgender populations of Alameda County and California where they exist, augmented by population-specific studies on other representative communities to form a composite picture of the diversity of LGBTQI2S populations in Alameda County.

⁸ Gates 2004.

Researchers at the Williams Institute describe the limits of data from the US Census:

[T]he Census data regarding same-sex couples do not capture all gay men and lesbians in the United States for at least two important reasons. First, the Census only captures data about same-sex couples of which one person in the couple is the partner of the householder. The Census does not identify single gay men and lesbians. Limited data make it difficult to assess exactly how coupled gay men and lesbians might differ from their single counterparts, but in the general population, single people tend to be younger, less educated, and have lower incomes than their coupled counterparts.⁹

The report also stresses that Census data likely undercounts same-sex couples since many people are still fearful of revealing their sexual orientation. In addition, the limitations of instrument wording (“unmarried partner” or “husband/wife”) that does not accurately describe many same-sex relationships means that some couples chose to leave the question blank rather than select an inaccurate category. Estimates beyond the Census indicate “the true counts are 10 to 50 percent higher than the Census figures”.¹⁰

The dearth of data on LGBTQI2S youth is even greater than data on adults. As noted above, many people are reluctant to risk identifying their sexual orientation in surveys. When it comes to youth, adults are often reluctant to consider that youth may identify as gay or questioning. And often, LGBTQI2S youth, like adults, are just not included in important population inquiries. An important Alameda County Behavioral Health Services report¹¹ on a strategic plan outlining and responding to the needs of TAY with serious mental illness provides population statistics on foster care, juvenile arrests, homelessness, community violence and poverty. Although we know that LGBTQI2S TAY are often in foster care or homeless precisely because of their sexual orientation or gender identity. The explicit absence of LGBTQI2S youth in the data presented in the report does not mean there were no LGBTQI2S transition age youth in the data sets or even the local focus groups – only that they were not seen and/or not counted.

⁹ Gates, Lau & Sears 2006.

¹⁰ Ibid.

¹¹ Alameda County Behavioral Health Care Services.

To give another example, we maintain that a study on African American seniors necessarily includes the realities experienced by African American lesbian, gay, bisexual and transgender seniors even if they are not explicitly mentioned. By marrying a report on low-income African American seniors in Oakland with research on transgender or lesbian seniors that focuses on the specific experiences of “sexual and gender minorities” we can obtain a composite picture that, while incomplete, begins to reveal what life is like for a low-income African American LGBTQI2S senior living in Alameda County.

Economic hardship is likely to have as great an impact on the mental health of lesbian, gay and bisexual populations as sexual orientation. Transgender and two-spirit people living in poverty struggle with the mental health concerns born of the instability caused by their economic marginalization. In the absence of more complete data on sexual minorities of color and transgender and intersex peoples, this report considers the magnitude of economic variables on LGBTQI2S low-income mental health consumers to be at least as relevant as sexual orientation or gender identity. While we will look at mental health risk factors for LGBTQI2S people based on their sexual orientation and/or gender identity, we believe it is important to stress that LGBTQI2S populations are as diverse as the general population when it comes to race, ethnicity, education, national origin, family relations and neighborhood. Nevertheless, low-income mental health consumers share a class reality and the risk of mental health illness simply by virtue of their economic status.

Money is the biggest problem for me right now as far as accessing mental health care. Money is a big issue in finding quality therapists and being able to find mental health support. And just to add... as we get older, mental health as well as other health issues come into play. It's little disconcerting to think what's going to happen ten years from now when I might need more care. – African/Native American older lesbian

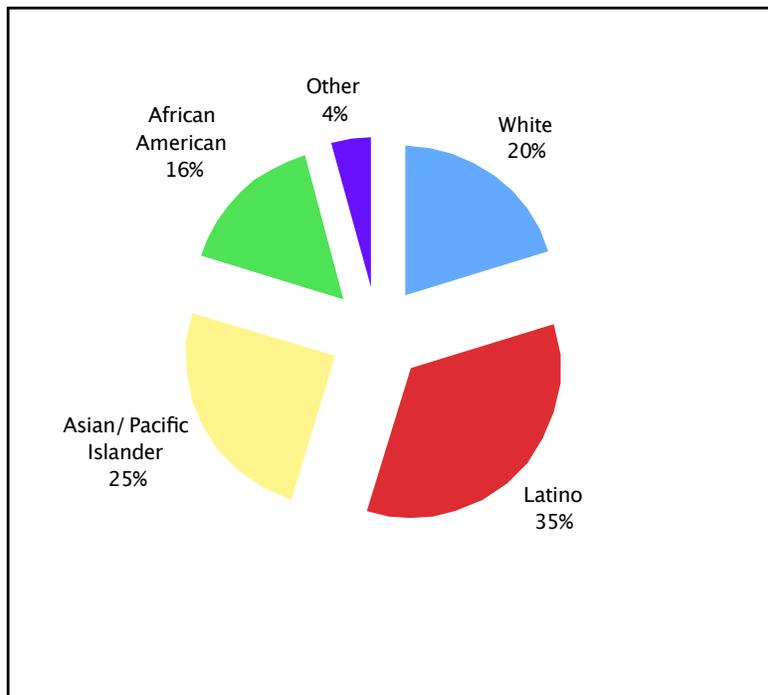
According to the Surgeon General’s Report on Mental Health, people in the lowest socioeconomic strata are about two and a half times more likely to have a mental disorder¹². In fact, in the state of California seventy-six percent of low-income adults have unmet mental health needs, and 53.9% had **no** treatment for their mental health needs. Accordingly, a majority

¹² US Department of Health and Human Services 1999.

of Alameda County’s low-income population are either mental health consumers or potential mental health consumers.¹³ Lesbian, gay and bisexual people are 4.2% of the County’s adult population¹⁴, and researchers have found that LGB people are as likely as their heterosexual counterparts to be poor.¹⁵

The pie chart below illustrates the 4.2% of the low-income population who are lesbian, gay and bisexual by race and ethnicity. 37% of Alameda County residents age 18 and over live at or below 200% of the Federal Poverty Level. Of this population, 34.5% or 101,775 are Latino, 25.1% or 74,045 are Asian or Pacific Islander, 20.2% or 74,045 are white, and 15.9% or 46,905 are African American¹⁶. The largest African American, Hispanic populations live in North County, where the proportion of gay and lesbian couples is 109% to 262% higher than the

**Low-income Lesbian, Gay & Bisexual Adults (including TAY 18-24)
by Race and Ethnicity – Alameda County – 2005**



¹³ California Health Interview Survey 2007.

¹⁴ Gates & Ramos 2008d. Based on a comparison of the US Census 2005/2006 American Community Survey (ACS) and the 2003 and 2005 California Health Interview Surveys.

¹⁵ Albelda, Badgett, Schneebaum, & Gates, 2009.

¹⁶ The numbers of Native Americans and Alaska Natives were not included in this data set, and this data does not include individuals who are homeless or living in institutions.

national average, the largest Asian populations are in South County (where same sex couples about the national average), and the largest Native population is in Central County¹⁷ where the number of gay and lesbian couples range between 39% to 113% above the national average.¹⁸ Transgender people are 0.3% of the US population. Given the that the Bay Area is a haven for LGBTQI2S people and it's higher LGB population, it is likely that the percentage of transgender people in Alameda County is likewise higher. Transgender individuals in California are transgender adults are twice as likely to be living below the poverty level, and are significantly represented in the low-income population.¹⁹ Two-spirit people are not represented in population surveys nationally or in Alameda County. The poverty rate for Native Americans, including two-spirit peoples, is three times that of any other ethnic or racial group²⁰. Intersex people are 0.5% of the population, given the absence of data on intersex people we don't know how many are likely to be low-income.

The Pacific Center, the LGBT mental health center serving Alameda County, has seen an increase in the number of people seeking support because of the economy – because of economic stress, the stress of being unemployed, the stress of having no housing. California has one of the highest levels of income inequality in the country; in Alameda County the income of the poorest residents has declined while the rate of wealth of the richest residents has increased over the past decade. Income inequality in Alameda County is stratified by race and gender – and unemployment is worse for people of color and people without a high school or general equivalency diploma.²¹

¹⁷ ACSSA 2001.

¹⁸ The Gay/Lesbian Index is derived from data provided by same-sex couples who responded to the U.S. Census Bureau's 2008 American Community Survey.

¹⁹ Transgender Law Center, 2009.

²⁰ Walters 2009.

²¹ Alameda County Social Services Agency 2001.

Adults age 18 to 59

Recent research suggests that lesbian, gay, bisexual, transgender and two-spirit populations have a greater prevalence of some mental health disorders. Gay and bisexual men show higher prevalence of depression, panic attacks and psychological distress. Lesbian and bisexual women had higher rates of generalized anxiety disorder – but not higher levels of current distress.²²

Wanting to delve further into this assertion, in 2008 King et al did a comprehensive systematic review and meta-analysis of population research conducted over a 40 year period on the prevalence of mental disorders in lesbian, gay and bisexual people.²³ They found twice the number of suicide attempts in lesbians, gay men and bisexuals, LGB people had 1.5 times the risk for depression and anxiety disorders than heterosexuals. All LGB had an increased risk for substance dependence – with lesbian and bisexual women at particularly high risk, and lifetime prevalence of suicide attempt was especially high in gay and bisexual men. Their conclusion was that lesbian, gay and bisexual people are at higher risk of mental disorder, suicidal ideation, substance misuse, and deliberate self-harm than heterosexual people.

“[M]ost studies showed a statistically significant association between indicators of poverty and common mental disorders” in low or middle income countries. Poverty is associated with increased prevalence of mental disorders, increased severity of mental disorders, and a longer course of illness and worse outcomes. In examinations of minority stress in communities of color in the United States, factors such as income insecurity, unemployment, and presence of violence are suggested factors (structural racism) that contribute to mental distress, anxiety and PTSD. However, in spite of the Surgeon General’s report concluding that low-income people are two and a half times more likely to have a mental illness, very little research – and therefore very little program alternative development – has been done on the association between income and mental illness.

A study aimed at defining mental health needs for Black patients with AIDS in Alameda County concludes that there is a need for ethnically sensitive psychiatric services for Black AIDS patients (39.8% of AIDS cases in Alameda County). The researchers found no difference in

²² Cochran, Sullivan, & Mays, 2001.

²³ King M., Semlyen J., Tai S.S., Killaspy H., Osborn D., Popelyuk D., & Nazareth I., 2008.

prevalence between Black and White patients – however, the patients in the study were all low-income, as well as having the combined health factor and stigma factor of AIDS. $\frac{3}{4}$ were bisexual or homosexual.²⁴

In Alameda County, 6,215 people are homeless on any given night – while over 30,000 County residents with mental illness have incomes that put them at risk of homelessness. There are nearly 1,000 people with mental illness homeless on any given night in Alameda County. Transgender adults and TAY, and LGBT TAY are % likely to be among the homeless. A majority of TAY seeking services at the Pacific Center are also looking for housing – given their lower earning ability and the fact that Alameda County is one of the top 10 least affordable housing markets in the US. 7.1% percent of US adults with serious mental illness were unemployed, compared to 5.6% SMI for adults employed part time and 3.6% for full time employed adults.²⁵

The primary obstacle to mental health treatment cited by our LGBTQI2S focus group participants was financial. It is important to note, therefore, that people of color in Alameda County have lower rates of health coverage, according to a county-wide survey.²⁶ Latinos have the highest uninsured rates (40%), followed by non-Latino whites (African Americans (17%) and American Indians / Alaska Natives (17%), Asian Americans and Pacific Islanders (15%) and non-Latino whites (8%).²⁷

African American lesbian, gay and bisexual population of California

There are approximately 55,000 lesbian, gay and bisexual African American adults in the state of California, or 3.2% of the state's African American population. African Americans are 6.4% of the LGB population of California. 57.3% of this population are male, 42.7% are female. The ages of African American LGB Californians are 11.9% 18-24 (TAY), 34.8% 25-39 years, and 52.8% 40-64 years.

²⁴ Hargrave, Fullilove, & Rullilove 1991.

²⁵ SAMSA.

²⁶ Ponce et al, 2001.

²⁷ Ibid.

Economic status

The percentage of African American LGB adults who are employed (74%) exceeds that of African American heterosexual adults (64%). African American LGB adults are more likely than African American heterosexual adults (36% versus 25%) [say something about the limitations of surveys missing people with lower education, homeless, “disconnected” and in jail or detention]. The median earnings of black men in same-sex couples in California are \$47,000 versus \$44,000 for Black men in heterosexual couples. However, gay/bisexual men have a median household income of \$25,000 compared to \$45,000 of black heterosexual males. Lesbian/bisexual black women have a median household income of \$45,000 versus \$35,000 of heterosexual black women. Black LGB people, like black heterosexual people, are less likely to own their own homes.

Raising children

Approximately 11% of African American men and 55% of African American women in same sex couples are raising children under the age of 18 – with fewer economic resources than heterosexual couples. African American same sex parents have a median household income of \$60,900 compared to \$76,000 for African American married couples. 29% of African American LGB parents own their own home versus 63% of black heterosexual parents.

Military status

23% of Black men and 5% of black women in same sex couples are veterans. Overall, 11% of black gay and bisexual men and 14% of black lesbian and bisexual women have served in the military.²⁸

Latino/a lesbian, gay and bisexual population of California

There are approximately 200,000 lesbian, gay and bisexual Latino/as in California – 2.4% of Latino/a adults. 53.4% are male, 46.6% are female. Latino/a LGB population is young -- 77% of latina/o lesbians, gay men and bisexuals are under 40 years of age. The age distribution of LGB Latinos/as in the state of California is 30.5% 18-24 years (TAY), 46.8% 25-39 years, and 22.1% 40-64 years.

²⁸ Ramos & Gates 2008b.

Citizenship and country of origin

Forty percent of LGB Latinos/as are likely to be a foreign citizen. Over 81% of Latinos/as in same-sex couples are of Mexican descent 15% are from Central America and 4% from other Latin American countries.

Education and income

Of the lesbian, gay and bisexual Latinos/as responding to the surveys, 25% have a college education compared to 9% of heterosexual Latinos/as. 69% of Latino/a LGB adults are employed – versus 67% of Latino/a heterosexual adults. Gay and bisexual Latinos have a median household income of \$35,000 and lesbian and bisexual Latinas have a median household income of \$45,000. This is higher than the \$25,000 median household income of heterosexual Latinos/as. However, for LGB individuals, earnings are 20% less than heterosexuals – Latinos/as in same-sex couples have median individual earnings of \$25,100, compared to the \$32,000 median individual earnings of Latinos/as in heterosexual couples.

Home ownership

38% of lesbian, gay and bisexual Latinos/as own their own home, compared to 42% of Latino/a heterosexual homeowners in California. 45% of Latinos/as in same-sex couples are home owners, compared to 60% of heterosexual Latinos/as. Latino/a LGB parents have fewer financial resources and only 36% own their home, compared to 57% of Latino/a heterosexual married parents.

Raising children

50% of Latinas and 43% of Latinos in same sex couples are raising children (Latino/a LGB adults are raising over 24,948 children in California), compared to 72% of married heterosexual Latino/a couples. Among Latino/a LGB individuals, 12% of men and 35% of women are raising children. The average household income of Latino/a same-sex parents is \$49,385 – compared to \$63,017 household income of Latino/a heterosexual married couples.

Military service

6% of Latinos in same-sex couples are veterans and 1.4% of Latinas in same-sex couples have served in the military.²⁹

Asian / Pacific Islander lesbian, gay and bisexual population of California

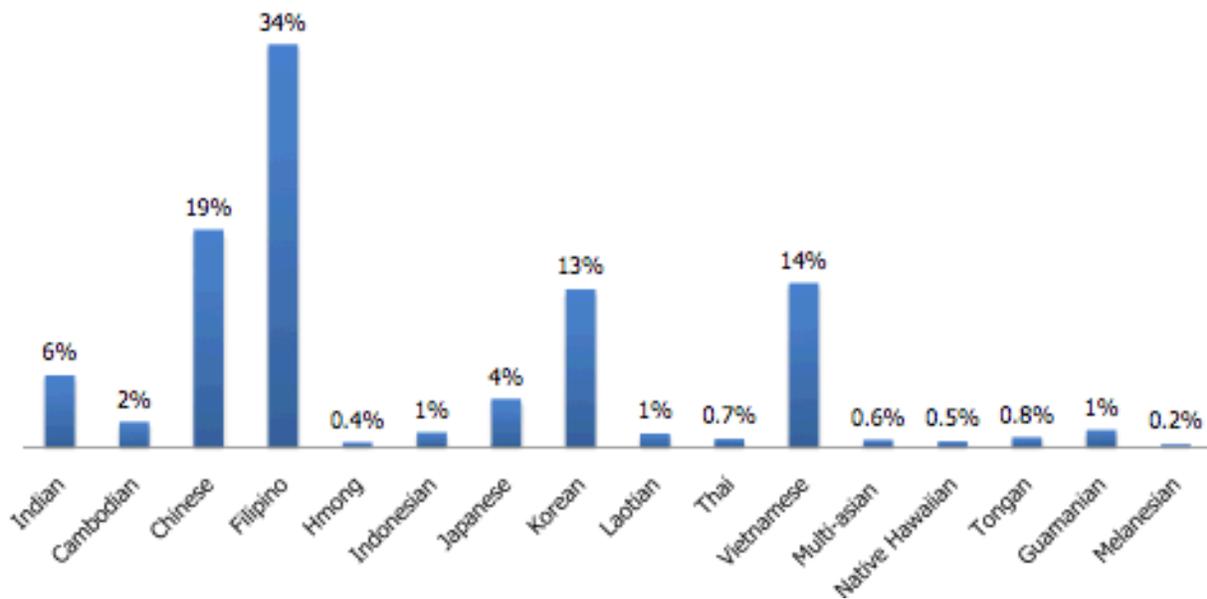
There are 66,000 lesbian, gay and bisexual Asians and Pacific Islanders in California, and more than 14,500 APIs who are in a same-sex couple. 42% of the LGB API population is female and 58% of the LGB population is female. The lesbian, gay and bisexual API population is young – 74% are under age 40. The overall age distribution of lesbian, gay men and bisexual API adults in the state of California is 15.1% are age 18-24 (TAY), 59.3% are age 25-39, and 24.8% are age 40-64.

Country of origin

40% of APIs are born in the US (compared to 20% of heterosexual APIs). The nationalities of APIs in same sex couples are Filipino (34%), Chinese (19%), Korean (13%) and Vietnamese (14%), other ethnicities shown below.

²⁹ Ramos & Gates 2008c.

Country of Origin - Asian/Pacific Islanders in Same-Sex Couples



Education and income

61% of lesbian, gay and bisexual APIs have a college degree, compared to 52% of heterosexual APIs. 76% of API LGB adults are employed, compared to 68% of heterosexual APIs. The median household income of API lesbian and bisexual women is \$35,000. The median household income of API gay and bisexual men is \$45,000. The median household income of heterosexual API men and women is \$55,000.

Raising children

31% of API women and 21% of API men in same-sex couples are raising children, compared to 55% of married different sex couples raising children. Of API individual LGB adults, 8% of men and 28% of women are raising children. While the average household income of API same-sex parents is \$96,290, there is a wide gap of the income level between Asians, South Asians and Pacific Islanders of different ethnicities. 69% of API same-sex couples own their own homes, compared to 71% of heterosexual API couples.

Military service

3% of API gay and bisexual males have served in the military compared to 7% of male heterosexual APIs; less than 1% of API women in same-sex couples are veterans.

Intersex adults

This section is a modified version of Being Accountable to the Invisible Community: A Challenge for Intersex Activists and Allies, by Emi Koyama³⁰

Technically, intersex is defined as "congenital anomaly of the reproductive and sexual system." Intersex people are born with external genitalia, internal reproductive organs, and/or endocrine system that are different from most other people. There is no single "intersex body"; it encompasses a wide variety of conditions that do not have anything in common except that they are deemed "abnormal" by the society. What makes intersex people similar is their experiences of medicalization, not biology.

Despite the fact that there are tens of thousands of intersex people in this country, only a small number of people have publicly come out as "intersex." Where are the rest of intersex people?

Some do not know that they have an intersex condition, either because they have not been properly diagnosed or have not been told by their doctors and parents about their condition. Some do know about the condition that they have, but do not know that their condition may be considered part of intersex. Some reject the term "intersex" because of its negative association with "hermaphrodite" and other freaky imagery. For many, intersex is a site of pervasive physical and sexual violation, which they do not want to re-visit at all. Some wish to push away intersex as something that has happened in the past. Some are struggling hard just to stay alive. Some feel isolated and alienated by everyone around them, and do not feel that it is possible to "come out."

When we talk about intersex, we are talking about a lifelong history of shame, secrecy and isolation that are imposed on children who were born with slightly different bodies. We are talking about childhood sexual trauma, dirty family secret, repeated stripping in examination rooms, and the knowledge that whatever body you were born with was defective on arrival. It is not surprising that most people born with intersex conditions do not identify as "intersex" either publicly or privately.

30

As a result, the demographics of the few intersex activists who "come out" is skewed to be: mostly white, often college-educated, often LGBT or genderqueer (because queer people are already familiar with the process of coming out and doing activism, and also because they are more willing to go outside of standard sex/gender categories). This group, however, does not necessarily represent the rest of the people who are born with intersex conditions.

As an ally, you will not get to hear from 99% of the people you are working to advocate for. Your best guide, aside from what "out" intersex activists will tell you, is your common sense.

Common sense should tell you that intersex people are regular people just like everyone else. Some are male, some are female, and there are few who explore alternative gender categories, just like the non-intersex population. Some are gay or lesbian, some are bisexual, and some are straight. It makes no sense to assume that someone is gay or transgender because s/he is intersex, because a) there are gays and transgender people who aren't intersex, and b) there are intersex people who are not gay or transgender.

Common sense should tell you that whether or not one's genitalia matches her or his gender identity is not the only thing that matters. The problem with the intersex surgery is that it's harmful and in violation of the child's right to self-determination. The risk of assigning the "wrong gender" is not the only argument against this surgery, nor is it the biggest one.

Most intersex people live happily as women or men just like everyone else, although they may be unhappy about the shame, secrecy and isolation that were imposed on them through medicine. Use your common sense and focus on how to improve the lives of people with intersex conditions now and in the future. Ask us questions, but sometimes be willing to question the answers coming from the few "out" intersex activists including myself.

Intersex activists are working to replace the current model of intersex treatment based on concealment with a patient-centered alternative. We are not suggesting that intersex babies are better off left alone; we want there to be social and psychological support for both the parents and intersex children so that they can deal with social difficulties resulting from being different than others. In the long-term, we hope to remove those social barriers through education and raising awareness.

Is intersex part of the "transgender" community?

While some people with intersex conditions also identify as transgender, intersex people as a group have a unique set of needs and priorities beyond those shared with trans people. Too often, these unique needs are made invisible or secondary when "intersex" becomes a subcategory of "transgender."

For example, people who talk about intersex in the context of transgender often stress the risk of assigning a "wrong" gender as an argument against intersex genital surgeries. While this is a valid concern, it overlooks the fact that intersex medical treatment is painful and traumatic whether or not one's gender identity happens to match her or his assigned gender.

It is for this reason that we prefer to have "intersex" spelled out explicitly rather than have it "included" in "transgender" umbrella.

Transgender adults

Worldwide estimates for transwomen are 1 in every 30,000 people. Transmen are estimated at 1 in every 100,000 people. (1, 2) However, these numbers are likely an underestimate because they only account for trans people diagnosed with Gender Identity Disorder and/or people receiving services at gender clinics, which we know are not inclusive of all trans people.³¹

Transgender people are 0.3% of the US population – and it is likely that the transgender population in Alameda County is higher. Transgender individuals in California are transgender adults are twice as likely to be living below the poverty level, and are significantly represented in the low-income population.³² According to the National Center for Transgender Equality, one in five transgender people have been homeless at some time in their lives because of discrimination and family rejection; and one in five transgender people in the US have been refused a home or apartment because of their gender identity. Transgender youth are particularly vulnerable – According to staff at Our Space, transgender youth have reported they feel safer living on the street than in a homeless shelter or some foster situations where the threat of violence and transphobia is constant. Living with this kind of discrimination is devastating to mental health.

Transgender youth make up Almost 1 out of 3 transgender participants in a San Francisco study had attempted suicide, associated with gender-based discrimination and victimization. Other studies have reported that 43 – 60 percent of transgender people struggle with depression. And yet accessing mental health care is a major challenge for transgender people.³³ The Pacific Center in Berkeley says that the number of transgender individuals seeking mental health services has quadrupled in the past two years. While the Pacific Center has a sliding scale for individual therapy and several peer led support groups, the range of mental health needs of transgender clients is greater than their scope of services. Both providers and low-income transgender consumers in Alameda County report that behavioral health resources for transgender people are few.

³¹ Center of Excellence for Transgender Health.

³² Transgender Law Center, 2009.

³³ Healthy People Transgender Health Fact Sheet.

The intersection of bias against transgender people and structural racism is particularly challenging for transgender people of color. According to the APA, transgender people of color generally fare worse than white transgender people, and African American transpeople have the greatest challenges.³⁴ Because the state (Medicaid systems, juvenile detention systems and foster care) regulate gender, the more contact people have with these agencies, “the more they are pressured – or forced, in the case of those in the criminal justice system and residential settings for youth – to comply with traditional gender norms”.³⁵

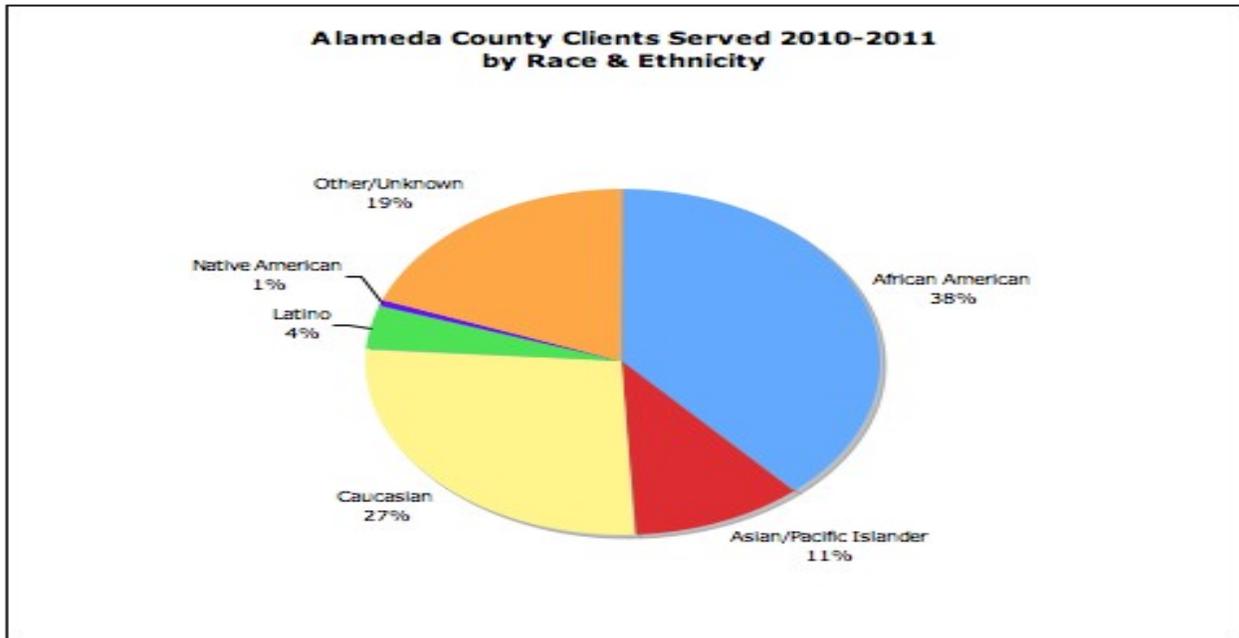
³⁴ APA 2008b.

³⁵ Currah & Spade, 2007.

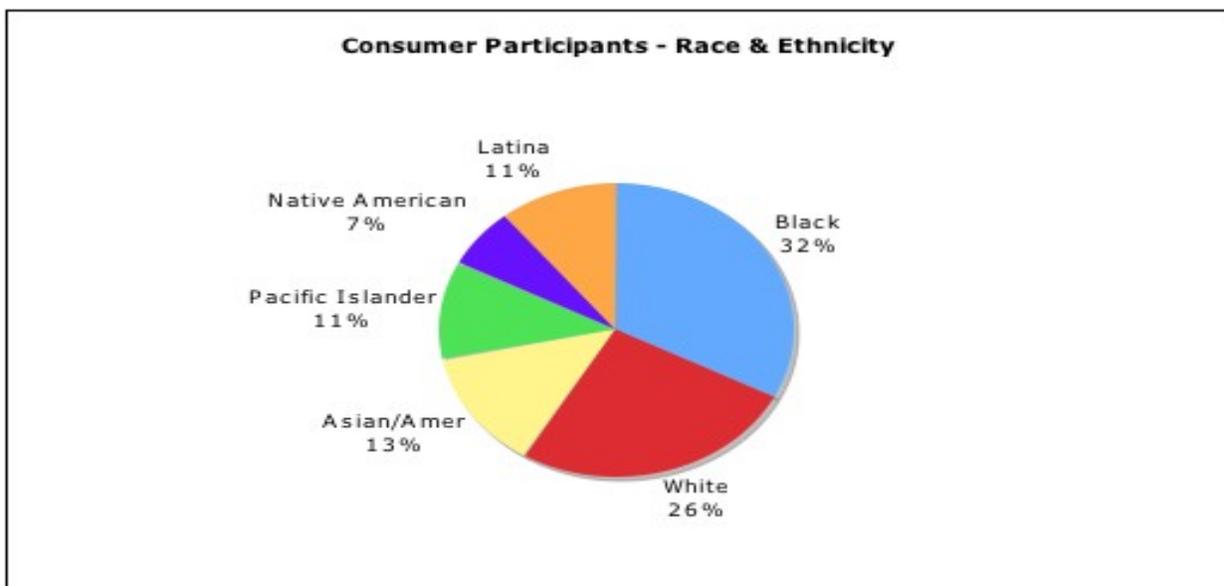
Consumer focus groups and interviews

Consumer participant demographics

Alameda County served 30,085 unduplicated low-income mental health clients in FY 2010-2011. 37% of County clients were African American, 27% Caucasian, 11% were Asian and Pacific Islander, 4% were Latino, 0.67% were Native American, and 19% were Other/ Unknown.



The consumer focus groups were not designed to constitute a statistically representative sample of the demographics of Alameda County low-income mental health consumers. Nevertheless,

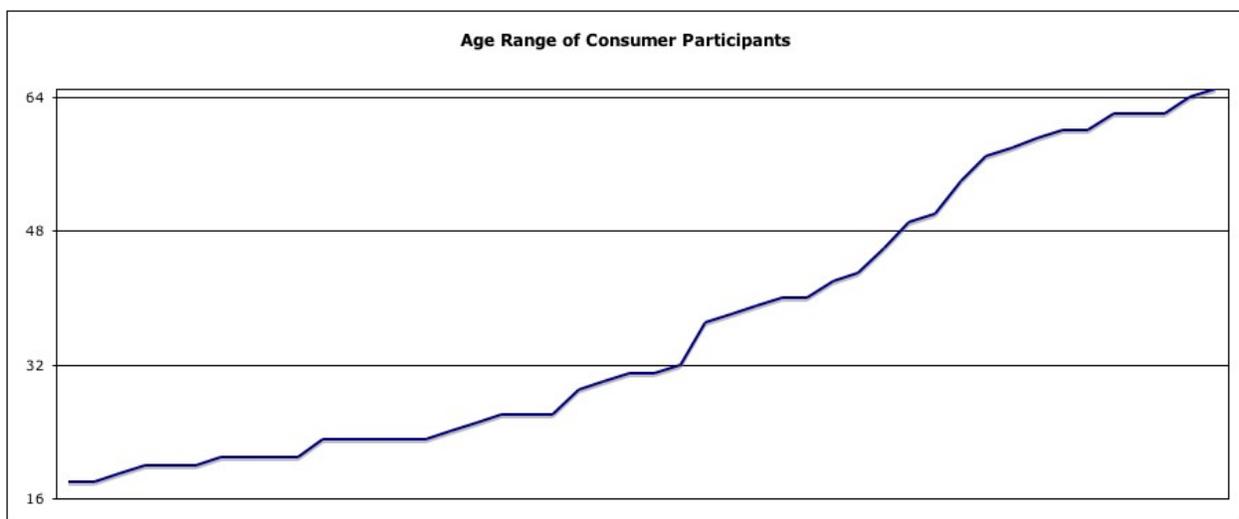


the LGBTQI2S consumer participants’ racial and ethnic identifications provide a broad reflection of the cultural diversity of Alameda County’s client base.

Consumer participant age range

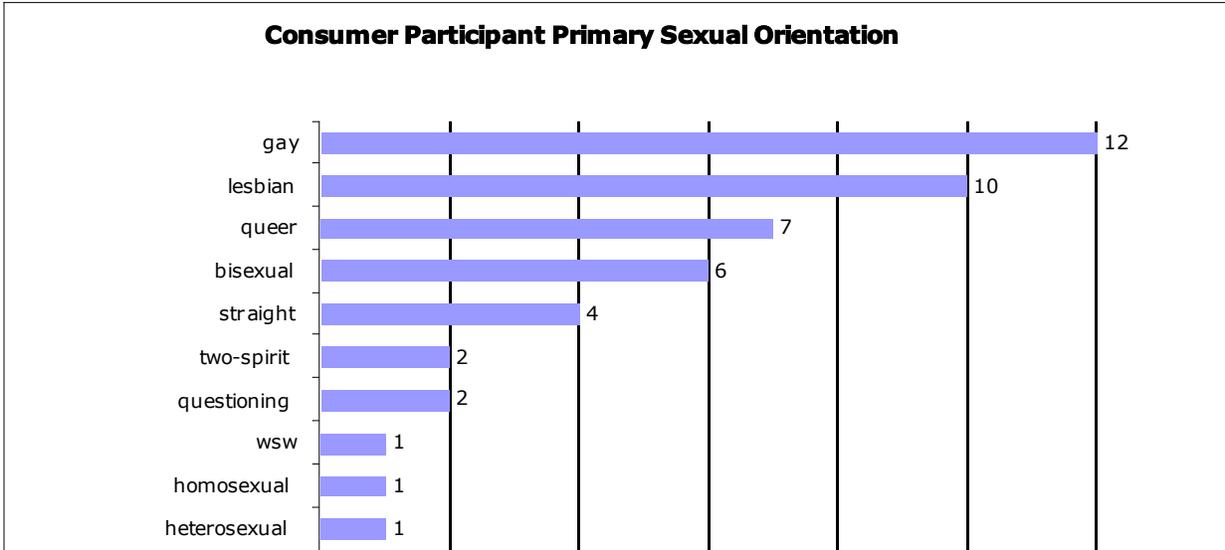
The age range of participants for the study’s four consumer target groups were:

1. Transitional Age Youth (16-24) – 16 total, 8 in TAY focus group
2. Adults (18-59) – 19 consumer respondents in non-TAY focus groups, 36 in total
3. Older Adults (60 and over) – 3 consumers in Senior focus group, 4 in total
4. Parents and Family members of LGBTQI2S persons – 4 in focus group, 6 total



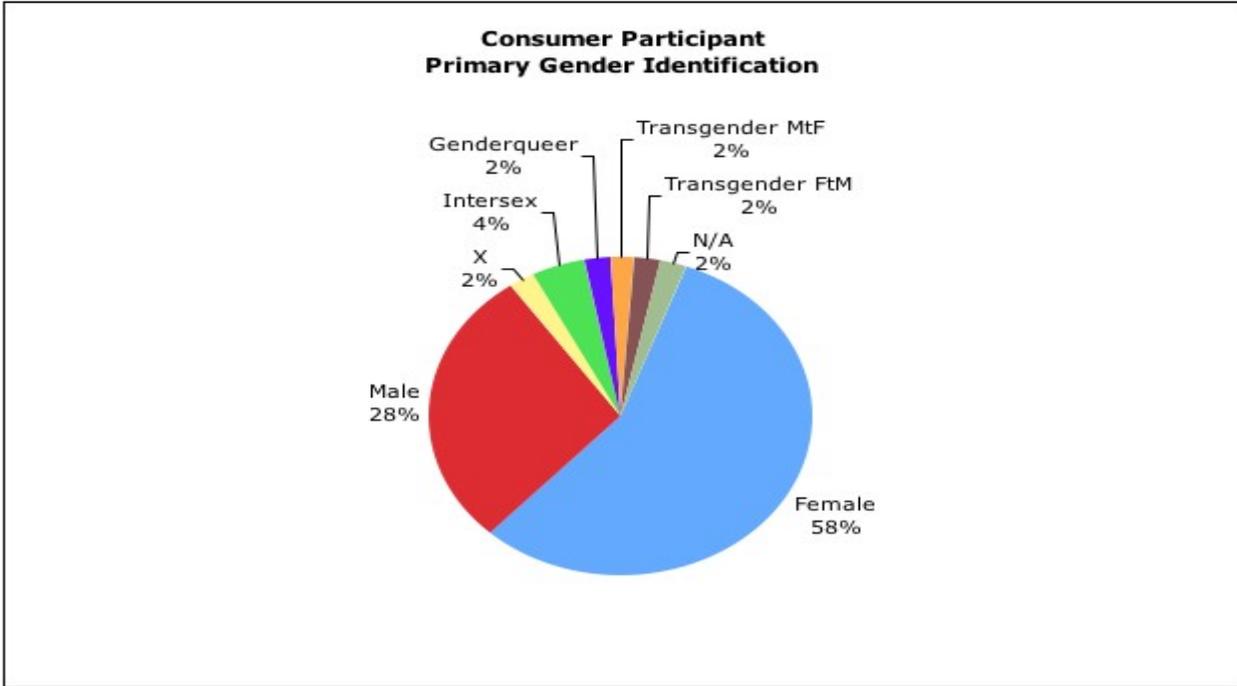
Consumer participant sexual orientation

Consumer participants were provided space to write in the sexual orientations they identified with – using their own words. 12 of 46 participants identified their primary sexual orientation as gay; 10 participants identified their primary sexual orientation as lesbian; 6 participants identified their primary sexual orientation as bisexual; 7 participants identified their primary sexual orientation as queer; 2 participants identified their primary sexual orientation as questioning; 3 participants identified their primary sexual orientation as two-spirit; 1 participant identified their primary sexual orientation as WSW (woman who has sex with women); 1 participant identified their primary sexual orientation as homosexual; 1 participant identified their primary sexual orientation as heterosexual; and 4 participants identified their primary sexual orientation as straight. Twenty-eight participants identified with two or more sexual orientations.



Consumer participant primary gender identification

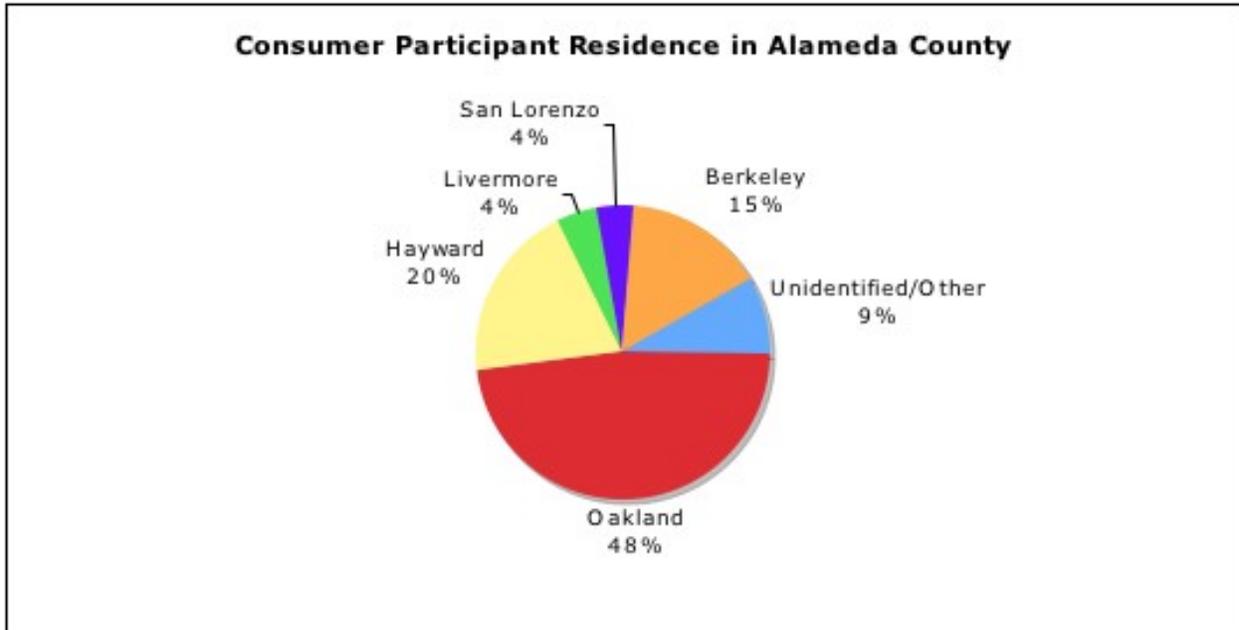
Twenty-six participants listed their primary gender identification as female, 13 participants listed their primary gender identification as male, 1 participant listed their primary gender identification as “X”, 2 participants listed their primary gender identification as intersex, 1 participant listed their primary gender identification as genderqueer, 2 participants listed their



primary gender identification as transgender, and 1 participant stated “N/A”. Six respondents identified with two genders, and two respondents identified with three genders.

Consumer participant city of residence

A majority – 22 – of consumer participants were residents of Oakland. 9 participants resided in Hayward, 7 in Berkeley, 2 in Livermore, 2 in San Lorenzo, and 4 in Unidentified/Other.



Behavioral health needs of low-income LGBTQI2S adult consumers

Focus group participants and interviewees were asked to share what programs or services they currently use to meet their needs as a mental health consumer, what medications/alternative therapies they use, and what the greatest challenges or barriers are to getting their mental health needs met. (See Focus Group Questions, Appendix A). Overall, the consumers in this study were very pro-active in caring for their mental health. Navigating the behavioral healthcare system, seeking and accessing therapy and support, managing medications and alternative therapies, and traveling to providers requires a substantial investment of time, energy and financial resources.

Accessing mental health service providers

Many consumer participants were currently seeing an individual therapist and/or other mental health provider from a range of provider-agencies in Alameda County and San Francisco. Eleven respondents are current Alameda County behavioral health clients. Other behavioral health

service providers currently being used by the consumer respondents are: Alameda County, Pacific Center, Center for Independent Living, Our Space, Native American Health Center, Kaiser, Lifelong Medical, San Francisco Department of Health, UC Berkeley Student Counseling Services, employer's EAP, Alta Bates, Arc of Refuge, Fairmont, Asian Health Services, and individual therapists in private practice.

Alternative therapies

Most participants utilized support groups for mental health maintenance. These include Alcoholics Anonymous and Narcotics Anonymous, as well as peer-support groups at the Pacific Center, *Be Present* empowerment support groups, a gay men's group at Kaiser, and a transgender group at Aids Project of the East Bay; youth depend on supportive programs at Our Space, Beyond Emancipation, LYRIC, LAMBDA. Culturally specific support groups and services play an important role in mental health maintenance for many of the consumer respondents – whether provided through traditional mental health providers or other Alternatives to talk therapy and medications mentioned by respondents included meditation, yoga, somatic therapy, acupuncture, traditional healing including ceremony, marijuana, and massage. Respondents in every group talked about using art, music, dance, gardening and running for their mental health maintenance.

Barriers to mental health care

Access... especially if you're on limited income and I don't have a car anymore. So getting around is hard. When I last had a job and I was underemployed I couldn't take time off to see a therapist.

The greatest barriers or challenges to obtaining needed mental health services that consumer participants identified were:

- financial
- insurance
- cultural competency of providers
- discrimination
- geographic access

- stigma
- information and choice about medications

Financial

Money is the biggest problem for me right now as far as accessing mental health care. Money's a big issue, in finding quality therapists and being able to find mental health support. And just to add... as we get older, mental health as well as other health issues come into play. It's little disconcerting to think what's going to happen 10 years from now when I may need more care. So financial issues.

When I ran out of my health insurance a year and a half ago, I was so sick. We need help transitioning on and off insurance... because there might be a gap and it makes you really sick.

In every focus group and interview, participants stated that the primary barrier to obtaining the behavioral health services is financial. Finances affect the ability of consumers to pay for services – for seeing a doctor or other provider, for counseling, for medications and other therapeutic modalities. Income impacts whether they can afford transportation to appointments and the pharmacy. Because of the shortage or absence of LGBTQI2S competent providers, finances will determine if a consumer can see a provider in private practice. For low-income mental health consumers, having limited economic resources limits, and sometimes prevents, critical access to care.

I want to do acupuncture. Even getting a massage would be great... there's different kinds of bodywork. It would just be great if there was a lower class or sliding scale service. If I had benefits I could take advantage of these things.

I have to go all the way to Lyon-Martin Community Health in San Francisco. I've looked in Alameda County and haven't found the services that I need over here. Comprehensive services for transgender people. For a while there was an initiative to start a weekly trans clinic and a few clinics were being looked at for that, but the project fell through.

Culturally appropriate and responsive providers

I had a flashback and I had to be hospitalized 15 years ago. The physician was doing his assessment and going thru my demographics... I was in this domestic violence relationship and the doctor said, "you know your people and his people traditionally don't get along." My partner at that time and my son's father was black. That had nothing to do with why I was there. I had tried to kill myself. I felt disrespected and insulted.

Finding culturally appropriate and responsive providers is an on-going challenge for LGBTQI2S consumers in Alameda County. Participants talked about the difficulty of finding providers that are knowledgeable about LGBTQI2S cultures including TAY-specific concerns; who are not only knowledgeable about the cultures of people of color but about the realities of living with racism and ethnocentrism for LGBTQI2S people. Transgender consumers encountered transphobia even in spaces serving lesbians, bisexuals and gay men, and women still encounter sexism.

When I was in San Francisco it was easier to find a therapist. They were open and they understand that I'm a same-gender loving man. In Alameda County it's a whole other thing—it's harder in Oakland. It's like "you're African American and you're gay?"

A lot of times if I'm seeing a professional I want someone who looks like me...like if I'm seeing a straight person they don't get the dynamics of queer relationships. It's also the same for women of color. I feel that if I'm paying for it, I should be able to get what I want. And then sometimes [the therapist] gets overwhelmed by my issues, and things get messed up.

I was in therapy with a lesbian therapist. I had to end therapy with her because she couldn't wrap her head around my family issues and the African American experience. It was a communication problem. There's culture. There's sexuality. I should just be able to share what I'm feeling and where I am at the moment, even if I don't fit inside a box. I feel resentful about providers... me spending my money when I have spend all these sessions giving them the backstory.

Discrimination

Consumer participants experienced discrimination in the behavioral health system both as LGBTQI2S clients, and as people of color and/or immigrant status.

There was one provider that I found thru an EAP program at a previous job. I needed to seek counseling after a physical assault. I went there in crisis and also continued to see the therapist. I was also coming out at this time. The therapist wasn't supportive. At the time was preparing for breast reduction surgery. There was a lot going on with me regarding the physical and mental thing around body image...my dealing with internalized sexism. I needed support around having that surgery and I did not feel supported by the therapist.... it was the last time I saw that therapist. It took another year to re-enter into a therapeutic relationship. I felt really judged and it made me fearful of any future therapy. I felt like I wouldn't be able to be my full self as a queer woman of color whose parents are immigrants. With that therapist I didn't feel that I could talk about oppression.

Once a consumer has experienced discrimination they become wary of seeking help again, sometimes to the detriment of their health.

I've been in and out of NA. I graduated from Walden House. I've been around a while. When I see myself needing help I look for it. But in Alameda County with HIV and mental health issues together, I don't feel that I'm welcome to the groups.

Every participant in the Gay Women's focus group and the Two-spirit Focus Group reported that their mental health is affected by the discrimination they experience as lesbians, as women, and as women of color.

I think discrimination makes a lot of us in the community depressed. I came out at 16. I was kicked out of church. My uncle threatened to kill me and my girlfriend [because we were lesbians].... I haven't had the money to go to therapy. I have self-medicated. I had drug issues, it's all in check now. But there was a lot of time where I was incredibly depressed.

My company had therapy through EAP and I took advantage of it. I was very depressed and suicidal. [The therapist] was nice until I started talking about my relationship. She was very homophobic. The feeling was visceral. I filed a complaint with EAP. But I stopped going to therapy for a while.

I grew up Mormon. I knew I was queer when I was 5. So I knew I wasn't going enter the Kingdom of God at age 5. So I was a bad little kid, I was going to hell anyway. Your sexuality is always with you. I don't get bothered.... you just walk around with that, knowing that people will kill you.

Coming from Korean culture, where you're expected to be tough and macho. I didn't quite live up to that. I wouldn't say I'm completely effeminate...but somewhere in the middle. They expect you to be really masculine, and if you aren't then you are looked down upon and thought of as really "less than". Or less than human... It's hard to take when you're not fully respected.

Access

Here in Alameda it's the uncertainty with the agencies, are they going to be there tomorrow—through no fault of their own. I like going to Fairmont. We used to have a men's group, but the facilitator had to cut her days back. The squeezing and squeezing because of the funding, I am worried about the services being there.

Geographic access presents another considerable barrier to getting behavioral health services – the LGBTQI2S-specific mental health providers that are affordable to low-income consumers are limited to the Pacific Center in Berkeley and Our Space and Lambda for LGBTQ transition age youth in Hayward. LGBTQI2S seniors trying to access geriatric mental health services close to home do not have many options. There are no transgender-specific mental health services in Alameda County – those who are able travel to San Francisco.

Since I've lived over here in Alameda County, my primary medical doctors are in San Francisco. They are at the VA where I was diagnosed in 1983. There's no way I am

going to give up my doctor. It's unfortunate...that's the way the system is set up here. I wanted to go to Fairmont, but they said no because my doctor is not there. I think it's unfortunate.... They don't get to count me at Fairmont because they don't get the dollar.

I currently go to meetings at LAMBDA. Although with the winter and no car ---it's hard getting around.

Stigma

Mental health stigma presents a challenge when family members – whether family of origin or family of choice – do not understand mental illness and are not only unsupportive but condemning of the person seeking behavioral health care. When mental health consumers feel they have to conceal their mental health status from their friends and community, it presents a barrier to making healthy decisions about treatment.

My family... thinks that it's a sign of weakness. "You got to be strong." "You need to keep your head up." If I were to seek a counselor I would need to get past my family.

There's a huge overlay of like people of color walking though the world... native people and historical trauma... intergenerational trauma... alcoholism... it takes a lot of energy and effort and consciousness to break out of that cycle.... Understanding that cycle and being able to name things is important. I thought I was crazy because I'd think about my grandfather and how he became an alcoholic and how he treated my grandmother.

Stigma keeps me from being who I really am.

Several consumers talked about the stigma associated with taking medication, causing distress with family members, peers, and health providers.

I felt shame during that time around accessing mental health services because of the stigma in my house. Taking the medication just added to the stigma that I felt from my family. I also had fear around using anything that would alter my 'healthy self' in any way.

Medication: information and choice

It would be helpful to have more information in general about what anti-depressants are and how they interact with other medications. And more anecdotal stories about how long people stay on medications, problems, the gains, being able to talk with other patients who are taking medications and how they work for them.

At least half of the consumer participants had experience with psychiatric medication in the treatment of depression, anxiety, and bipolar disorder³⁶. There was universal frustration with the cavalier attitude of some providers when prescribing medication, often prior to developing a complete treatment plan.

When I left Walden house, I went to San Francisco General Hospital to see a therapist there. He immediately prescribed thiorazine, without even knowing me. I refused to take it. I've been an advocate for the 3-visit rule with any psychiatrist. Only after the third visit do you negotiate your meds.

Consumers want education prior to medication: including detailed information about the medications being prescribed – what they are for, if there are potential side effects, what alternative therapies might also be available.

I take a bunch of different kinds of anti-depressants. I was really scared to stop. I put it off for about 7 years. I got the meds from a therapist who'd only seen me for about 10 minutes and then wanted to put me on meds.

Participants talked about the effects of discontinuing their psychiatric medications, and not having sufficient information about the effects of withdrawal. In every focus group we heard about the complexity of challenges to negotiating medications when a client loses insurance coverage or when there is an abrupt change in their income.

³⁶ Medications respondents said they were currently prescribed: Lithium, Depakote and Zyprexa for bipolar disorder; Celexa, Paxil, Prozac, Zoloft, and Welbutrin for depression and anxiety.

Balancing the side effects of mood stabilizers and antidepressants was a major challenge for consumer respondents who identified as bipolar.

I take lithium. There are two sides—the positive is that it helps my manic episodes. But it also makes me feel depressed. I don't want to add more medications to deal with the depression. Lithium and depression, there is nothing that can make treatment easier.

A number of people talked about the importance of diet, along with or instead of medication. Being low-income presents a challenge to maintaining a healthy diet. Respondents reported that it is often difficult to find healthy foods close to home, and that the cost of healthy foods and supplements is prohibitive.

I do not take any meds for mental health needs. I primarily avoid sugar and try to exercise regularly. It's difficult to do because the lack of access to healthy foods and nutrients for low-income people is a challenge. Eating lots of processed food actually makes me feel really down. It would make it easier if there were more local supportive resources... I stopped seeing my therapist because I couldn't afford it.

Mental health services that are designed specifically for transgender consumers are non-existent in Alameda County outside of programs that are housed within “LGBT” services.

I go to Lyon-Martin Community Health clinic in San Francisco. I've looked for services in Alameda County and haven't found the services that I need over here, like comprehensive services for transgender people.

The lack of services compared to heterosexual and cis-gender people contributes to stress and is really challenging. Having more support to access those services would be helpful. I feel as if there are structures for helping women with children and heterosexual families that aren't in place for trans people. I think that there are stressors that I face that cis-gender people do not. Like going to public restrooms, not having safe restroom facilities.

Behavioral health services targeting two-spirit consumers are limited as well. It is intersectional, addressing concerns of two-spirit people both within native and other indigenous providers, as well as in mainstream organizations.

That's what I'm in the closet about – my mental health. I don't tell very many people because it's so stigmatizing. They think you're stupid. Even at the Native American Health Clinic they give me a hard time. "That's Western... not traditional." So I don't even tell people at the Native American Health Clinic.

A lot of family members go to Asian-Pacific Islander stuff, but it's targeted more to the Asians. So we go to more Native American places. Most of the people in my family get turned off when they go to an "API place" and it's all Asians. They just won't go back.

In response to the lack of culturally relevant services, some consumers turn to each other to form their own support networks.

I was in a group of college Natives. We all ended up liking school because we were trying to avoid the trauma of being at home. It was like a safety net.

I'm in a queer Pacific Islander collective. They're pretty much like a support group. They play the role of my auntie or mom.

Low-income LGBTQI2S mental health consumers want providers to be responsive to the distinct realities and challenges encountered by clients who are LGBTQI2S. They want an awareness of the intersectionality of oppressions, of the complexities of class, culture and race and gender beyond binary paradigms.

The information is really important. People assume that if a Native person has a Spanish surname that they are Latino. Or that Pacific Islanders are Asian... and their cultures are so different.

Everyone thinks I'm straight when they look at me so that doesn't fit... People will say whatever around me because they think I'm straight. If someone is like, "do you have boyfriend?" I try to get them to realize it. Gender has been more of an issue. I feel like more of my abuse happened because I was a girl. And the trauma is rooted in that.

I think asking questions about how we experience the world is important. Because no amount of staff workshops is going to instill what it's like to be a queer person. Just ask the questions. I went to a new doctor and there was a questionnaire with a question that I'd never seen before: "do you like your work?" Even the fact that they wanted to know that made an impact on me.

Older adults

Accessing care... who do you trust to tell your sexual identity to? Who do you talk to about that? Who do you not talk to about that? I've gotten to the point where I can gauge when it feels safe enough to say or not to say. But it's an issue. It's funny, a lot of these questions that you're asking bring up things that I've kind of stopped thinking about. So you're making me rethink about stuff that I'd kind of put away.

Low-income LGBTQI2S older adults are particularly vulnerable and experienced additional challenges to maintaining their mental health. There are fewer resources that address the specific health concerns of older adults. LGBTQI2S seniors came of age prior to the social movements and shifts in societal norms that opened the doors for LGBTQI2S people to be more open about their sexual orientation and/or gender expression.

There's a certain amount of condescension that goes on in the medical profession. I want to be treated as an adult. Especially as a person they consider as a senior... I better not be patted on the head or told what to do. Or try to coerce me to take medication I don't want to take and not be open to alternative methods or therapies. If I don't take the pharmaceuticals and I have another idea of what to do, at least explore that with me.

I'd been open since 19 when being gay was a psych disorder. This doctor shut me down...told me that I was the problem. The doctor told me that I was 'deviant'. I fled... I quit my job within a month moved to another part of the country and did not get the help that I needed. This put me into a cycle of turmoil that kept going and going until I had my break at age 55... I was homeless after it for a while, living in the car with my dog. There were all kinds of ramifications. It sent me back to drug and alcohol.

Older LGBTQI2S participants also experience discrimination based on sexuality and race.

I experienced discrimination at Kaiser when I went with my girlfriend. Before I went I said I want to see someone who has worked with lesbians or gay people. And I was told, "all of our therapists work with those issues." I said, "yeah, okay, whatever...I want to see

the person who really does do that." She said, "okay, okay". So she set me up with this woman. We got there...she called our names and we stood up. She looked so shocked. "You two are together?" So that didn't give me much confidence in her ability to help us. It made me not go to Kaiser anymore for stuff like that.

Being of African descent, discrimination has happened so often it just kind of rolls off my back.... When I think of it, it sounds small to me. I did have a little incident... just a funny look at a senior center here in Oakland that caused me to feel bad... but it wasn't from the staff... it was some other clients in the place. Actually, it was a little bit from the staff too.

For low-income LGBTQI2S seniors there are distinct challenges to caring for their mental and physical health and living concerns related to aging and being low-income.

I go to Center for Independent Living for Shelter plus care. My housing is under Shelter Plus Care...over by Ashby BART. I used to have a psychiatrist at Broadway by Smart & Final... it's a community mental health thing by Kaiser drug program. They take my Medicare. And then I go to Lifelong for dental, and my private doctor I see through my plan. I'm in two support groups and that's my mental health well-being check-in. We meet five hours twice a month... it's good. I've had to piece together services for myself from some really divergent places.

I didn't have dental care for two years because they cut off my dental coverage for MediCal / Medicare. I had five cavities... I just find it so infuriating.... I'm so protective of my glasses because if they break I have no eye care, and I can't really see too well without my glasses.

Money is the biggest problem for me right now as far as accessing mental health care. Money's a big issue for finding quality therapists and being able to find mental health support. And just to add: as we get older, mental health as well as other health issues come into play. It's little disconcerting to think about what's going to happen ten years from now when I might need more care. So yeah, financial issues are the barrier.

LGBTQI2S seniors have carried their experiences with their sexuality and discrimination often for years. How this affects their mental health and continues to impact their lives is something rarely addressed in the behavioral health care system. It is another aspect of the intersectionality of provider cultural competency that needs to be addressed.

I'm remembering from way back when I couldn't be out with my therapist. You could end up in electric shock treatment for being gay, and I saw that happen to people I knew. It meant I couldn't work on parts of my self.

My sexual orientation affects me much less now... I came out when I was 40. I knew that I was gay, but I had two sons and I couldn't figure out how to juggle all that. It felt like 'all that' because I had no role models. Then I met some Black lesbians who had teenagers, and I thought "okay...." since then I've had no problem being gay.

Older participants were concerned about getting the support they need as mental health consumers, and as LGBTQI2S elders needing support.

I'd like to see some real changes in elder care specific to LGBT communities... Places to go so we can age within our community.... I'd like to see places that deal specifically with the needs of aging LGBT community. And therapists who are sensitive to that population, who are not just non-judgmental but who are sensitive and experienced. And perhaps some peer support, peer advocacy... People are already going back into the closet and they shouldn't have to do that when it took them this long to get out. Ain't nothing worse than trying to be gay and homeless. Really...we need financial support. These are supposed to be our golden years, not our garbage can years!

Transition age youth

Like older adults, LGBTQI2S transition age youth experience particular challenges because of their age. Like other LGBTQI2S consumers, TAY struggle with being low-income and accessing services, with family and mental health stigma. In addition to homophobia and transphobia they must deal with challenges of foster care, abuse in youth detention facilities, bullying in schools, and the lack of support services.

I really needed therapy... I was teased by my own mom. I was going through a lot more than she could understand or more than she could ever understand. She'd say "my daughter can't handle teasing at school, so I'm taking her to therapy because she's driving me up the wall". She'd joke with her friends. This wasn't a way to teach me to look at therapy positively.

While low-income TAY are already a vulnerable population, being LGBTQI2S brings mental health additional challenges.

I think my sexual orientation did affect my mental health at one point in my life when I came out in to my mom as a gay man. My father was physically and emotionally abusive and it was a lot to struggle with, I attempted suicide.... Now I've coped with it... going to groups and therapies. Now I realize I can love myself. But in middle school... it affected me really bad.

When youth consumers have family members who also live with mental illness they must struggle with their own mental health issues as well as that of their loved ones, with fewer resources and fewer supports.

I would visit... the school therapist when I was in the 4th or 5th grade. I remember getting a lot of shit for that. I definitely became too embarrassed to tell my dad so I just kept it to myself out of fear of being discriminated against more. I just stopped going to

therapy out of embarrassment. And my mom has bipolar, so I grew up with a lot of discrimination towards her. Everyone from family members and neighbors were calling her the crazy person. That was painful to watch. I didn't know how to help her, but I wanted to.

Many TAYs have experienced violence and abuse as young LGBTQI2S people. This has ramifications for their mental health treatment and recovery which traditional behavioral health service providers may not have been trained to address.

I've been denied mental treatment. I was incarcerated at Santa Rita and one of the workers there raped me when I was 15. I just went crazy. I was isolated, I wanted to get help and I wanted to talk to someone about it, but I didn't get any help. I got sick with asthma and panic attacks. Maybe it was because of my age. I didn't come out then because I was in jail.

The TAY consumer participants were clear that being LGBTQI2S was a factor in their mental health.

Your sexual identity is going to take a toll on your emotional and mental health. It's hard as a queer youth. I used to get harassed and made fun of. People would harass me and my family. People would call my house and leave these stressful hateful messages. My mom would listen and it would stress her. She doesn't need that. I started cutting really bad everyday. It was an addiction. You're isolated and alone. Why are you by yourself? It's because your school, your family, your community, they won't accept you.

Having adult allies and role models is critical to all young people. TAY consumer participants were enthusiastic in their praise of the support they receive from existing LGBTQI2S youth programs. A community of peers and mentors is critical to TAY mental health and survival.

My youth advocate was a really amazing person. I look at him as my older brother. He's queer and Latino. He used to be overweight. I can talk with him about other guys... stuff that I'd feel weird talking to (my female counselor) about. It's just really nice to have that

support and to not feel alone.

The main place is Youth Speaks – that's about the literary arts – that's where I learned to heal myself thru my writing and find community. I found Our Space and LYRIC through Youth Speaks.

Low-income TAY consumers struggle with the financial challenges to meeting their mental health needs.

I can't afford it. You're lucky if you can find any kind of job with the economy as it is. And then you need insurance. The barriers are more financial than anything else, it's very discouraging.

And then being low-income, the services that you are eligible for...those staff are dealing a lot of the people so they're not passionate about what they're doing. They're just really rushed. That's how it is for low-income people, there are just too many people on one caseload.

To see my mentor in North Oakland and I live in East Oakland—and my youth advocate is in the Castro—I have to spend ten to twelve dollars.

When asked what they'd like to see happen as a result of their participation in the study's focus group, TAY consumer participants were clear that they wanted providers to learn.

I want mental health providers to have more education on working with LGBTQ youth and to seriously take something from this. Sometimes you do stuff like this, but then they don't do anything with it. It's just not relevant to how they make decisions, like it's a waste of time. I really want them to help youth.

I would like to see evidence that it changes some therapists' minds... so they aren't just focusing on just one aspect – oh, you're gay—let's just talk about that. Oh, you're molested---let's just talk about that. Be a bit more understanding. Like I just heard about

the statistics on male rape. Men who've been raped don't get helped... they are turned away. If what we're doing today can help open some eyes, so that no one else would have to go through what we went through, that would elicit a sigh of relief.

I want therapists to learn about our community. Like the cosmetologist goes back to school to get new techniques and learn beauty, the therapists should do that... go to school and learn about youth...hang out with our community, get to know us and have a relationship. I know social workers are told they can't have relationships with their clients, but how can they do their job if they don't know their client?

Parents

Parent caregivers of LGBTQI2S consumers with serious mental illness have few places to turn for support. LGBTQI2S advocacy organizations do not in general have a mental health component. Most mental health advocacy organizations lack an LGBTQI2S focus. Not only is it difficult for parents to find support for themselves, but they struggle to find support for their children.

Kaiser has a tendency to leave it to the patient to initiate treatment. If the patient is not inclined to want treatment---which often happens---Kaiser's just fine leaving it like that... If they were a little more proactive in making sure that people who they knew needed treatment had access or got to treatment and... there are just no community organizations that are integrated into mental health services delivery. The only LGBT group that I know of that works with people who also have some mental health challenges that's close by is in Hayward. Our Space. There's nothing down in Fremont where I live. And certainly not easily integrated into the services that Kaiser provides.

Experiences with discrimination were mixed. Heterosexual parents reported that their gay children had not experienced discrimination in the healthcare system. The LGBTQI2S parents had different experiences with their consumer children.

We experienced discrimination when I took my son to see the therapist. He's going through some gender dysphoria. The therapist was too quick to write it off as a phase. It affected both of us a lot. He didn't get any kind of support, and I felt helpless. It just compounded my own emotional issues and not feeling safe.

Parents described the difficulties their LGBTQI2S children had navigating social spaces with mental illness.

My son being gay puts him in one world and excludes him from others. Being both gay and mentally ill... he's had the experience of going to gay groups and just being so inappropriate in what he says—he winds up making a scene and getting chased out. I

think even in the gay community they don't even know what to make of him. He's very up front about being gay and he's had a lot of conflicts as a result, but at least it clears out his scene. He doesn't try to pretend that he's not gay. Although as delusional as he is... my son suffers from delusions. Occasionally he'll say "I'm heterosexual now—I'm going to join the Army." He goes off on some wild tangents, and I know that's in response to some bad experiences that he's had.

Parents of LGBTQI2S mental health consumers have found support in NAMI and in their faith communities and friends:

NAMI Tri-Valley. I gain tremendous inner strength in being involved with an organization that understands the situation and there's common bond. Most of my family is gone... my husband is a silent supporter... he's not a strong source of support. NAMI, that's my extended family now.

I'm lucky enough to be in a program where the only requirement is we take care of someone in our family with mental health challenges. We help each other depending on who's up or down at a particular time. They're very supportive of me. There is also church, one particular retired pastor and current counselor who I talk to over there. The few friends that we have left are all people who understand my daughter's situation and are not put off by it. That's one thing about mental illness, you get to find out exactly who your good friends are. You don't have many but they're generally pretty good ones.

Like other consumer participants, parents of LGBTQI2S mental health clients believe that education for providers as well as for the broader community is essential for addressing mental health concerns over the long term.

I'd like to see education for the LGBT community about mental health. It's been my frustration that the only that the only mental health issues that get addressed are around bullying and depression and suicidality.... I'd like to ask (gay community centers) what happens if someone has a psychiatric disorder and is gay? What are you doing about that? I hope this opens doors and enlightens the LGBTQ community not only about

mental health issues, but mental illness issues, because they are two separate entities.

Back when I was a PFLAG member years ago there were no social places for a young LGBT person, mental health social places where they could be. All of these things that are not considered part of mental health treatment are still part of an overall recovery model. And I want to see them incorporated.

Provider interview narrative

Fourteen behavioral health care providers and mental health advocates were interviewed for the study, representing the Pacific Center, Our Space, Native American Health Center, Asian Health Services, Lavender Seniors of the East Bay, Goals for Women, NAMI Alameda County, Center of Excellence for Transgender Health, Community Health for Asian Americans, and Project Eden/Horizon Services³⁷. Eight of those interviewed were members of the Pride Committee -- composed of behavioral health care providers working for changes in Alameda County's behavioral health care system to ensure that LGBTQI2S consumers and their families receive the services they need.

In our conversations with providers a number of recurrent themes and common concerns emerged: the economic stress and LGBTQI2S mental health; cultural competency for LGBTQI2S providers; oppression and LGBTQI2S mental health; training and education; safe spaces and access; consumer isolation; collaboration; and the limitations of funding.

Economic stress

Economic stress is an underlying factor for low income mental health consumers. One provider observed that: "finding a job is a mental health issue, getting by in this economy is a mental issue." Clinicians need to be prepared to help LGBTQI2S consumers navigate the impact of homophobia and transphobia on individuals seeking employment in a negative economy, and for many, that cannot be separated from the realities of age, race and gender. There are the therapeutic implications of addressing depression resulting from economic stress for clients who may also be addressing PTSD or a serious mental illness, and then there is the question of complementary support services such as vocational training, housing services, and affordable health care.

We have seen and an increase in what we call the economic stress factor, we've seen an increase in the number of people coming here because of the economy, being out of work, we have seen that become more of a factor than ten years ago or even five years ago. We can gage a lot by peer groups – when people come in wanting to start a peer group what

³⁷ 2 African American, 6 white, 1 Latina, 1 Pacific Islander, 3 Asian, 1 Native American; 2 straight, 2 gay, 1 bisexual, 5 lesbian, 4 unknown/other; 4 executive directors, 3 program directors, 1 outreach/educator, 2 counselor/therapist, 1 program staff, 1 physician, 1 clinician, 1 retired.)

concerns do they want to address? Economic issues are now topping the list. We have requests for employment services now. Of the cold calls we get, people looking for resources, are people looking for such and such and housing comes up all the time. It is a very pressing concern for youth and transgender people. Both populations have to face barriers of discrimination in employment and housing in an already tough economy. The Bay Area is one of the most expensive places to live – it is highly transient. This increases isolation.

Mental health consumers who have lost housing and employment will be in crisis mode when they come for services, whether they are Latina lesbians going to Goals for Women, questioning youth at Our Space or LAMBDA, a transgender woman and her two-spirit partner at the Pacific Center, or an African American gay elder at the Native American Health Center.

Transition age youth

Youth need access to safe space to hang out with peers, with cool leadership programs and cool activities. If you have art, and fun, then there is a huge therapeutic impact that often doesn't get funded. Peer support is more accessible to youth who wouldn't necessarily say they wanted a therapist but want to do a cool activity.

There is also such a link between having your basic needs meet, housing, food, transportation, and mental health. We see a lot of youth struggling to get their basic needs met – housing, food, transportation, and mental health. That affects their mental health, but then they can't afford counseling. There's that intersectional part, so many are youth of color, how do we make it safe for them as youth of color, who are gender queer, who are aging out of the foster care system with mental health needs?

Transgender

If you are an adolescent in a family where they don't have the tools to support you coming into your gender identity or understanding what you are going through, or they are labeling you as sinful, your pastor/priest rejects your mere existence, your peers in your school setting don't understand what you are going through – with all of that it is very hard not to absorb all that negative stimulus. So you have the negative stimulus that trans people experience, and then a mental health system that focuses in on gender

identity and gid as a diagnostic criteria, as opposed to focusing in on depression and anxiety and PTSD, on the other diagnoses that could lead to treatment for the distress as opposed to treatment for your existence.

Older adults

We need programs that reduce isolation because LGBT elders don't typically have the resources for socialization. Senior centers are typically heteronormative. If a client is frail and vulnerable and homebound then we send volunteers to them because their socialization is so limited. Social programs, and visits, even though they are not clinical programs they have a clinical impact. There mental health outcomes of this type of programming. Where are LGBT elders going to go for support? If they are closeted, if they don't have kids, if they were coming of age during the oppressive years, that can have a profound effect on their well being.

Cultural competency

There was general agreement that Alameda County providers—from clinicians to counselors to staff—need education and training beginning with a broader definition of cultural competency that goes deeper than a one-dimensional overview of LGBTQI2S. Providers complained that too often in behavioral health advocacy and policy setting arenas, LGBTQI2S equals white and middle class, and that African American equals heterosexual – misperceptions which only perpetuate the paucity of clinical services for LGBTQI2S mental health consumers.

Queer people are in all neighborhoods, in all classes, there is no way to talk about our community with out talking about these different subsets. Much of the cultural competency work ignores classism, which is rampant in all cultures, sexism, ableism. We focus so much on ethnicity and race that we get the impression that everything is the same in one group. When you are talking about the queer community - I tell you that what a disabled, African American lesbian experiences is different from what a very femme able-bodied white lesbian experiences – cultural competency is more than about race.

Oppression

A majority of those interviewed believe that the behavioral health community needs to incorporate an understanding of how oppression affects mental health, and how the intersections

of sexuality, race, class, gender, age, and physical and mental ability function in the lives of individuals and the broader community.

We are looking at it as a multifaceted concept... understanding the diversity within different marginalized groups. Virtually every one in the queer community is dealing with more than one vector of discrimination. Race, class, sexuality, gender and age, and how that informs the work that we do with queer people and families that is unique. We want to look at the overarching paradigm of oppression.

Access

With a drop-in support group you can create an environment that shows them you can talk with adults. They may not want to talk with their therapists, or have to listen from the parents' side. I would like to see programming where insurance is not a caveat. Where youth can access services free or low sliding scale, with counseling but also other services.

Providers and consumer respondents alike expressed concern about community access to behavioral health services in Alameda County. Given the diversity and size of the population, there are gaps in services for several subgroups who are particularly underserved or invisible even in LGBTQ agencies. There are limited mental health services in the County for LGBTQI2S immigrants and Latinos, and a great need for preventive and complementary care for LGBTQI2S youth and elders.

Families

There are more families issues now for counseling, there is an increase in family counseling but there are limited resources addressing the particular concerns of lesbian couples and their children. There are private therapists, but for low-income families there is very little.

There are insufficient resources for family members of LGBTQI2S mental health consumers, and for LGBTQI2S low-income mental health consumers who are parents. Providers envision behavioral health programs that support LGBTQI2S teen parents learn how to build healthy

families, supportive community resources like NAMI and PFLAG that marry the best of both of these and are reflective of the distinct cultures of Alameda County. Currently there are no support groups for Chinese-speaking parents of LGBTQI2S consumers, nor therapeutic programs that serve African American, Latino and Pacific Islander families in their communities and places of worship. These gaps mean that far too many consumers are not getting the mental health services they need, and LGBTQI2S families of all kinds are suffering.

Isolation

For lesbians in Alameda County isolation is a common denominator – isolation, especially at the transitions of life. Berkeley, Albany, and parts of Oakland are bedroom communities. Where do lesbians go for support when their relationship falls apart? In the past there were bars that were de facto community centers, but today they either no longer exist or are geared towards younger women. For middle-aged lesbians and bisexual women, and for older adults, there is an increase in isolation.

Isolation contributes to the mental health needs of disconnected low-income LGBTQI2S consumers. Older adults, transgender individuals of all ages, and consumers who do not speak English and/or live in insular cultural communities are all vulnerable Alameda County populations who are currently underserved.

Collaboration

Not every one feels comfortable walking past the rainbow flag – that can be a barrier to accessing mental health services. We are working hard on building collaborations with other agencies who are not necessarily LGBT but who may provide services at another site that is more accessible for a range of reasons. People who are transgender and questioning, looking for support services beyond the individual therapy we offer.

LGBTQI2S programs are rarely integrated into full service agencies. Asian Health Services and the Native American Health Center, like other agencies, have been able to provide some LGBTQI2S-related programming through HIV and AIDS-funded programs. Horizon Services /

Project Eden has an LGBT-dedicated LAMBDA youth program. All of these agencies are seeking ways to expand LGBTQI2S services, and have begun to do in-service trainings for all staff that include LGBTQI2S competency, and developing gay-straight alliances among staff.

Those provider agencies that have an LGBTQI2S focus are already collaborating with each other and with other community agencies in order to provide education and training to their peers and other health and social service professionals. Of course training, staffing, and program expansion all require funding and funder buy-in.

Training & education

Every provider we spoke with stressed the need for training and education for clinicians and staff. The Pacific Center is unique amongst the LGBTQI2S behavioral health care agencies in that on-going in-service training for 15 clinical interns each year is already an integral feature of their work. They envision the development of LGBTQI2S-trained clinicians in other agencies in order to best meet the needs of Alameda County consumers across race, ethnicity, language, and culture. Already the LGBTQ-specific agencies and programs – including Our Space, LAMBDA and Lavender Seniors – all conduct competency trainings for other behavioral health and social service agencies in the county. But the need is greater than the existing resources. How do we ensure that providers are prepared for the distinct subgroups within populations? Who will develop clinician education focusing on the cultural distinctions between the needs of an African American who identifies as stud and lives with their heterosexual parents in West Oakland, a Samoan elder who identifies as a two-spirit transgender who is a primary caregiver for their grandchildren, and a white genderqueer youth who is currently homeless and without familial support?

Inclusion and alliances

I'm thinking inclusion in all of our Native events. I think that might be the greatest need. Where there is safety to come out if the two-spirit person wants that. I think the heterosexual community needs to be reeducated about our traditional ways of thinking. Traditionally two-spirits were valued, not stigmatized, they had special functions in the community and ceremonial responsibilities, teaching survival ways – amongst the Navajo

it was the two-spirit responsibility. The heterosexual native community needs to remember it was not traditional to stigmatize and ostracize.

We are addressing homophobia and heterosexism as a community. We plan for all staff gay and straight to address some of these issues.... what we need to address is not so much blatant homophobia or heterosexism so much as breaking the silence, LGBT issues were not something discusses openly so staff are looking at that. The other half will look clinical issues that the providers face around LGBTQ primary care issues, STD testing, sexual history taking, as an agency that provides medical we will need to do both concurrently.

Beverly Bergman, chair of the Pride Committee, describes the Pacific Center as the “mother ship” of LGBTQI2S services and support in the community since the early 1970s. When asked what resources exist for LGBTQI2S clients, all the behavioral health providers interviewed acknowledged the key role of the Pacific Center in serving Alameda County’s LGBTQI2S populations. The Pacific Center is the primary referral given by other providers for clients seeking an LGBTQI2S-responsive therapist or support group.

The intersections of race, gender, sexual orientation and culture that the providers interviewed represent are one of the strengths of the diversity of Alameda County. Many providers have expertise in some aspects of cultural competency, and all of them acknowledge that they do not have the capacity to serve everyone. All of the behavioral health providers we interviewed have a knowledge base and expertise that others can tap into – either in collaboration or to serve as a referral agency. The LGBTQI2S population of Alameda County is far too diverse and the needs of the LGBTQI2S mental health consumers too great to expect any one agency to do it all.

Literature Review

In order to review the literature on the mental health of LGBTQI2S populations we had to stop and acknowledge the limits of utilizing an umbrella term for a range of very diverse populations. There is research on the mental health of “sexual minorities” – lesbians, women who have sex with women, and bisexual women; gay men, men who have sex with men, and bisexual men. There is very limited research on the mental health of transgender populations. The research that exists focuses primarily on transgender women, that is, individuals who were assigned male at birth and who have transitioned, are transitioning, or who identify as women, MTFs, or simply transgender. Very little investigations into the mental health of transgender men – individuals who were assigned female at birth and who have transitioned, are transitioning, or who identify as men, FTMs, or on the masculine spectrum of transgender. Much of the research on transgender populations is in the context of HIV, as is the research on gay men and men who have sex with men.

There is a small body of literature on two-spirit populations, some of it again HIV-related. To examine the mental health of two-spirit people we had to look at the mental health of Native people – to be two-spirit is to be Native. We found no research on the mental health of intersex people. “Questioning” is a term used almost exclusively in the context of mental health research on young people – for whom the term LGBTQ is most frequently used. In order to look at the mental health of LGBTQ transition age youth we included some research on the mental health of TAY of color, and the mental health risks of homelessness TAY.

In order to expand our field of knowledge, and because some of the examinations of sexual minority mental health has theorized that “minority stress” – meaning the mental, emotional and somatic stress experienced as a result of oppression, discrimination, and stigma due to a person or community’s “minority” status in society, we included in our scope some literature on the mental health of racial and ethnic minorities / people of color, and women.

The literature on the mental health of LGBTQI2S populations over the past two decades represents efforts by researchers to establish a basic foundation of knowledge where there was none at all. Two primary questions have driven much of this research: 1) are lesbian, gay,

bisexual and transgender populations at higher risk for mental illness? 2) If LGBT populations are at higher risk for mental illness, why is this the case? Additionally, LGBT mental health research has examined disparities between the mental health of LGBT people and heterosexual and non-transgender individuals, learning from and building on earlier research done on the mental health disparities experienced by racial / ethnic minorities.

As outlined in this report, lesbian, gay, bisexual and transgender adults, transition age youth and seniors all experience mental health disparities in higher levels of mental illness, ptsd, and suicidality, as well as disparities in mental health treatment. These disparities are even greater for low-income populations, and for people who are also racial and ethnic minorities. Most research on the mental health of LGBT populations has been done with predominately white samples. The mental health issues and needs of LGBT people of color are still largely unknown and understudied.³⁸

Mental health disparities are determined by the very real social injustices that continue in society today. As the African American Strategic Planning Workgroup of the California Reducing Disparities Project aptly sub-titled their draft report on Reducing Mental Health Disparities in Black Californians: “*we ain’t crazy*”.³⁹ That is to say – social, economic and cultural disparities and discrimination create and maintain barriers to health – and attempting to respond to those disparities individually can be crazy making.

According to the recently introduced Health Equity and Accountability Act, “Health disparities are a function of not only access to health care, but also the social determinants of health—including the environment, the physical structure of communities, nutrition and food options, educational attainment, employment, race, ethnicity, sex, geography, language preference, immigrant or citizenship status, sexual orientation, gender identity, socioeconomic status, or disability status—that directly and indirectly affect the health, health care, and wellness of individuals and communities.”

³⁸ NAMI 2007.

³⁹ CRDP 2011.

*Clearly, race and ethnicity matter in health. So do gender, poverty, and ability. So too do sexual orientation, gender identity, and other characteristics linked to discrimination or exclusion.*⁴⁰

King et al conducted a systematic review of the prevalence of mental illness and substance abuse in lesbians, gay men and bisexuals by looking at articles published between 1966 and 2005 – ultimately yielding data on 214,344 heterosexual and 11,971 non heterosexual people for meta-analysis. Their study confirmed what other researchers had asserted, that lesbian, gay and bisexual people are at higher risk of mental disorder, suicidal ideation, substance misuse and deliberate self-harm than heterosexual people.

Meyer⁴¹ and others⁴² suggest using a theory of “minority stress” for understanding lesbian, gay and bisexual’s higher risk for mental illness. That is, much like people of color, lesbians, gay men and bisexuals live with stress based on stigma that negatively affects their mental health, exacerbating health disparities between heterosexual and LGB people.⁴³

In a later study Meyer et al found that stigma deprives LGB individuals of safety and acceptance, and deprives them of access to critical possibilities and opportunities. This lack of physical safety or the fear of it, the lack of acceptance from family and society, and the denial of access to jobs, housing, etc. creates a constant pressure upon the mental health of lesbians, gay men and bisexuals.⁴⁴

Stigma is a product of oppression, and *minority stress* is the result of the ongoing effects of oppression as it relates to mental health.

Gay men, lesbians, bisexual women, bisexual men, and the transgendered (GLBTs), members of ethnic minority groups, and persons with physical disabilities (PWDs) have historically epitomized the meaning of stigma in our society. Membership in any one of these groups generally ascribed inferior status carries with it particular emotional

⁴⁰ Baker 2011.

⁴¹ Meyer 2003.

⁴² Cochran & Mays 2000, Nabors et al 2001, Mimiaga, Berg & Safren 2002, Haas et al 2010.

⁴³ Meyer et al 2011.

⁴⁴ Ibid, p 204.

burdens, i.e., “minority stress”. Simultaneous membership in more than one (e.g., ethnic minority and GLBT) can compound these effects).⁴⁵

The literature on theories of oppression (racism, sexism, heterosexism, etc) and how different oppressions function in the United States is extensive. In Alameda County several activist-theorists⁴⁶ whose work impacted anti-oppression curriculum, diversity trainings, and social movements both locally and nationally over the past three decades provide us with a working definition of oppression: the systematic, pervasive, routine, institutionalized mistreatment of individuals on the basis of their membership in various groups which are disadvantaged by imbalances of power in society. Oppression is the invalidation, denial, or non-recognition of the complete humanness of others. Oppression takes the form of institutional as well as individual mistreatment, including violence.⁴⁷

Minority group members may experience oppression by both the dominant society and other minority groups of perceived higher status. This double or triple oppression is particularly salient for those who belong to multiple minority groups such as lesbian, gay, bisexual, and transgendered (LGBT) individuals of color.⁴⁸

In a study on the lifetime prevalence of mental disorders and suicide attempts in diverse lesbian, gay and bisexual populations, Meyer et al found that LGB people reported more lifetime and day-to-day experiences with discrimination, suggesting a relationship between higher levels of discrimination and mental illness. The researchers showed that Black and Latinos had a higher risk for suicide as young people, but the risk for mental disorders was the same as for White LGB counterparts, indicating more research is needed on the differences in social stress outcomes.⁴⁹

Pieterse, Todd, Neville and Carter have documented the link between perceived discrimination and mental health in Black Americans. Their findings show that African American mental health is negatively impacted by racism, and that the greater the exposure to and perceived stressfulness

⁴⁵ Nabors et al 2001.

⁴⁶ Ricky Sherover-Marcuse, Harrison Simms, Hugh Vasquez, Paul Kivel, Isoke Femi, Alan Creighton, and others.

⁴⁷ Femi & Vasquez.

⁴⁸ Nabors et al.

⁴⁹ Meyer, Dietrich, & Schwartz 2007.

of racist events, the greater the mental distress. Pieterse and colleagues support the theory that experiences of racism should be considered as traumatic events, and that the psychological responses to racism are consistent with PTSD.⁵⁰ Even physical health indicators like hypertension are stress and depression related, supporting our growing understanding of the somatic components of trauma.

Chae and Walters⁵¹ found that discrimination had negative health outcomes for two-spirit American Indians /Alaska Natives. Higher reports of discrimination were associated with significantly greater levels of self reported physical pain and impairment, supporting the link between stress and physical health.

Psychiatrist Chester Pierce described life for many African Americans as a consistent pattern of invalidation, negation, dehumanization, disregard and disenfranchisement, and experience of daily stress where there is no relief from that pattern nor the “worrisome quest to survive on a day-to-day basis”.⁵² Other racial and ethnic groups as well LGBTQI2S people, also experience this daily pattern that describes oppression. Brave Heart⁵³ refers to the chronic, daily injustices that Natives endure “micro aggressions” – the interpersonal and environmental messages that are denigrating, demeaning or invalidating. She identifies three types of micro aggressions:

1. Microinsults -- Behaviors that convey rudeness, insensitivity, or reflect unfair treatment or demean identity or heritage (e.g., eye-rolling)
2. Microinvalidations -- Communications that nullify the experiential reality or identity of Native persons (e.g., are you a “real Indian?”)
3. Microassaults -- Characterized by explicit racial derogatory attacks or purposeful discriminatory actions— (e.g., “don’t go and do a war whoop now”)

Such micro aggressions take different forms according to the oppression. A recent study on the mental health and the physiological and cognitive implications of racism for people of African descent describes another scenario of what Brave Heart calls micro aggressions:

⁵⁰ Pieterse, Todd, Neville, & Carter. 2011.

⁵¹ Chae & Walters 2009.

⁵² Quoted in CRDP p 33.

⁵³ Brave Heart n.d.

Here is a typical scenario for many people of African descent living today in the United States: There is daily psychological pressure from juggling work and family while negotiating the challenges of culturally embedded negative perceptions of your ethnic group. You are the only person of African descent on the job, and you feel your European American colleagues frequently treat you as if you do not know what you are talking about. You worry about your children becoming a victim of the gang violence plaguing the neighborhood. You suffer from various chronic ailments disproportionate to people in other ethnic groups. Such a scenario is consistent with a growing body of scientific literature linking together daily stressors, perceived racism, ethnic group membership and poor health.

The authors assert that racialized experiences alone can be responsible for stressors that are associated with disease – that racism underlies health disparities for people of African descent, including mental health. Likewise, the work of Chae & Walters and Brave Heart points to racism as one of the factors underlying the extreme health disparities for Native Americans.

A recent study shows the negative impact of oppression in the form of social discrimination (homophobia, racism and financial hardship) on the risk for HIV transmission in the case of Latino gay and bisexual men. Díaz and Ayala⁵⁴ found that racism, classism and homophobia powerfully shape and organize the health behaviors of Latino gay men.

Díaz and Ayala interviewed Latino gay men and found that those who engaged in “high-risk” behaviors also reported more life experiences of homophobia, racism and poverty than their “low-risk” counterparts. Experiences of homophobia took place early in life in the form of high levels of verbal abuse, physical abuse, and the impact of their homosexuality on their families. Experiences of racism in childhood and adulthood ranged from rude treatment to police harassment due to race, ethnicity or skin color. Classism was experienced as poverty – evidenced by running out of money for basic necessities. The study also found that men in their high-risk group displayed resiliency factors – including family acceptance and the presence of a gay role model during childhood.

⁵⁴ Díaz & Ayala 2001.

Díaz and Ayala's work is relevant to our understanding of minority stress, oppression and mental health. As the authors conclude, rarely have studies on the direct impact of social inequality measured and examined specific factors of discrimination. While their work suggests a course for addressing HIV prevention, we suggest their model of analysis has a mental health correlation.

*Such analysis within specific groups affected by social discrimination and oppression could illuminate both the specific lived experiences and the specific mechanisms by which oppression affects individuals within those groups.*⁵⁵

Children who are the victims of racism are at higher risk for mental illness. In a 2009 review of the limited research relating to racism and racial discrimination as a predictor or contributor to a child's behavioral, mental and physical health the authors found most studies show there is a relationship between perceived racism and behavioral and mental health.⁵⁶ A 2011 study found that among 5,000 fifth graders in three urban areas (Birmingham AL, Los Angeles CA, and Houston TX) that Hispanics who report racism are three times as likely as other children to have symptoms of depression and Blacks are twice as likely. The author concludes that children who experience racial abuse are more likely to develop symptoms of depression.⁵⁷

Another study of children and youth of color (ages 9-18) found again that minority children who experience racism in their daily lives have more symptoms of depression. Co-author Pachter says "Not only to most minority children experience discrimination, but they experience it in multiple contexts: in schools, in the community, with adults and with peers."⁵⁸

LGBTQI2S youth, regardless of race and ethnicity, have higher levels of exposure to violence during childhood. Roberts et al found profound disparities between LGB individuals and heterosexuals in the risk of PTSD and violence exposure beginning in childhood. LGB individuals are also more likely than heterosexuals to experience violence in their communities.⁵⁹

⁵⁵ Ibid.

⁵⁶ Pachter & García Coll 2009.

⁵⁷ Campbell 2011.

⁵⁸ Oliver 2011.

⁵⁹ Roberts et al.

LGBTQI2S people experience stigma based on their sexual orientation and/or gender identity, people of color experience stigma based on their membership in racial/ethnic minority populations, and people with mental illness live are stigmatized for their illness. The Surgeon General's Report on Mental Health released over a decade ago identified mental health stigma as a key concern for the treatment of mental illness in society.

Stigma erodes confidence that mental disorders are valid, treatable health conditions. It leads people to avoid socializing, employing or working with, or renting to or living near persons who have a mental disorder, especially a severe disorder like schizophrenia. Stigma deters the public from wanting to pay for care and, thus, reduces consumers' access to resources and opportunities for treatment and social services. A consequent inability or failure to obtain treatment reinforces destructive patterns of low self-esteem, isolation, and hopelessness. Stigma tragically deprives people of their dignity and interferes with their full participation in society.⁶⁰

A review of the literature on the mental health of lesbians, gay men, bisexuals, transgender people, and two-spirit people reveals that LGBTQI2S people are at a higher risk for mental illness and experience disparities in mental health treatment and service. It is suggested that much like people of color whose mental health is impacted by the stigma, micro-aggressions, discrimination and violence of social oppression, LGBTQI2S people's mental health is negatively impacted by "minority stress". So too, the stigma of living with mental illness in our society is an additional factor that adds to the burden of being an LGBTQI2S mental health consumer.

⁶⁰ US Department of Health and Human Services, 1999.

Conclusions

*We must constantly ask ourselves if competency is defined by a standard of privilege that includes a white, urban-centered, middle class, and English- speaking set of realities. The health disparities that exist in this country afflict the black, the poor, the illiterate, the Latino, and the queer. The disparities act as borders. These divisions are real and create a reality for disenfranchised communities.*⁶¹

After listening to LGBTQI2S behavioral health consumers and providers articulate their concerns and reviewing the literature on LGBTQI2S mental health, it is clear that a major challenge in addressing the specific needs of low-income LGBTQI2S consumers is to respond to them at the intersection of their identities. Whether they are gay or transgender (or both), whether they are older adults or transition age youth, LGBTQI2S mental health consumers do not fit into one box. National policy expert Aisha C. Moodie-Mills (2012) articulates this in a recent article about national policy and advocacy for black gay and transgender people:

black gay and transgender people fall through the cracks when lumped under either a gay or black umbrella. Such categorical thinking ignores the fact that black gay and transgender people are at once both gay and transgender and black. As a result they experience complex vulnerabilities that stem from the combination of racial bias and discrimination due to their sexual orientation and/ or gender identity. So advocacy agendas that prioritize the eradication of one bias over the other do not fully respond to the needs of the population....

An agenda that prioritizes one bias over the other, concludes Moodie-Mills, does not fully respond to the needs of this population. Most focus group participants expressed that their mental health needs were not about their gender identity or sexual orientation – the challenge is finding a provider who is affordable, accessible, *and* culturally competent.

⁶¹Velasquez, in Díaz & Ayala 2001.

In an examination of disparities in mental health treatment for gay, lesbian, bisexual and transgender consumers, NAMI reports that while many therapists in training have positive attitudes towards gay, lesbian and bisexual populations, they felt they had received inadequate training to effectively counsel those clients.⁶² In addition to expanding and improving curricula and training to ensure mental health professionals are culturally competent, cultural competency must extend to the entire care institution and its staff and policies.

*Individuals who carry multiple minority statuses are faced with the task of integration, which involves not only aspects of the self, but relationships to the larger majority. Ethnic minority GLBT individuals must bear the additional task of integrating two major aspects of their identities when both are conspicuously devalued.*⁶³

Alameda County's behavioral health service providers likewise must shoulder the responsibility of integrating an understanding of heterosexism/homophobia, transphobia, and the other social oppressions that impact low-income LGBTQI2S consumers' mental health, and proactively begin to change the culture of our local mental health system relative to both therapeutic approaches and service provision.

Learning what we don't know

The Alameda County Behavioral Health Care Services (ACBHCS) Transition Age Youth Strategic Plan opens with the observation "TAY with severe mental illness (SMI) often 'fall between the cracks' of the mental health care system..."⁶⁴ Unfortunately, LGBTQI2S TAYS are not mentioned once in this plan. What we know is that of those who fall between the cracks, LGBTQI2S are the invisible of the invisible. With the current look at the demographics and needs of LGBTQI2S low-income mental health consumers, Alameda County is taking a first step towards making the invisible visible.

Acknowledging that we don't know what we don't know means behavioral health professionals need to take off their "expert" hats to listen to how the most underserved populations identify

⁶² NAMI 2007.

⁶³ Nabors et al 2001.

⁶⁴ ACHBCS n.d.

their own priorities. One provider at a community-based organization shared with us an example of how **not** to conduct a focus group: not only was the facilitator unfamiliar with the culture of the community being questioned, and the questions were framed for white people. Because the facilitator and recorder were unfamiliar with the culture of community, they neglected to record key comments coming from the group because they weren't following the strict order of the questions, missing an opportunity to learn from the community members.

Research that is not sensitive to cultural differences produces findings that might not be what would have been produced if the community had been able to talk their own story. Sometimes you have to break away from the research design if you are really going find answers to the problems in our communities.⁶⁵

With an increased understanding of the role oppression plays in creating and maintaining mental health disparities, researchers providers, consumers and activists make clear that there is a need for a radical shift in the mental health system's response and treatment of LGBTQI2S mental health consumers. Scholar and practitioners have suggested strategies and outlined frameworks for addressing the impact of historical trauma and continuing oppression on the mental and physical health of two-spirit and other Native people (Chae & Walters, Brave Heart), addressing the impact of racism in the mental and physical health of Black people (Pieterse, Todd, Neville & Carter 2012⁶⁶, Wheeler, Brooks & Brown⁶⁷) and addressing homophobia, racism, poverty, sexism and stigma in order to impact the health outcomes for Latino gay men and other gay men of color (Díaz & Ayala). These frameworks and strategies are equally applicable to addressing the mental health needs of low-income LGBTQI2S clients in Alameda County.

From the Surgeon General's report to research on LGBT youth, and from interviews with providers and consumers alike in Alameda County, it is clear that LGBTQI2S low-income mental health consumers are currently not being adequately served. Like the disparities experienced by people of color

These disparities have been attributed to a limited ability of publicly funded mental health systems to understand and value the need to adapt service delivery processes to

⁶⁵ Anonymous provider interview.

⁶⁶ Pieterse, Todd, Neville & Carter 2012.

⁶⁷ Wheeler, Brooks & Brown 2011.

*the histories, traditions, beliefs, languages and values of diverse groups. This inability results in misdiagnosis, mistrust, and poor utilization of services by ethnically/racially diverse populations.*⁶⁸

Mental health service providers in Alameda County have already been called upon to understand and address the role of racism in the causes and responses to the mental health of clients of color.⁶⁹ Focus group participants of color stressed that culturally competent services for low-income LGBTQI2S mental health consumers must address the realities of race and ethnicity as well as the realities of sexual minorities, transgender and two-spirit clients.

*[A]ll health professionals must be provided with training in delivering culturally competent health care services including awareness of the impact of racial status and racial discrimination on health, barriers that prevent access to health care and effective strategies for engaging patients and clients in treatment to overcome cultural mistrust and prevent treatment dropout.*⁷⁰

Focus group participants and providers alike spoke to the need for safe spaces. A consumer needs to feel they are welcome and that their sexual orientation, gender identity, and racial and cultural reality is understood and appreciated as factors in their lives and as elements in their treatment strategy.

Pieterse and colleagues recommend an assessment for racism-related experiences for intake protocols when working with African American clients. They point out that just as assessing trauma is routinely done with intake interviews, when working with Black clients the assessment of trauma should be expanded to include experiences of race-related trauma and stress.

Expanding this to incorporate LGBTQI2S clients' needs, intake interviews should include questions relative to experiences of oppression based on sexual-orientation, race, ethnicity, gender and sex.

⁶⁸ African American Strategic Planning Workgroup.

⁶⁹ ACBHCS 2011.

⁷⁰ Ibid.

With regard to therapeutic interventions, providing Black clients with a framework in which to understand and make sense of the psychological toll associated with exposure to racism might also ameliorate the sense of powerlessness and shame that is often experienced by individuals who encounter various forms of race-based oppression.⁷¹

Culturally competent training for therapists and strategies for interventions should likewise provide LGBTQI2S clients with a framework in which to understand the psychological toll of transphobia, heterosexism and homophobia. Pieterse et al recommend counseling that includes the establishment of adaptive coping mechanisms and the teaching of strategies for empowerment and resistance. The lesbian and queer-identified Asian and Pacific Islander focus group participants emphasized the importance of a support group they were all a part of that taught about the histories of Asian and Pacific Islander women, culturally relevant strategies for healing and empowerment, and organizing as a form of resistance.

In line with the observations of both the providers and consumers we spoke with, Pieterse et al advocate that clinicians should be educated about the manner in which racism shapes the lives of Black Americans and that antiracism advocacy be included in their teaching curricula.⁷² Going a step further, a comprehensive education for providers should include teaching about the manner in which social oppressions – heterosexism, transphobia, classism, sexism and racism, shape the lives of lower income LGBTQI2S people. Anti-oppression advocacy need be an integral part of clinician’s education and training, and mental health agencies should be places that embrace a social justice framework and where the rights of all people are advanced.

⁷¹ Pieterse, Todd, Neville & Carter 2012.

⁷² Ibid.

Recommendations

The recommendations are based on the data gathered from the focus group participants, individual and provider interviews. Initially we anticipated providing recommendations for each sub-target group, however as we began formulating the recommendations, based on the data, similar needs became evident for each sub-group in creating culturally informed LGBTQI2S mental health services. All groups spoke to access issues, both financially and location; all groups felt the need for their therapist/service provider to be more capable in understanding the myriad of issues and complexities presented by their lives, and the desire for more support—socially and personally. Where clearly identified as a distinct age appropriate need we have placed those recommendations under its respective sub-group heading.

The Parents and Family Members sub-group expressed similar concerns as the LGBTQI2S consumers and still as a family member they have distinct needs for their own mental health when supporting loved ones. Their recommendations are presenting following the other three sub-groups targeted in this mental health assessment needs report.

Recommendations to serve the mental health needs of low-income LGBTQI2S people

1. Increase the capacity of existing LGBTQI2S focused mental health agencies to serve the diverse needs of low-income LGBTQI2S people.
2. Encourage the development of mental health services and providers that are responsive to the diversity of low-income LGBTQI2S and recognize diverse sexual orientations, gender identification and ethnicity.
3. Create easier access throughout the county for mental health prevention and intervention services for low-income LGBTQI2S as opposed to the often-used crisis response.
4. Provide training to Access therapists and BHCS contracted organizations that will increase the opportunity for low-income LGBTQI2S to receive culturally competent and responsive mental health services.
5. Increase the number of diverse geographically located low-income LGBTQI2S support groups throughout the county.
6. Develop mind body spirit mental wellness approaches that include nutrition, wellness, fitness and holistic therapies as alternatives to medication.

7. Create alliances within the mental health system similar in models to PFLAG and school based Gay-Straight programs.
8. Create service systems designed to respond to the cultural and linguistic needs of low-income LGBTQI2S racial and ethnic minorities.

Transitional Age Youth (16-24)

1. Incorporate mental health issues related to generational differences, influences of pop culture, limited access to employment and educational opportunities and acknowledgement of fear from the likely prospect of trauma from bullying and peer harassment for their sexual orientation and/or gender identity.
2. Provide consistent wrap-around services to assist with housing, transportation, health care, employment, and becoming self-sufficient.
3. Provide supportive transitional services when an LGBTQI2S TAY ages out of a youth program and is still in need of adult mental health services.
4. Provide mental health support for Transgender TAY, particularly young men of color that does not identify the “trans” process as the mental health problem.

Adults (18-59)

1. Develop LGBTQI2S mental health services for Latinos and immigrants, include Spanish speaking only groups.
2. Develop a network of clinicians and LGBTQI2S support groups that are representative of the various “letters” of low-income LGBTQI2S residents (i.e.; Black lesbians, Gay HIV positive men, Transgender M to F, etc.)
3. Encourage more agency collaborations to provide wrap around services related to housing, healthcare, employment and transportation.
4. Develop mental health wellness activities centered on preventative care and social interaction with other low-income LGBTQI2S people.
5. Create depression specific groups for the diversity of low-income LGBTQI2S to address a life time of repression and societal oppression and stigma associated with their sexual orientation or gender identity.
6. Develop mental health wellness activities centered on preventative care and social interaction with other low-income LGBTQI2S people.

Older Adults (60 and over)

1. Integrate mental health services with primary health care services.
2. Provide mental health support services for LGBTQI2S seniors who are caregivers for their parents.
3. Develop mental health wellness activities throughout the county centered on preventative care and social interaction with other low-income LGBTQI2S people.
4. Create depression specific groups for the diversity of low-income LGBTQI2S to address a life time of repression, oppression and stigma associated with their sexual orientation or gender identity.

Parents and Family Members

1. Create an LGBTQI2S Systems' Advocate program to assist parents and family members in getting mental health services for their loved ones that is culturally responsive to the needs of families that have LGBTQI2S family members experiencing mental illness.
2. Develop parent and family networks and supportive activities throughout the county that focus on mental health and are similar to the PFLAG model.

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Appendices

1. Consumer Focus Group Questions
2. American Psychological Association Fact Sheet on homosexuality
3. American Psychological Association Fact Sheet on individuals with intersex conditions
4. American Psychological Association Fact Sheet on transgender people
5. Fenway Health Sample Intake Form
6. Gay & Lesbian Medical Association's Guidelines for Care of LGBT Patients

Consumer Focus Group Questions

1. What programs or services do you currently use to meet your needs as a mental health services consumer?
2. If you or a family member has ever experienced discrimination when seeking mental health services or treatment, what effect did this have on your mental health?
3. How does your sexual orientation or gender affect your mental health?
4. What medications and/or alternative therapies do you use to take care of your mental health needs? If you have any problems with these medications or therapies: What would make using these treatments easier for you?
5. What is the biggest challenge or barrier to getting your mental health needs met?
6. What would you like your health care providers to know about you as a lesbian/gay man/trans person/bisexual/questioning/intersex/two-spirit person regarding your mental health care?
7. Who is the person or people that you depend on most to get your mental health needs met?
8. What social groups or organizations do you depend on for support? How are you involved in these groups or organizations?
9. What changes would you like to see as a result of participating in this focus group?