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**LGBTQ+ INDIVIDUALS, HEALTH
INEQUITIES, AND POLICY
IMPLICATIONS**

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I. INTRODUCTION

When the Office of Disease Prevention and Health Promotion (“ODPHP”) released its Healthy People 2020 goals and objectives, it recognized the public health needs of the lesbian, gay, bisexual, and transgender (“LGBT”) community for the first time.¹ The stated goal of Healthy People 2020 is to “improve the health, safety, and well-being of [LGBT] individuals.”² One barrier to obtaining the needed information for achieving this goal is a lack of necessary data collection, particularly as it regards the LGBTQ+ community. This paper will provide a basic overview of health inequities experienced by the LGBTQ+ community and introduce interventions of interest to the legal and public health communities.

II. DESCRIPTION OF LGBTQ+ COMMUNITY

A. ALL COMMUNITIES ARE NOT THE SAME

While the LGBTQ+ community is frequently discussed as one community, it is actually a collection of unique communities. The LGBTQ+ community is inclusive of both sexual orientation and gender identity (“SOGI”) minorities. It is important to note both the similarities and the differences between the groups in order to adequately examine health inequities in a way which meaningfully provides avenues to lower the impact of marginalization and increase wellbeing. The discussion of the LGBTQ+ community as a whole, without considering the unique differences among the groups, can gloss over mean-

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1. *Lesbian, Gay, Bisexual, and Transgender Health*, OFFICE OF DISEASE PREVENTION & HEALTH PROMOTION, <https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health> (last visited June 30, 2019).

2. *Id.*

ingful differences, both in gender experiences and sexual orientation. Additionally, there are those whose attraction and behaviors encompass same-sex persons but who do not define themselves as nonheterosexual.³⁴ Despite the need to engage in a discussion regarding the distinctions between the groups within the LGBTQ+ collective, Ilan H. Meyer notes that “LGBT people share remarkably similar experiences related to stigma, discrimination, rejection, and violence across cultures and locales.”⁵

1. *Lesbian*

The term lesbian generally refers to women who are romantically or sexually attracted to other women.⁶ These women include all female-identified individuals. For example, a transgender woman⁷ who is attracted to women could be a lesbian, although she may identify as queer or pansexual. Likewise, women who like women (“WLW”) may prefer to be called gay or queer instead.⁸

2. *Gay*

The term gay generally refers to persons who are attracted to members of the same sex.⁹ This includes transgender men who like men and transgender women who like women. Recently, the term gay has been applied most commonly to men, though some WLW prefer the term gay rather than lesbian.¹⁰

3. INST. OF MED. (US) COMM. ON LESBIAN, GAY, BISEXUAL, & TRANSGENDER HEALTH ISSUES & RESEARCH GAPS & OPPORTUNITIES, THE HEALTH OF LESBIAN, GAY, BISEXUAL, AND TRANSGENDER PEOPLE: BUILDING A FOUNDATION FOR BETTER UNDERSTANDING (2011).

4. The communities of men who have sex with men (“MSM”) or women who have sex with women (“WLW”) but do not adopt a non-heterosexual identity will not be explicitly discussed in this paper. It is important to note that some of the public health implications here (medical knowledge and treatment) may be applicable to these groups, but some of the issues around stigma and even inclusion as a part of the LGBTQ+ community are beyond this paper’s scope.

5. Ilan H. Meyer, *Why Lesbian, Gay, Bisexual, and Transgender Public Health?*, 91 AM. J. PUBLIC HEALTH 856 (2001).

6. *Glossary of Terms*, HUMAN RIGHTS CAMPAIGN, <http://www.hrc.org/resources/glossary-of-terms/> (last visited Apr 15, 2019).

7. See *infra* Section II(A)(4).

8. INST. OF MED. (US) COMM. ON LESBIAN, GAY, BISEXUAL, & TRANSGENDER HEALTH ISSUES & RESEARCH GAPS & OPPORTUNITIES, *supra* note 3.

9. HUMAN RIGHTS CAMPAIGN, *supra* note 6.

10. *Id.*; INST. OF MED. (US) COMM. ON LESBIAN, GAY, BISEXUAL, & TRANSGENDER HEALTH ISSUES & RESEARCH GAPS & OPPORTUNITIES, *supra* note 3.

3. *Bisexual*

The bisexual community is diverse. It generally includes those who are attracted to more than one sex.¹¹ Some use this term only for those who identify within the gender binary,¹² while others prefer the term pansexual for those who are attracted to a person regardless of gender identity or sex. Most data collection processes will include in the term bisexual anyone attracted to more than one sex or gender. The term is about the attraction, not the current relationship.¹³ So, even if a person is currently in a heterosexual relationship,¹⁴ that person may still identify as bisexual.

4. *Transgender and Nonbinary*

Transgender is a broad term for those whose gender identity does not comport with their assigned sex at birth (“ASAB”). Persons who are transgender may identify as a man or woman, or they may find their gender identity does not fit on the gender binary and identify as nonbinary. Nonbinary identities include anyone who does not identify as exclusively male or female, including those who identify as gender-queer or gender fluid. Transgender and nonbinary identities are about gender and not sexual orientation. Persons who are transgender or nonbinary may identify as straight, gay, lesbian, bisexual, pansexual, etc. in terms of their sexual orientation. Sexual orientation will be in reference to their gender identity, not their ASAB. For example, transgender women who are attracted to women identify as lesbians.¹⁵

5. *The Q+ in LGBTQ+*

The Q in LGBTQ+ can stand for queer or questioning. For purposes of this paper, Q+ is inclusive of the many SOGI minorities in addition to the definitions above. Examples may include those who are questioning their sexual or gender identity. While queer has had a controversial history as a slur, as well as an empowered reclaimed term, a resurgence of individuals are identifying as queer or pansexual because they are sexual identities that are inclusive of many genders, including transgender and nonbinary. Others who do not identify within a specific group on the LGBT spectrum and do not fit

11. Wendy B. Bostwick & Brian Dodge, *Introduction to the Special Section on Bisexual Health: Can You See Us Now?*, 48 ARCHIVES SEXUAL BEHAV. 79 (2019).
12. Those who are attracted to men and women.
13. HUMAN RIGHTS CAMPAIGN, *supra* note 6.
14. A relationship with a person of the opposite gender.
15. HUMAN RIGHTS CAMPAIGN, *supra* note 6.

into the cisgender, heterosexual framework, such as the asexual and intersex communities, also fit under the Q+ umbrella term.¹⁶

6. *Intersectional Identities Within the LGBTQ+ Community*

The LGBTQ+ community is wildly diverse in age, race, ethnicity, gender, geography, and other demographics. Although the community is often seen as monolithic with white cisgender gay men front and center, the community is far more diverse than it is often represented. Despite this diversity, studies rarely explore comparisons between intersectional identities, particularly concerning intersections between sexual orientation, gender, race, and ethnicity.¹⁷ Studying intersectional identities,¹⁸ particularly studying gender along with race and ethnicity,¹⁹ could increase understanding of within-group (e.g., by age, race, ASAB)²⁰ and between-groups (e.g., binary transgender and nonbinary)²¹ comparisons.

A recent article advocates for LGBTQ research to be conducted with an intersectional approach that explores the differences between sexual orientation, gender, and the identities within each group.²² Such an intersectional approach is crucial because when between-groups comparisons are included, unique experiences can be under-

16. INST. OF MED. (US) COMM. ON LESBIAN, GAY, BISEXUAL, & TRANSGENDER HEALTH ISSUES & RESEARCH GAPS & OPPORTUNITIES, *supra* note 3.

17. Anneliese A. Singh et al., *"I Am My Own Gender": Resilience Strategies of Trans Youth.*, 92 J. COUNSELING & DEV. 208 (2014); Anneliese A. Singh & Vel S. McKleroy, *"Just Getting Out of Bed Is a Revolutionary Act": The Resilience of Transgender People of Color Who Have Survived Traumatic Life Events*, 17 TRAUMATOLOGY 34 (2011).

18. Stephanie L. Budge et al., *Coping and Psychological Distress Among Gender-queer Individuals: The Moderating Effect of Social Support.*, 8 J. LGBT ISSUES IN COUNSELING 95 (2014); Jessica Domm, *Minority Stress, Sexual Minorities and Psychological Wellbeing: Implications for Positive Psychology* (Feb. 2, 2017) (unpublished Psy.D. thesis, Victoria University) (on file with the Victoria University Research Repository); Chassitty N. Whitman & Kevin L. Nadal, *Sexual Minority Identities: Outness and Well-Being Among Lesbian, Gay, and Bisexual Adults*, 19 J. GAY & LESBIAN MENTAL HEALTH 370 (2015).

19. Z. Nicolazzo, *'It's a Hard Line to Walk': Black Non-Binary Trans* Collegians' Perspectives on Passing, Realness, and Trans*-Normativity*, 29 INT'L J. QUALITATIVE STUD. IN EDUC. 1173 (2016); Ellen D.B. Riggle et al., *The Positive Aspects of a Transgender Self-Identification*, 2 PSYCHOL. & SEXUALITY 147 (2011).

20. Hélène Frohard-Dourlent et al., *"I Would Have Preferred More Options": Accounting for Non-Binary Youth in Health Research*, 24 NURSING INQUIRY 1 (2017).

21. Budge et al., *supra* note 18; Riggle et al., *supra* note 19; Stephanie L. Budge et al., *The Work Experiences of Transgender Individuals: Negotiating the Transition and Career Decision-Making Processes*, 57 J. COUNSELING PSYCHOL. 377 (2010); Bonnie Moradi et al., *Counseling Psychology Research on Sexual (Orientation) Minority Issues: Conceptual and Methodological Challenges and Opportunities*, 56 J. COUNSELING PSYCHOL. 5 (2009).

22. Shanna K. Kattari et al., *One Size Does Not Fit All: Differential Transgender Health Experiences by Gender Identity and Sexual Orientation* (2019) (on file with author).

stood which serve to inform policy and practice. A statewide study of transgender and nonbinary individuals in Colorado conducted a differential analysis between gender identity, sexual orientation, and age. The study found individuals who were older and heterosexual were less likely to delay care due to anticipated discrimination²³ as compared to young and queer individuals. Compared to transfeminine respondents, transmasculine respondents were twice as likely to delay care and nonbinary individuals were 25% less likely to delay care.²⁴ A similar study exploring the intersectional identities of gender and LGB on outness and well-being found that those who identify as a gender minority scored significantly lower on well-being and thriving scales than those who identified as cisgender and LGB.²⁵ Recent studies that have focused on intersectional identities within the LGBTQ+ community have demonstrated a need within the scientific and medical communities to view gender from a multi-dimensional and intersectional perspective.²⁶

In addition to experiencing homophobia and racism from society at large, LGBTQ people of color (“POC”) may experience intragroup marginalization, such as racism within an LGBTQ community or homophobia within an ethnic community.²⁷ Research has shown that Black LGBTQ people experience a disproportionate level of disapproval for their sexual identity, which may lead to a conflict of identity.²⁸ However, presence and awareness of LGBTQ POC has been shown to ameliorate conflict between LGBTQ and racial and ethnic identities.²⁹ Acceptance plays a key role in a person’s ability to remove competition between their sexual identity and racial identity.³⁰ When a person does not feel a sense of belonging as part of a minority group, it can lead to further self-marginalization.³¹ Findings from another study exploring the tacit and implicit self-marginalization of black nonbinary students emphasized the invisibility of nonbinary identities, and even more so black nonbinary individuals, not only

23. *Id.*
24. *Id.*
25. Whitman & Nadal, *supra* note 18.
26. Nicolazzo, *supra* note 19.
27. Kimberly F. Balsam et al., *Measuring Multiple Minority Stress: The LGBT People of Color Microaggressions Scale*, 17 CULTURAL DIVERSITY & ETHNIC MINORITY PSYCHOL. 163 (2011); Angelique Harris et al., *The Sociopolitical Involvement of Black, Latino, and Asian/Pacific Islander Gay and Bisexual Men*, 21 J. MEN’S STUD. 236 (2013); Mignon R. Moore, *Articulating a Politics of (Multiple) Identities: LGBT Sexuality and Inclusion in Black Community Life*, 7 DU BOIS REV. 315 (2010).
28. Balsam et al., *supra* note 27; Moore, *supra* note 27.
29. Moore, *supra* note 27.
30. *Id.*
31. Harris et al., *supra* note 27.

within the larger society but also within transgender spaces.³² Feeling connected to the LGBTQ community is the strongest predictor of involvement within both LGBT communities and POC communities.³³

Understanding intersectionality of LGBTQ identities can be aided through an approach rooted in anti-oppressive theory (“AOT”), which posits that individuals and their experiences are intersectional and fluid because their experiences and individuality are inextricable from their identities.³⁴ Exploring how these identities interact together can aid in understanding oppression, how oppression is experienced, and discovering different methods of disrupting oppression.

III. HEALTH INEQUITIES DESCRIBED

A. BEHAVIORAL HEALTH

Members of the LGBTQ community have an enormous risk of health inequities in the field of behavioral health. Overall, the community experiences an increase in the incidence of mental health challenges, especially suicide when compared to their cisgender and heterosexual counterparts.³⁵ A systematic review of mental health disorders among LGB individuals showed that depression, anxiety, and substance misuse were at least one-and-a-half times more common among sexual minorities compared to their heterosexual peers.³⁶ While the LGB community experiences a suicide attempt rate of two to three times that of the general population, the transgender community experiences suicide attempts at nine times the rate of the general population.³⁷ Additionally, studies of gender minorities have shown extremely high rates of suicidal ideation,³⁸ with suicidal ideation as high as 51% and attempted suicide rates as high as 30% among trans-

32. Nicolazzo, *supra* note 19.

33. Juan Battle & Angelique Harris, *Connectedness and the Sociopolitical Involvement of Same-Gender-Loving Black Men*, 16 MEN & MASCULINITIES 260 (2013).

34. Kimberle Crenshaw, *Mapping the Margins: Intersectionality, Identity Politics, and Violence Against Women of Color*, in VIOLENCE AGAINST WOMEN: CLASSIC PAPERS 282 (Raquel Kennedy Bergen et al. eds., 2005) (1994); Mehmoona Moosa-Mitha, *Situating Anti-Oppressive Theories Within Critical and Difference-Centered Perspectives*, in RESEARCH AS RESISTANCE: CRITICAL, INDIGENOUS AND ANTI-OPPRESSIVE APPROACHES 37 (Leslie Brown & Susan Strega, eds., 2005).

35. Michael King et al., *A Systematic Review of Mental Disorder, Suicide, and Deliberate Self Harm in Lesbian, Gay and Bisexual People*, 8 BMC PSYCHIATRY, Aug. 18, 2018, at 1.

36. *Id.*

37. NAT’L CTR. FOR TRANSGENDER EQUAL., THE REPORT OF THE 2015 U.S. TRANSGENDER SURVEY (2016) 1-298, <https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf>.

38. Johanna Olson et al., *Baseline Physiologic and Psychosocial Characteristics of Transgender Youth Seeking Care for Gender Dysphoria*, 57 J. ADOLESCENT HEALTH 374 (2015).

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gender youth,³⁹ compared to the national average of 4.6% for cis-gender heterosexuals.⁴⁰

As understood through Minority Stress⁴¹ and an intersectional lens,⁴² LGBTQ individuals with multiple marginalized identities are at even higher risk of mental health disparities than those with a single marginalized identity and these experiences may be unique between each subgroup. LGBTQ POC face racism and LGBTQ-based discrimination, the latter sometimes within their own racial and ethnic communities, which contribute to compound adverse effects on mental health that can lead to suicidal ideation.⁴³ Furthermore, LGBT individuals may be further marginalized and, thus, be at higher risk of suicide due to the additional barriers of homelessness, incarceration (whether in the juvenile justice system or in prison), and mental illness.⁴⁴

Age may also be a consideration for additional behavioral health risks and coping among older LGBTQ adults. Regarding support, older LGBTQ adults may have fewer family connections and rely more on families of choice, such as long-term friends, social organizations, small groups or networks of people,⁴⁵ and have less support in illness and disability if they did not raise children.⁴⁶ Older LGBTQ+ adults are also at higher risk of poor mental health, smoking, excessive drinking, cardiovascular disease, diabetes, and obesity.⁴⁷ Due to historical LGBTQ-based discrimination experienced throughout their lives—perhaps one of the more impactful factors on behavioral

39. *Id.*; JAIME M. GRANT ET AL., NAT'L CTR. FOR TRANSGENDER EQUAL., INJUSTICE AT EVERY TURN: A REPORT OF THE NATIONAL TRANSGENDER DISCRIMINATION SURVEY (2011); Jack Harrison et al., *A Gender Not Listed Here: Genderqueers, Gender Rebels, and Otherwise in the National Transgender Discrimination Survey*, 2 LGBTQ POL'Y J. HARV. KENNEDY SCH. 13 (2012).

40. 2015 U.S. Trans Survey, 2015 U.S. TRANS SURVEY, <http://www.ustranssurvey.org/> (last visited Apr 25, 2019).

41. Ilan H. Meyer, *Prejudice, Social Stress, and Mental Health in Lesbian, Gay, and Bisexual Populations: Conceptual Issues and Research Evidence*, 129 PSYCHOL. BULL. 674 (2003).

42. Doug Meyer, *An Intersectional Analysis of Lesbian, Gay, Bisexual, and Transgender (LGBT) People's Evaluations of Anti-Queer Violence*, 26 GENDER & SOC'Y 849 (2012).

43. Megan Sutter & Paul B. Perrin, *Discrimination, Mental Health, and Suicidal Ideation Among LGBTQ People of Color*, 63 J. COUNSELING PSYCHOL. 98 (2016).

44. Vincent M.B. Silenzio et al., *Sexual Orientation and Risk Factors for Suicidal Ideation and Suicide Attempts Among Adolescents and Young Adults*, 97 AM. J. PUB. HEALTH 2017 (2007).

45. Richard A. Friend, *Older Lesbian and Gay People: A Theory of Successful Aging*, 20 J. HOMOSEXUALITY 99 (1991).

46. KEVIN L. ARD, NAT'L LGBT HEALTH EDUC. CTR., UNDERSTANDING THE HEALTH NEEDS OF LGBT PEOPLE (2016).

47. Leah Eskenazi, *How to Find Care for LGBT Seniors*, PBS NEWS HOUR (June 11, 2015, 2:41 PM), <https://www.pbs.org/newshour/health/lgbt-older-adults-emerging-community>.

health—many older adults may be hesitant to disclose their sexual orientation or gender identity and may even become closeted when entering assisted living,⁴⁸ with concealment leading to anxiety and depression. This may be especially concerning for older transgender adults whose gender may be exposed during physical assistance.⁴⁹

Higher psychological distress and behavioral problems were reported for youth whose parents rejected their gender nonconformity compared to more accepting parents.⁵⁰ In another study, transgender youth reported verbal and physical abuse, high rates of depression, and 47% of respondents reported attempting suicide.⁵¹ Conversely, research continues to reinforce the importance of family acceptance, which has been found to be a protective factor against suicidality⁵² that serves to promote positive health outcomes.⁵³

Recent studies are replete with the corrosive effects of a hostile environment, such as stigma, prejudice, and discrimination, on LGBTQ individuals' overall health. In addition to the corrosive effects of discrimination on mental health, stigma and oppression may inhibit one's ability to cope and further traumatize individuals.⁵⁴ When unique experiences are examined among groups within the LGBT community, the disparities can be even greater, stressing the importance of this information to better serve each population.⁵⁵ These findings highlight the important role of mental and physical health-care providers and organizations to support LGBTQ clients and their families, to provide competent services, and to create inclusive and

48. Iain Johnson, *Gay and Gray: The Need for Federal Regulation of Assisted Living Facilities and the Inclusion of LGBT Individuals*, 16 J. GENDER, RACE, & JUST. 293 (2013); Michael J. Johnson et al., *Gay and Lesbian Perceptions of Discrimination in Retirement Care Facilities*, 49 J. HOMOSEXUALITY 83 (2005).

49. Mo Perry, *The Challenge of Being Transgender in a Nursing Home*, THE ATL. (Aug. 12, 2015), <https://www.theatlantic.com/health/archive/2015/08/transgender-nursing-home-aging/400580/>.

50. H. A. Bradley, *Transgender Children and Their Families: Acceptance and Its Impact on Well-Being*, 71 DISSERTATION ABSTRACTS INT'L 650 (2010).

51. Kenta Asakura, *It Takes a Village: Applying a Social Ecological Framework of Resilience in Working with LGBTQ Youth*, 97 FAMILIES IN SOC'Y 15 (2016).

52. Caitlin Ryan et al., *Family Rejection as a Predictor of Negative Health Outcomes in White and Latino Lesbian, Gay, and Bisexual Young Adults*, 123 PEDIATRICS 346 (2009).

53. SANDY E. JAMES ET AL., NAT'L CTR. FOR TRANSGENDER EQUAL., THE REPORT OF THE 2015 U.S. TRANSGENDER SURVEY (2016); Singh et al., *supra* note 17; ROBB TRAVERS ET AL., IMPACT OF STRONG PARENTAL SUPPORT FOR TRANS YOUTH: A REPORT PREPARED FOR CHILDREN'S AID SOCIETY OF TORONTO AND DELISLE YOUTH SERVICES (2012), https://www.researchgate.net/publication/284988129_Impacts_of_strong_parental_support_for_trans_youth_A_report_prepared_for_Children's_Aid_Society_of_Toronto_and_Delisle_Youth_Services.

54. Lauren Mizock & Kim T. Mueser, *Employment, Mental Health, Internalized Stigma, and Coping with Transphobia Among Transgender Individuals*, 1 PSY. SEXUAL ORIENTATION & GENDER DIVERSITY 146 (2014).

55. Kattari et al., *supra* note 22.

affirming environments⁵⁶ with adaptations to address and ameliorate the increased behavioral health risks due to the unique and marginalized experiences of LGBT individuals.⁵⁷

1. *Violent Injury*

Andrea L. Roberts reported in a national study that the differences in exposure to violence due to sexual orientation were “striking.”⁵⁸ LGB populations were almost twice as likely to have been exposed to violence.⁵⁹ In fact, a key finding of the study was that “lesbians, gay men, bisexuals, and heterosexuals with same-sex sexual partners—but not heterosexuals with same-sex attraction only—had significantly elevated risk of exposure to nearly every [traumatic] event type except war-related traumas.”⁶⁰ Sexual orientation minorities are at an increased risk of experiencing intimate partner violence, sexual assault, physical and sexual abuse in childhood, and violence in their communities, including hate crimes.⁶¹

Violence in the transgender community is particularly concerning. The results of the 2015 U.S. Transgender Survey indicate an increased risk of violence and harm to mental and physical health. Verbal harassment, physical attacks and harassment, and physical or sexual assault accessing bathrooms in the last year were all attributed to reactions to individuals being transgender.⁶² Eight percent of survey respondents attributed urinary tract infections, kidney infections, or other kidney problems in the past year to avoiding restrooms for fear of violence.⁶³

School is a significant factor for LGBTQ youth. In the 2016 Youth Risk Behavior Survey (“YRBS”), LGBT teens reported being bullied in school, having forced sex, and being victims of sexual and physical vio-

56. Megan E. Gandy, *Assessing LGBTQ Youth Cultural Competency in Direct-Care Behavioral Health Workers: Development and Validation of a Measure* (Apr. 2015) (unpublished Ph.D. dissertation, Virginia Commonwealth University) (on file with Virginia Commonwealth University); THE FENWAY GUIDE TO LESBIAN, GAY, BISEXUAL, AND TRANSGENDER HEALTH (Harvey J. Makadon et al., 2d ed. 2015); Patricia E. Penn et al., *LGBTQ Persons with Co-Occurring Conditions: Perspectives on Treatment*, 31 ALCOHOLISM TREATMENT Q. 466 (2013).

57. Ann P. Haas et al., *Suicide and Suicide Risk in Lesbian, Gay, Bisexual, and Transgender Populations: Review and Recommendations*, 58 J. HOMOSEXUALITY 10 (2011); Silenzio et al., *supra* note 43.

58. Andrea L. Roberts et al., *Pervasive Trauma Exposure Among US Sexual Orientation Minority Adults and Risk of Posttraumatic Stress Disorder*, 100 AM. J. PUB. HEALTH 2433, 2437 (2010).

59. *Id.*

60. *Id.*

61. *Id.*

62. JAMES ET AL., *supra* note 50.

63. *Id.*

lence.⁶⁴ Nonbinary students also reported verbal harassment and feeling unsafe in school.⁶⁵

B. MITIGATORS OF NEGATIVE HEALTH OUTCOMES

Acceptance and support have been found to be some of the strongest mitigators to disparate health outcomes for persons in the LGBTQ+ community. As policies are designed, the potential to positively influence acceptance and support may be variables to consider. Below is additional information regarding the kinds of behaviors which mitigate negative health outcomes.

1. Family Support

Research reinforces the importance of family acceptance, a protective factor for LGBTQ youth.⁶⁶ Family acceptance has been found to not only be a protective factor against depression, substance abuse, and suicidal ideation and behaviors⁶⁷ but also to promote higher self-esteem, social support, and general health status among LGBTQ youth and adolescents.⁶⁸ In one of the first studies to assess gender nonconformity among LGB youth, 30% of participants reported negative reactions from parents who discouraged gender atypical behavior through counseling, punishment or restriction, and insistence to change.⁶⁹

64. Hudaisa Hafeez et al., *Health Care Disparities Among Lesbian, Gay, Bisexual, and Transgender Youth: A Literature Review*, 9 CUREUS 1184 (2017); Laura Kann et al., *Sexual Identity, Sex of Sexual Contacts, and Health-Related Behaviors Among Students in Grades 9–12 — United States and Selected Sites, 2015*, 65 MORBIDITY & MORTALITY WKLY. REP. (SURVEILLANCE SUMMARIES) 1 (2016).

65. Harrison et al., *supra* note 39; Russell B. Toomey et al., *Gender-Nonconforming Lesbian, Gay, Bisexual, and Transgender Youth: School Victimization and Young Adult Psychosocial Adjustment*, 46 DEVELOPMENTAL PSYCHOL. 1580 (2010).

66. Maria E. Eisenberg & Michael D. Resnick, *Suicidality Among Gay, Lesbian and Bisexual Youth: The Role of Protective Factors*, 39 J. ADOLESCENT HEALTH 662 (2006); Elizabeth M. Saewyc et al., *Protective Factors in the Lives of Bisexual Adolescents in North America*, 99 AM. J. PUB. HEALTH 110 (2009).

67. Ryan et al., *supra* note 44; Caitlin Ryan et al., *Family Acceptance in Adolescence and the Health of LGBT Young Adults*, 23 J. CHILD & ADOLESCENT PSYCHIATRIC NURSING 205 (2010).

68. JAMES ET AL., *supra* note 50; Ryan et al., *supra* note 65; Anneliese A. Singh et al., *"I am my own gender": Resilience strategies of trans youth*, 92(2) J. COUNSELING & DEV. 208, 208-214 (2014); ROBB TRAVERS ET AL., *IMPACT OF STRONG PARENTAL SUPPORT FOR TRANS YOUTH: A REPORT PREPARED FOR CHILDREN'S AID SOCIETY OF TORONTO AND DELISLE YOUTH SERVICES* (2012).

69. Anthony R. D'Augelli et al., *Childhood Gender Atypicality, Victimization, and PTSD Among Lesbian, Gay, and Bisexual Youth*, 21 J. INTERPERSONAL VIOLENCE 1462 (2006).

2. School Acceptance

School acceptance has been found to be associated with lower anxiety, depression, skipping of classes, and negative coping mechanisms, such as drinking and smoking.⁷⁰ In particular, the presence of school GSAs (previously Gay-Straight Alliances, now Gender and Sexuality Alliances) have been shown to have a significant impact on the wellbeing of LGBTQ youth, as well as lower rates of truancy, tobacco use, alcohol use, attempted suicide, and casual sexual behavior.⁷¹ Even without actively participating, the mere presence of a GSA was a strong indicator of well-being as reported by LGBTQ young adults⁷² and an official sign of support.⁷³

Additionally, GSAs are a meaningful venue for youth to engage in gender and sexual orientation activism.⁷⁴ Despite the need for support, research has also shown that LGBTQ youth lack access to such protective resources.⁷⁵ In the 2015 National School Climate Survey assessing the experience of LGBTQ youth, 23.1% of youth ages thirteen to twenty-one identified as nonbinary, genderqueer, or another gender.⁷⁶ The majority, 56.6% of the sample, reported their school did not have policies that addressed the needs of gender minority students, which were offered as a result of not including nonbinary needs.⁷⁷ Furthermore, even when anti-discrimination policies are in place, Jennifer Schindel reported from her fieldnotes that teachers may not know how to proceed with such things as bathroom usage and accepted pronouns with gender minority students.⁷⁸ In related findings, transgender and nonbinary high school students reported signifi-

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71. V. Paul Poteat et al., *Gay Straight Alliances Are Associated with Student Health: A Multischool Comparison of LGBTQ and Heterosexual Youth*, 23 J. RES. ON ADOLESCENCE 319 (2013).
72. Russell B. Toomey et al., *High School Gay-Straight Alliances (GSAs) and Young Adult Well-Being: An Examination of GSA Presence, Participation, and Perceived Effectiveness*, 15 APPLIED DEVELOPMENTAL SCI. 175 (2011).
73. Carol Goodenow et al., *School Support Groups, Other School Factors, and the Safety of Sexual Minority Adolescents*, 43 PSYCHOL. IN THE SCHOOLS 573 (2006).
74. Jennifer E. Schindel, *Gender 101 – Beyond the Binary: Gay-Straight Alliances and Gender Activism*, 5 SEXUALITY RES. & SOC. POL’Y 56 (2008).
75. Kenta Asakura & Shelley L. Craig, “It Gets Better” . . . but How? Exploring Resilience Development in the Accounts of LGBTQ Adults, 24 J. HUM. BEHAV. IN SOC. ENV’T 253 (2014).
76. JOSEPH G. KOSCIW ET AL. GLSEN, THE 2015 NATIONAL SCHOOL CLIMATE SURVEY: THE EXPERIENCES OF LESBIAN, GAY, BISEXUAL, TRANSGENDER, AND QUEER YOUTH IN OUR NATION’S SCHOOLS (2016).
77. Such policies include adopting pronouns approved by LGBTQ community members and providing all-gender facilities.
78. Schindel, *supra* note 72.

cantly lower-quality student-teacher relationships compared to their cisgender counterparts.⁷⁹

Although hostile school environments have been found to severely compromise the psychosocial wellbeing of LGBTQ youth,⁸⁰ research has found that school-related protective factors against adverse mental health outcomes, such as depression and suicidality, to include perceived school safety and caring adults and teachers.⁸¹

3. Community Support

In a 2018 report, Andrew R. Flores and Andrew Park examined the link between social acceptance of LGBTQ people and legal inclusion of sexual minorities, such as non-discrimination policies. The study found a strong statistical link between social acceptance and legal inclusion of SOGI.⁸² As policies are considered, it may be prudent to examine the impact the policy may have on the LGBTQ community both directly and in terms of societal acceptance.

Research has consistently shown community support to be crucial for wellbeing among transgender and nonbinary adults.⁸³ Interpersonal relationships that allow LGBTQ individuals to be seen and accepted have been repeatedly found to be influential across the lifespan.⁸⁴ Early social development has significant long-term effects on mental health outcomes with social support being necessary for establishing healthy interactions and serving as a protective factor

79. Marla E. Eisenberg et al., *Risk and Protective Factors in the Lives of Transgender/Gender Nonconforming Adolescents*, 61 J. ADOLESCENT HEALTH 521 (2017).

80. Asakura & Craig, *supra* note 73.

81. Eisenberg & Resnick, *supra* note 64; JOSEPH G. KOSCIW ET AL., GLSEN, THE 2009 NATIONAL SCHOOL CLIMATE SURVEY: THE EXPERIENCES OF LESBIAN, GAY, BISEXUAL AND TRANSGENDER YOUTH IN OUR NATION'S SCHOOLS (2010).

82. ANDREW R. FLORES & ANDREW PARK, UCLA SCH. OF LAW, EXAMINING THE RELATIONSHIP BETWEEN SOCIAL ACCEPTANCE OF LGBT PEOPLE AND LEGAL INCLUSION OF SEXUAL MINORITIES (2018).

83. Barbara L. Fredrickson, *The Broaden-and-Build Theory of Positive Emotions*, 359 PHIL. TRANSACTIONS OF THE ROYAL SOC'Y B 1367 (2004); Ilan H. Meyer & David M. Frost, *Minority Stress and the Health of Sexual Minorities*, in HANDBOOK OF PSYCHOLOGY AND SEXUAL ORIENTATION 252 (Charlotte J. Patterson & Anthony R. D'Augelli eds., 2013); ELLEN D.B. RIGGLE & SHARON S. ROSTOSKY, A PRIMITIVE VIEW OF LGBTQ: EMBRACING IDENTITY AND CULTIVATING WELL-BEING (2011); MARTIN E.P. SELIGMAN, AUTHENTIC HAPPINESS: USING THE NEW POSITIVE PSYCHOLOGY TO REALIZE YOUR POTENTIAL FOR LASTING FULFILLMENT (2002); Asakura & Craig, *supra* note 77; Riggle et al., *supra* note 19; Megan C. Stanton et al., *Individual, Social and Community-Level Predictors of Wellbeing in a US Sample of Transgender and Gender Non-Conforming Individuals*, 19 CULTURE, HEALTH & SEXUALITY 32 (2017).

84. Riggle et al., *supra* note 19; Michelle D. Vaughan & Eric M. Rodriguez, *LGBT Strengths: Incorporating Positive Psychology into Theory, Research, Training, and Practice*, 1 PSYCHOL. OF SEXUAL ORIENTATION & GENDER DIVERSITY 325 (2014).

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against isolation, depression, anxiety, and severe mental health challenges.⁸⁵

C. HEALTH ACCESS

Barriers to healthcare access have a significant impact on mental and physical health for LGBTQ+ individuals. Structural and personal forces can work to either assist in access or make it more difficult. The Institute of Medicine describes four primary areas recognized for negatively impacting health access for the LGBTQ community.

1. *Stigma (Personal Level)*⁸⁶

Of the many barriers for LGBTQ individuals, stigma⁸⁷ is associated with lower levels of health care access. Stigma can be experienced explicitly in the form of slurs or violence (“enacted”), indirectly via conversations not directed at the person but nevertheless harmful or in conversations directed at the person with heteronormative language (“felt”), and via the person’s internalized belief learned over time from a society which treats SOGI minorities as others (“internalized”).⁸⁸ Furthermore, anticipated discrimination is a barrier to accessing healthcare for many sexual and gender minorities.⁸⁹ All of these forms of stigma make it more unlikely that the person impacted will trust a health system to be able to meet their needs free of bias. Conversely, a positive LGBTQ identity has been found to bolster resilience and better cope with future minority-related stressors.⁹⁰

85. Budge et al., *supra* note 18; Cara Jean Hale et al., *Social Support and Physical Health: The Importance of Belonging*, 53 J. AM. C. HEALTH 276 (2005).

86. The Institute of Medicine emphasizes that “[p]ersonal-level barriers are created by the attitudes, beliefs, and behaviors of individuals within the health care system—both providers and patients.” INST. OF MED., *THE HEALTH OF LESBIAN, GAY, BISEXUAL, AND TRANSGENDER PEOPLE: BUILDING A FOUNDATION FOR BETTER UNDERSTANDING* (2011). Structural stigma, or institutional stigma, is the manifestation of stigma within the institutions of society. Patrick W. Corrigan et al., *Structural Stigma in State Legislation*, 56 PSYCHIATRIC SERVICES 557 (2005). Structural stigma often perpetuates stigma-based differentials in status and power and may operate even in the absence of prejudice on the part of individual members of an institution. Bruce G. Link & Jo. C. Phelan, *Conceptualizing Stigma*, 27 ANN. REV. SOC. 363 (2001).

87. INSTITUTE OF MEDICINE, *supra* note 84.. The Institute of Medicine defines stigma as: “inferior status, negative regard, and relative powerlessness that society collectively assigns to individuals and groups that are associated with various conditions, statuses, and attributes.” *Id.*

88. INST. OF MED. (US) COMM. ON LESBIAN, GAY, BISEXUAL, & TRANSGENDER HEALTH ISSUES & RESEARCH GAPS & OPPORTUNITIES, *supra* note 3.

89. Michael L. Hendricks & Ryan J. Testa, *A Conceptual Framework for Clinical Work with Transgender and Gender Nonconforming Clients: An Adaptation of the Minority Stress Model*, 43 PROF'L PSYCHOL. 460 (2012).

90. Vaughan & Rodriguez, *supra* note 82.

2. *Structural Stigma*

Structural stigma impacts access to services whether or not the provider or the individual themselves has perpetrated or experienced stigma. These are institutional policies and/or attitudes adopted by society at large, which fail to support inclusion. For example, hospital rules around visitation of same-sex partners, particularly prior to marriage equality, impact the patient whether or not individual providers act to stigmatize patients. These structural problems leave LGBTQ individuals without needed access to services and support.

3. *Professional Knowledge and Training*

While the American Medical Association has recommended improved and increased training in LGBTQ care, the lack of cultural competency across healthcare fields impacts the willingness of the LGBTQ community to enter into treatment with those who do not understand their needs.⁹¹ A review of the literature shows a lack of sufficient training in the needs of the LGBTQ communities.⁹² Some practitioners report feeling incompetent to work with LGBT clients, which may be due to a lack of personal initiative along with a lack of agency responsiveness to prepare professionals.⁹³ Research has shown a significant relationship between LGB-competence among mental health practitioners and organizational LGBT-competence, with the latter increasing the former, strengthening the argument for needed LGBT training.⁹⁴

Transgender individuals are particularly impacted in the area of practitioner competence due to the cultural discomfort with those who do not conform to gender norms.⁹⁵ A systematic review of literature on mental health providers' attitudes towards transgender people showed more frequent positive attitudes compared to the general population, with most negative attitudes among white, heterosexual men who identified as religious and conservative.⁹⁶ However, some mental health professionals report feeling unprepared for working with trans-

91. INST. OF MED. (US) COMM. ON LESBIAN, GAY, BISEXUAL, & TRANSGENDER HEALTH ISSUES & RESEARCH GAPS & OPPORTUNITIES, *supra* note 3.

92. Suzanne Brown et al., *Mental Health Practitioners' Attitudes Towards Transgender People: A Systematic Review of the Literature*, 19 INT'L J. TRANSGENDERISM 4 (2018).

93. Carmen Logie et al., *Evaluating the Phobias, Attitudes, and Cultural Competence of Master of Social Work Students Toward the LGBT Populations*, 53 J. HOMOSEXUALITY 201 (2007).

94. David McCarty-Caplan, *LGBT-Competence in Social Work Education: The Relationship of School Contexts to Student Sexual Minority Competence*, 65 J. HOMOSEXUALITY 19 (2017).

95. Frohard-Dourlent et al., *supra* note 20.

96. Brown et al., *supra* note 90.

gender clients, with some holding religious or political-based prejudiced attitudes.⁹⁷ A study of attitudes towards transgender people among counseling professionals found that in addition to training and experience, factors related to positive attitudes towards transgender people include personal familiarity with transgender people and belief in a biological or other individual etiology for transgender identities.⁹⁸ Despite the expectation that psychologists will engage with transgender clients, little to no training on transgender issues is included during or after their formal education, highlighting the need for cultural competency training,⁹⁹ which is arguably also applicable to other professions.

D. HEALTH INSURANCE

While marriage equality has positively impacted the ability of the LGBTQ community to access employer-sponsored health insurance, disparities in the employment levels of the LGBTQ community, including a lack of anti-discrimination labor laws in many states, still create disparities between the LGBTQ community and the general population in health coverage. Health insurance policies on items such as gender confirmation surgery (“GCS”) and hormone replacement treatments (“HRTs”) can also create structural barriers to health access.¹⁰⁰ In particular, even those with GCS-inclusive policies continue to be written on the binary spectrum and, thus, exclude nonbinary individuals. For example, someone assigned female at birth (“AFAB”) attempting to access top surgery¹⁰¹ who has an insurance policy that uses the language “to affirm their *male* identity” as a requirement for deeming the surgery medically necessary, therefore, excludes anyone who does not identify their gender as male (e.g., nonbinary individuals). Individually, and especially accumulatively, these barriers create a significant burden to the LGBTQ community as individuals attempt to access health care. Health policy discussions should include these issues if we are to begin to increase health care access for LGBTQ individuals.

97. Jill M. Chonody et al., *Attitudes Toward Gay Men and Lesbian Women Among Heterosexual Social Work Faculty*, 50 J. Soc. WORK EDUC. 136 (2014).

98. Emily A. Nisley, *Counseling Professionals' Attitudes Toward Transgender People and Responses to Transgender Clients* (Dec. 2010) (unpublished Ph.D. dissertation, Western Michigan University) (on file with Western Michigan University).

99. AM. PSYCHOLOGICAL ASS'N, REPORT OF THE TASK FORCE ON GENDER IDENTITY AND GENDER VARIANCE (2008).

100. INST. OF MED. (US) COMM. ON LESBIAN, GAY, BISEXUAL, & TRANSGENDER HEALTH ISSUES & RESEARCH GAPS & OPPORTUNITIES, *supra* note 3.

101. The removal of breast tissue and masculinization or neutralization of the chest.

E. ACCESS TO PUBLIC SPACES

1. *Non-Discrimination Legislation*

Affirmation and inclusion of sexual and gender minorities seemed to be gaining momentum the early 2000s, as legislative and organizational policies, including the legalization of gay marriage, increased in the inclusion of non-discrimination policies.¹⁰² However, in 2016, the changing sociopolitical climate saw an increase in discriminatory state-level legislation with proposed and passed laws with negative repercussions, particularly for gender minorities. Currently only nineteen states and the District of Columbia have protections against discrimination based on sexual orientation and gender identity concerning statewide public accommodations.¹⁰³

In 2011, the United Nation’s General Assembly Report acknowledged the discrimination faced by LGBTQ individuals, as documented over the previous two decades, and has recommended each nation to recognize the rights of transgender individuals.¹⁰⁴ More recently, the European Union’s Council of Europe Parliamentary Assembly proposed the transgender-inclusive Resolution 2048. Of the proposed policies, the most nonbinary-applicable were to remove required mental health diagnoses for changing gender markers and to recommend countries include a third gender option.¹⁰⁵ Additionally, research concerning transgender experiences was called for to include discrimination, hate crimes, suicide prevention, and the effectiveness of anti-discrimination legislation.¹⁰⁶

2. *Bathroom Bills*

Historically, bathrooms have been the battleground of human rights movements for Blacks, women, people with disabilities, and now for transgender Americans.¹⁰⁷ The collective bathroom bills began in March 2016 when North Carolina passed House Bill 2 (“N.C.

102. Ray Sanchez, *Feds’ Transgender Guidance Provokes Fierce Backlash*, CNN (last updated May 14, 2016, 6:44 PM), <https://www.cnn.com/2016/05/14/politics/transgender-bathrooms-backlash/>.

103. STATE MAPS OF LAWS & POLICIES: PUBLIC ACCOMMODATIONS, HUMAN RIGHTS CAMPAIGN (last updated June 11, 2018), <https://www.hrc.org/state-maps/public-accommodations>.

104. U.N. Human Rights Council, Rep. of the U.N. High Comm’r for Human Rights, U.N. Doc. A/HRC/19/41 (2011).

105. Discrimination Against Transgender People in Europe, PARL. EUR. DOC. 13742 (2015).

106. *Id.*

107. Alia E. Dastagir, *The Imaginary Predator in America’s Transgender Bathroom War*, USA TODAY (Apr. 28, 2016 5:34 PM), <https://www.usatoday.com/story/news/nation/2016/04/28/transgender-bathroom-bills-discrimination/32594395/>.

H.B. 2”).¹⁰⁸ N.C. H.B. 2 was reportedly a response to several trans-affirming bathroom bills that allowed transgender individuals to use the bathroom according to their gender.¹⁰⁹ Conversely, N.C. H.B. 2 required transgender and nonbinary people to use the bathroom that aligned with their ASAB.¹¹⁰ Although it has since been repealed, N.C. H.B. 2 ignited sixteen other states to propose similar legislation.¹¹¹

The implications of such requirements placed transgender and nonbinary people at risk of physical and mental health risks as a result of facing daily suspicion, harassment, and hostility. According to the 2015 U.S. Transgender Survey,¹¹² bathrooms continue to be increasingly dangerous spaces for transgender persons with increasingly harmful legislation. When attempting to use bathrooms, 9% of respondents reported being denied access, 12% reported being verbally harassed, 1% reported being physically attacked or sexually assaulted with the majority, 53%, of nonbinary respondents reporting avoidance of bathrooms sometimes to always in the last twelve months for fear of harassment and other potential invidious forms of discrimination. For fear of confrontation, 59% of respondents avoided public restrooms in the last year and 32% limited fluid intake to limit necessary bathroom use with 8% reporting urinary tract infection or related infections in the past year due to bathroom avoidance.¹¹³ Even more disparaging is the fact that being denied access to bathrooms has been linked to suicide among transgender individuals.¹¹⁴

The argument of bathroom bill proponents has focused on the protection of women and children from the perceived threat of transgender sexual predators.¹¹⁵ Despite the heightened fear, there have been no recorded cases of assault in a bathroom by a transgender person in the United States.¹¹⁶ Ultimately, the sexual predator argument has been called a *red herring*.¹¹⁷ The Obama administration took a clear stance on bathroom bills with a statement from the Departments

108. H.B. 2, 2016 Gen. Assemb., 2nd Extra Sess. (N.C. 2016).
109. Kevin Drum, *A Very Brief Timeline of the Bathroom Wars*, MOTHER JONES (May 14, 2016), <https://www.motherjones.com/kevin-drum/2016/05/timeline-bathroom-wars/>.
110. Joellen Kralik, *“Bathroom Bill” Legislative Tracking*, NAT’L CONF. OF ST. LEGISLATURES (July 28, 2017), <http://www.ncsl.org/research/education/-bathroom-bill-legislative-tracking635951130.aspx>.
111. *Id.*
112. JAMES ET AL., *supra* note 50.
113. *Id.*
114. Max Kutner, *Denying Transgender People Bathroom Access Is Linked to Suicide*, NEWSWEEK (May 1, 2016, 8:00 AM), <http://www.newsweek.com/transgender-bathroom-law-study-suicide-454185>.
115. Katy Steinmetz, *Why LGBT Advocates Say Bathroom ‘Predators’ Argument Is a Red Herring*, TIME (May 2, 2016), <http://time.com/4314896/transgender-bathroom-bill-male-predators-argument/>.
116. Dastagir, *supra* note 104.
117. Steinmetz, *supra* note 112.

of Education and Justice directing school administrations to ensure that “transgender students enjoy a supportive and nondiscriminatory school environment.”¹¹⁸ At this time, administrative interpretations of these rules have been moving away from including transgender persons from protections.¹¹⁹ Even if legislation passes to allow individuals to use the bathroom according to gender, nonbinary individuals will continue to be excluded unless all-gender bathrooms are present.

3. *The Patient Protection and Affordable Care Act*

The Patient Protection and Affordable Care Act (“PPACA”) provided LGBTQ individuals increased protections and access to services,¹²⁰ even though gender diverse individuals still experience gatekeeping, such as required professional letters to validate their gender,¹²¹ and discrimination in health care.¹²² With the emergence of the World Professional Association of Transgender Health (“WPATH”) standards of care for transgender and gender non-conforming (“SOC”) clients, guidelines have been established with the intent to guide practitioners in providing affirmative care.¹²³ Particular to nonbinary individuals, to the most recent version (“SOC 7”) changed from binary to nonbinary language and included a statement to recommend practitioners not impose the gender binary on youth.¹²⁴ These modifications evidenced an increasing professional awareness of nonbinary identities and established a need for more inclusive practices.¹²⁵

F. MINORITY STRESS THEORY

The minority stress model was developed by Ilan H. Meyer and theorizes that minorities experience diminished mental and physical health as a result of harmful social environments that create stress due to stigma, prejudice, and discrimination.¹²⁶ In particular, a higher prevalence of anxiety, depression, and substance use are at-

118. Sanchez, *supra* note 99.

119. For a more detailed discussion, see *infra* Section IV(C).

120. The White House, *Here's How Obamacare Helps the LGBT Community*, INTERNET ARCHIVE (archived Mar. 7, 2015), <https://web.archive.org/web/20150307034356/https://www.whitehouse.gov/share/lgbt-aca-benefits>.

121. Aiden Collazo et al., *Facilitating Transition Among Transgender Clients: Components of Effective Clinical Practice*, 41 CLINICAL SOC. WORK. J. 228 (2013).

122. GRANT ET AL., *supra* note 39; JAMES ET AL., *supra* note 50.

123. Eli Coleman et al., *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7*, 13 INT'L J. TRANSGENDERISM 165 (2012).

124. *Id.*

125. Frohard-Dourlent, *supra* note 20.

126. Meyer, *supra* note 42.

tributed to minority stress among LGB individuals as compared to heterosexuals. Stigma associated with nonconformity to prevailing sexual orientation and gender norms is a collective experience for LGBT individuals and, therefore, a significant social determinant of health.¹²⁷

Minority stress has been categorized as distal or external¹²⁸ and proximal or internal¹²⁹ processes.¹³⁰ Enacted stigma has been reported to range from seemingly innocuous remarks to physical assault and death threats.¹³¹ Minority stress also results from anticipated discrimination, concealment of identity, and internalized stigma (acceptance and internalization of a negative message about one's identity).¹³²

Michael Hendricks and Ryan Testa theorized additional gender identity-specific stressors of *expectations of violence and discrimination* and *internalized transphobia*.¹³³ Gender nonconformity was found to be a consistent and robust predictor of psychological distress, which was theorized to be in part due to the hypervigilance related to rejection based on perceptions of gender expression.¹³⁴ Some transgender and nonbinary individuals report anticipating rejection “anytime they left home and entered a public space.”¹³⁵

Another group with unique minority stressors is older, LGBTQ adults. In addition to the barriers to care faced by LGBTQ youth and adults, such as a lack of culturally competent providers and experiences with, and a fear of, discrimination, they face additional barriers because of isolation and a lack of social services specific to their needs.¹³⁶ Over 1.5 million LGBTQ people are over sixty-five in the United States, a number expected to double by 2030,¹³⁷ and currently

127. INST. OF MED. (US) COMM. ON LESBIAN, GAY, BISEXUAL, & TRANSGENDER HEALTH ISSUES & RESEARCH GAPS & OPPORTUNITIES, *supra* note 3.
128. An objective, enacted stigma that is directly experienced.
129. A subjective, felt stigma that is internally experienced.
130. Gregory M. Herek, *Sexual Stigma and Sexual Prejudice in the United States: A Conceptual Framework*, 54 NEB. SYMP. ON MOTIVATION 65 (2009); Graham Scambler & Anthony Hopkins, *Being Epileptic: Coming to Terms with Stigma*, 8 SOC. HEALTH & ILLNESS 26 (1986); Meyer, *supra* note 42.
131. Brian A. Rood et al., *Identity Concealment in Transgender Adults: A Qualitative Assessment of Minority Stress and Gender Affirmation*, 87 AM. J. ORTHOPSYCHIATRY 704 (2017).
132. Meyer, *supra* note 42.
133. Hendricks & Testa, *supra* note 87.
134. Domm, *supra* note 18.
135. Brian A. Rood et al., *Expecting Rejection: Understanding the Minority Stress Experiences of Transgender and Gender-Nonconforming Individuals*, 1 TRANSGENDER HEALTH 151, 156 (2016).
136. The White House, *supra* note 117.
137. Perry, *supra* note 48.

only seven LGBTQ+ retirement communities exist in the U.S.¹³⁸ Some older, LGBTQ adults are reluctant to share their sexual or gender identity, becoming closeted when entering assisted living.¹³⁹ Assisted living can be a stressful environment for older transgender adults due to sex-segregated spaces, such as housing, bedrooms, bathrooms, and potentially exposing their gender identity by receiving physical assistance.¹⁴⁰ Furthermore, decades of chronic stress may lead to adverse health effects.¹⁴¹ In particular, survivors of the 1980s and 1990s HIV/AIDS crisis may still be hesitant to engage with medical care and service providers.¹⁴²

IV. LEGAL & PUBLIC HEALTH APPROACHES

A. DATA COLLECTION

Public health relies heavily on data collection to consider both what interventions are needed to protect a population’s health and to determine whether such interventions are effective. Unfortunately, it is difficult to use these methodologies for the LGBTQ population as data collection for this population is scarce and utterly lacking in resources. Healthy People 2020, an initiative of ODPHP, created goals for increased data collection for the LGBTQ community as a necessary step to increase the public health community’s ability to serve this population better. Recommendations included extensive surveys on the demographic and social characteristics of the SOGI community; data gathering on LGBTQ household composition; surveys of income and education in the SOGI community, including comparisons of partnered and unpartnered persons; examination of impact of barriers to care; and studies of the impact of stigma at personal and structural levels on LGBTQ health.¹⁴³ Without this baseline data, it will be challenging to move forward in determining the best ways to serve the LGBTQ community. It will be important to understand the impact of policy on this community in addition to traditional public health data

138. *LGBT Resources, LGBT Senior Housing*, GAY & LESBIAN ASS’N OF RETIRING PERSONS, INC., <http://www.gaylesbianretiring.org/lgbt-resources.html> (last visited Aug. 24, 2019).

139. Johnson, *supra* note 47; Johnson et al., *supra* note 47.

140. Perry, *supra* note 48.

141. MOVEMENT ADVANCEMENT PROJECT & SERVS. & ADVOCACY FOR GAY, LESBIAN, BISEXUAL & TRANSGENDER ELDERS, IMPROVING THE LIVES OF LGBT OLDER ADULTS (2010).

142. Friend, *supra* note 44.

143. *Lesbian, Gay, Bisexual, and Transgender Health*, OFFICE OF DISEASE PREVENTION & HEALTH PROMOTION, <https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health> (last visited Feb 13, 2019).

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statistics because policies alone can be social determinants of health for the LGBTQ community.¹⁴⁴

B. EDUCATION

Despite the American Medical Association's recommendation for more considerable training on LGBTQ topics, there exists a lack of cultural competency in the field, which impacts the willingness of the LGBTQ community to enter into treatment with those who do not understand their needs.¹⁴⁵ The medical community continues to need training regarding the needs of the LGBTQ community. Providers report discomfort or feeling unprepared when taking histories and understanding the treatment needs of the LGBTQ community.¹⁴⁶ Transgender individuals are particularly impacted by this area. Conversely, having "transgender-inclusive" primary care practitioners has been found to significantly reduce the likelihood that transgender and nonbinary individuals will experience depression or suicidal ideations, as well as a strong predictor that transgender and nonbinary individuals will seek medical interventions and not delay care due to fears of discrimination.¹⁴⁷

Recent studies in the field speak to the need for an ongoing commitment for competency training for working with LGBTQ clients. Education for health care providers that are culturally responsive across sexual orientation and gender identity is extremely important.¹⁴⁸ In addition to the medical field, LGBTQ individuals would benefit from professionals in all social service professions receiving LGBTQ education, especially in schools. Formal LGBTQ education plays an essential role in removing the onus on the marginalized population to be educators. Furthermore, priority LGBTQ education can contribute to a more welcoming and affirming environment for recruiting and retaining LGBTQ professionals.

144. Scott Burris, *From Health Care Law to the Social Determinants of Health: A Public Health Law Research Perspective*, 159 UNIV. PA. L. REV. 1649 (2011); Scott Burris et al., *Better Health Faster: The Five Essential Public Health Law Services*, 131 PUB. HEALTH REP. 747 (2016).

145. Greta R. Bauer, "I Don't Think This Is Theoretica; This Is Our Lives": How Erasure Impacts Health Care for Transgender People, 20 J. ASS'N NURSES IN AIDS CARE 348 (2009); Luisa Keomt, *Profound Health-Care Discrimination Experienced by Transgender People: Rapid Systematic Review*, 58 SOC. WORK IN HEALTH CARE 201 (2019).

146. R.E. Knight et al., *Exploring Clinicians' Experiences Providing Sexual Health Services for LGBTQ Youth: Considering Social and Structural Determinants of Health in Clinical Practice*, 29 HEALTH EDUC. RES. 662 (2014).

147. Shanna K. Kattari et al., *Exploring the Relationship Between Transgender-Inclusive Providers and Mental Health Outcomes Among Transgender/Gender Variant People*, 55 SOC. WORK IN HEALTH CARE 635 (2016).

148. Kattari et al., *supra* note 22.

C. STATUTES AND REGULATIONS

The federal landscape under which the LGBTQ+ population lives and accesses health services has been changing. The transgender community, in particular, has seen a number of changes to administrative rules and the interpretation of administrative rules which have made it more difficult to live free from stress and stigma and to access services.

The PPACA nondiscrimination language under section 1557 created an opportunity to expand access to health care for the LGBTQ+ population. Section 1557 prohibited discrimination on the basis of race, color, national origin, sex, age, or disability in health programs receiving federal funding.¹⁴⁹ The definitions for protected groups incorporated pre-existing laws rather than enumerating new protected groups with definitions. In 2016, the administration promulgated an administrative rule specifically directing that Title IX was to be interpreted to include sexual orientation and gender identity under sex discrimination.¹⁵⁰ Within months, a lawsuit on behalf of Catholic health care providers and physicians, *Franciscan Alliance v. Burwell*,¹⁵¹ challenged the rule and the court issued a nationwide injunction.¹⁵²

In 2017, President Trump issued Executive Order 13765, “Minimizing the Economic Burden of the Patient Protection and Affordable Care Act Pending Repeal.”¹⁵³ The order allowed for the Department

149. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1557, 124 Stat. 119 (codified at 42 U.S.C. § 18116). Section 1557 provided:

Except as otherwise provided for in this title? (or an amendment made by this title), an individual shall not, on the ground prohibited under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), the Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.), or section 794 of title 29, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title? (or amendments). The enforcement mechanisms provided for and available under such title VI, title IX, section 794, or such Age Discrimination Act shall apply for purposes of violations of this subsection.

Id.

150. Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31,375 (May 18, 2016) (codified at 45 C.F.R. pt. 92).

151. 227 F. Supp. 3d 660 (N.D. Tex. 2016).

152. *Franciscan Alliance, Inc. v. Burwell*, 227 F. Supp. 3d 660 (N.D. Tex. 2016).

153. On January 20, 2017, the President issued Executive Order 13765 “Minimizing the Economic Burden of the Patient Protection and Affordable Care Act Pending Repeal,” that requires, among other things, “[t]o the maximum extent permitted by law, the Secretary of Health and Human Services . . . shall exercise all authority and discretion available to [] waive, defer, grant exemptions from, or delay the implementation of any provision or requirement of the [PPACA] that would impose a fiscal burden on any State or a cost, fee, tax, penalty, or regulatory burden on individuals, families, health-care providers, health insurers, patients, recipients of healthcare services, purchasers of

of Health and Human Services to waive requirements of the PPACA which would cause fiscal or administrative burdens to states or individuals. This order, in addition to the court’s injunction, effectively undermined the goals of the rule interpreting section 1557 to include sexual orientation and gender identity. In May 2019, the administration set forth a new proposed rule for comment.¹⁵⁴ This proposed rule explicitly changes the administrative interpretation of sex discrimination to be a binary one, allowing states to determine for themselves whether or not to include protections for sexual orientation and gender identity.¹⁵⁵

The next year will be a pivotal one for those seeking to ensure access and non-discrimination for the LGBTQ community. The Supreme Court has granted certiorari to three cases, which will examine whether Title VII workplace discrimination protections apply to sexual orientation and transgender individuals.¹⁵⁶ While these cases are based on Title VII, the Court’s interpretation of sex in under Title VII will have an impact on Title IX and other civil rights laws where the term “sex” is used. The 2019 Supreme Court Term will have significant implications for LGBTQ access to health care in the future.

V. CONCLUSION

It is important to note that, as discussed above, it was not until the Healthy People 2020 initiative that the LGBTQ community was included in this prominent national public health objective. Though the LGBTQ community has been with us from the beginning, it has only relatively recently received attention for the pertinent health disparities and inequities the community experiences. As the public health community continues to improve its ability to work with and for this community, the legal and policy-making community would do well to increase its understanding of the impact of policy on the community. The next few years will be critical for this work, as all three branches of government continue to grapple with the best ways to

health insurance, or makers of medical devices, products, or medications.” Exec. Order No. 13,765, 82 Fed. Reg. 8,351 (Jan. 24, 2017).

154. Nondiscrimination in Health and Health Education Programs or Activities, 84 Fed. Reg. 27,846 (proposed June 14, 2019) (to be codified at 45 C.F.R. pt. 438).

155. *Id.* See the rule’s description of the interpretation to include sexual orientation and gender identity described as a “novel” definition: “The Department proposes to repeal the novel definition of “sex” in the Section 1557 regulation in order to make the Department’s regulations implementing Title IX through the Section 1557 Regulation more consistent with the Title IX regulations of other Federal agencies.” *Id.*

156. *Bostock v. Clayton Cnty.*, 723 F. App’x 964 (11th Cir. 2018), *cert. granted*, 139 S. Ct. 1599 (U.S. Apr. 22, 2019) (No. 17-1618); *Zarda v. Altitude Express, Inc.*, 883 F.3d 100 (2d Cir. 2018), *cert. granted*, 139 S. Ct. 1599 (U.S. Apr. 22, 2019) (No. 17-1623); *EEOC v. R.G. & G.R. Harris Funeral Homes, Inc.*, 884 F.3d 560 (6th Cir. 2018), *cert. granted*, 139 S. Ct. 1599 (U.S. Apr. 22, 2019) (No. 18-107).

work with this community. Importantly, there is some suggestion that the decision may be made to move away from helping this community that continues to face pervasive health inequities. The legal community has a role to play in working to decrease the health disparities of the LGBTQ community. It would be well served to do so.