Advancing Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual, and Two-Spirit (LGBTQIAP2+) Efforts

U.S. Department of Health and Human Services Region VIII

(Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming)

Listening Sessions: April – May 2022

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Executive Summary

Introduction

Between April 26 and May 12, 2022, the collaborative OpDivs and StaffDivs within the U.S. Department of Health and Human Services representing the R8 HHS LGBTQIAP2+ Efforts Working Group in Region 8 held six virtual listening sessions for lesbian, gay, bisexual, transgender, queer, intersex, asexual, pansexual, and two-spirit (LGBTQIAP2+) people and service providers in Region 8 states and Tribes (Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming). Special sessions were held for youth and Tribes. The listening sessions aimed to identify key LGBTQIAP2+ issues and recommendations across Region 8, including:

- Access to health care and human services, including mental health, substance use issues, sexual health, and gender-affirming care
- Challenges relating to intersecting identities (e.g., race, ethnicity, socioeconomic status [SES], neurodivergence)
- Impacts of rurality on LGBTQIAP2+ communities
- Challenges specific to LGBTQIAP2+ youth, young adults, and older adults
- Impacts of federal, state, and local policies on health outcomes and quality of life

The sections below highlight key themes and actionable recommendations across the listening sessions.

Key Themes

Disparities Between Urban and Rural Areas

Participants consistently highlighted disparities between urban and rural areas in LGBTQIAP2+ acceptance, health resources, community organizations, and legal protections. Many LGBTQIAP2+ people in rural communities hide their identities or move to larger cities. One participant living in a small community in Wyoming described hiding his identity and relationship with his partner:

> *"I can't hold hands with my partner and feel safe anywhere in town. I can't show him any type of affection in public and still feel safe."*

The movement of LGBTQIAP2+ people to urban areas further exacerbates the urban/rural polarization regarding LGBTQIAP2+ acceptance and visibility, including the belief among many rural communities that LGBTQIAP2+ people do not exist in their communities. The social isolation of LGBTQIAP2+ individuals is compounded by the isolation of rural life, particularly for LGBTQIAP2+ minors, older adults, and permanently disabled people who are unable to move to larger cities.

Multiple participants described safety concerns in many rural and socially conservative areas, including the cancellation of Pride events due to threats of violence. One participant in South Dakota described how fears of potential violence led community organizers to cancel a Pride event:

> *"It was deemed unsafe for us to have a Pride event, especially when I wanted to have a Pride event in other to show that queer people in rural communities exist, and hopefully we could get together and celebrate our identities—for young kids who have no idea what their identity is to know that it is possible. I can't remember the exact name of it but it is a right-leaning conservative gun group. The community organizer said that* [the gun group] *has a lot of meetings happening, and that if we hosted* [Pride]*, there would be fear that there would be violence with guns at the event."*

Similarly, LGBTQIAP2+ participation in hearings and other local legislative processes is often hampered by safety concerns, including the presence of counter-protesters using explicitly anti-LGBTQIAP2+ and white nationalist rhetoric and symbols. Even in urban areas such as Denver, participants expressed concern about potential violence at Pride and other LGBTQIAP2+ community events.

Distrust in Local Authorities and Law Enforcement

The isolation of rural areas can allow local authorities to carry out implicitly or explicitly anti-LGBTQIAP2+ actions, even in states with laws that prohibit discrimination based on sexual orientation and gender identity. Multiple participants noted that increased nationwide polarization and anti-LGBTQIAP2+ rhetoric have emboldened many local authorities to disregard federal and state legal protections, including curriculum requirements, public accommodation laws, and student privacy regulations. Law enforcement in rural areas can disproportionately target LGBTQIAP2+ people, including through harsher punishments for relatively minor infractions. As a result, many participants from rural areas expressed distrust in local law enforcement.

Sexual Education and Health Resources

Sexual health and education resources vary dramatically between urban and rural areas. Many rural Region 8 states do not require sexual education. Rural schools that do provide sexual education often use abstinence-based curricula that focus only on cisgender and heterosexual needs and issues. Many rural schools lack resources and educational materials specific to LGBTQIAP2+ sexual health concerns. Moreover, some curricula perpetuate sexual stigma, especially stigmas about female sexuality and number of sexual partners, as described by one participant in North Dakota:

> "[Sexual education] *is very heteronormative and not LGBTQIAP2-friendly at all. Even the heteronormative sexual education is basically just 'don't have sex.' A friend told me her sexual education teacher targeted her and her boyfriend, and* [the teacher] *had them go up on a bed in front of the class and then had other people join them on the bed to represent that whenever you're sleeping with one person, you're sleeping with all their partners."*

Rural areas also often have few resources and providers for sexual health and sexually transmitted infection (STI) or HIV testing. Many LGBTQIAP2+ people in rural communities seek testing outside their communities or avoid getting tested for fear that positive test results will be leaked to the community or they will be unable to access treatments in their communities. Although at-home STI and HIV testing is becoming increasingly available, people who test positive may not seek treatments due to stigma within health care settings. Participants expressed concern that the overturning of Roe v. Wade would further limit sexual and reproductive health access in rural and socially conservative areas.

Most rural health care providers also lack knowledge and experience with pre-exposure prophylaxis (PrEP), which can significantly reduce the chances of HIV infection. Educating doctors about sexual health issues can lead to insensitive exchanges, including unnecessarily detailed questions about a patient's sexual history, making patients reluctant to continue seeking PrEP or other sexual health resources.

Participant Recommendations

- Tailor LGBTQIAP2+ resources, outreach strategies, and messaging for rural and socially conservative areas. Participants recommended continued analyses and listening sessions in rural and politically conservative areas to evaluate and prioritize the most urgent LGBTQIAP2+ needs.
- Add LGBTQIAP2+ inclusivity and representation requirements to federal grants and funding (e.g., Title X family planning funding).
- Increase education regarding PrEP and LGBTQIAP2+ sexual health needs for rural health care providers.

Access to LGBTQIAP2+ Health Resources

Limited Access to LGBTQIAP2+ Providers in Rural Areas

Beyond sexual health, many rural areas have limited access to other forms of health care, including mental health, substance use treatments, and LGBTQIAP2+ health care. Many rural health care practitioners (e.g., primary care physicians, hospital staff) lack training or knowledge regarding LGBTQIAP2+ health issues and cultural competency. Many participants from rural areas described how patients' sexual orientation or gender identity can lead to negative reactions from health care providers (e.g., casting LGBTQIAP2+ patients as belligerent), lower quality of care, religious explanations for health issues, and misdiagnoses (e.g., falsely attributing symptoms to hormone replacement therapy [HRT]). Transgender, nonbinary, and two-spirit patients are also often misgendered or deadnamed by many rural health care providers, making them reluctant to seek medical care. Even if physicians are affirming, many other clinical staff may lack cultural competency in LGBTQIAP2+ issues, and many medical forms lack options for nonbinary gender identities and often force LGBTQIAP2+ patients to out themselves.

Multiple participants expressed concern about the confidentiality of their health information at health care providers in small and close-knit communities. Transgender, two-spirit, and nonbinary people are particularly reluctant to seek gender-affirming care within their communities due to fear of their health information being leaked to the community. Concerns about confidentiality lead many LGBTQIAP2+ people to seek health care outside their communities or to avoid seeking medical care. One participant living in a tribal community described these concerns:

> *"One of the obstacles in healthcare is people don't trust that their information is going to remain confidential. They're afraid that so-and-so's aunt works at the* [Indian Health Service]*, and she will tell so-and-so, and* [their information] *will be spread all across the reservation. I don't know whether that occurs, but that's the perception, so it's difficult to talk about health issues related to being gay, and especially for transgender people."*

Because most LGBTQIAP2+ health care resources are located in larger urban areas, transportation to these urban areas can present a significant barrier to health care for LGBTQIAP2+ people in rural areas. Participants noted that access to mental health services in rural areas has improved with the widespread adoption of virtual meetings during the COVID-19 pandemic, but this access is often hampered by limited rural broadband availability.

Long Waitlists for Affirming Providers

Many affirming health care providers and LGBTQIAP2+ health resources become overwhelmed by demand, including from patients and families traveling or moving from rural areas and surrounding states, leading to long waitlists for care. One clinic in Denver that provides gender-affirming care for minors stated:

> *"We started 2021 with no waitlist. We were able to get patients scheduled right away. Something happened starting in April, and our waitlist is about 12-18 months long for new patients. We are seeing a huge increase in patients coming from other states and moving from other states. We are really struggling on how to best serve everyone and yet also prioritize our Colorado patients, and also recognize that it is just not possible for us to see everyone in the Rocky Mountain region. From a clinical perspective, one of our struggles is how to maintain quality of care, how to ensure that we have access for all youth, especially under 18, since they are very marginalized right now. And also how to continue to support patients and families in states where these rights are threatened. We are working on it, taking it one day at a time and our staff is amazing. I'm sure everyone here is experiencing compassion fatigue and burnout with really no end in sight."*

These waitlists impact most forms of gender-affirming care, including hormone replacement therapy (HRT), electrolysis, counseling for letters required under the World Professional Association for Transgender Health (WPATH) Standards of Care (SOC), and gender-affirming surgeries. Participants in Colorado noted waitlists of 12 months or longer for electrolysis and even longer waitlists for some gender-affirming surgeries.

Insurance denials based on diagnoses of gender dysphoria and complex pre-authorization procedures for many services further limits access to affirming providers, particularly since many affirming providers do not accept Medicaid. Similarly, long waitlists for affirming care can exacerbate mental health issues among LGBTQIAP2+ people.

Participant Recommendations

- Offer mental health assistance programs for LGBTQIAP2+ people on long waitlists or unable to reach affirming providers.
- Revise medical forms and electronic health record (EHR) systems to include options for nonbinary gender identities, account for transgender-specific health issues, and avoid outing LGBTQIAP2+ people when not medically necessary.
- Increase education regarding LGBTQIAP2+ health issues at all levels of health care providers, including staff, nurses, and medical assistants.
- Develop and expand transportation assistance programs for patients in rural areas who are moved to distant hospitals due to specific medical needs.
- Continue the increased usage and expansion of telehealth capabilities initially adopted in response to the COVID-19 pandemic.

Variation Among the LGBTQIAP2+ Community

Multiple participants highlighted variation in acceptance, health care access, and safety among the LGBTQIAP2+ community, with transgender, nonbinary, and two-spirit individuals facing greater obstacles than their cisgender counterparts. Even in larger cities such as Salt Lake City, transgender and nonbinary acceptance can lag behind acceptance of cisgender lesbian, gay, bisexual, and pansexual people. One participant in Utah described this disparity:

> *"Salt Lake City itself is a pretty safe place, especially for the LGB community. I think the state in general, even in the cities, is pretty far behind on transgender equity and safety. The transgender community is a target in policy, legislation, and culture. We're talking broadly about the LGBTQIAP2+ community, but the transgender experience is a lot more marginalized and lagging in progress* [compared to] *sexual orientation."*

Multiple transgender and nonbinary participants noted their safety and acceptance often depends on their ability to "pass" as cisgender. Many recent bills introduced and passed in Region 8 states specifically impact transgender and nonbinary youth, and more such laws will likely be introduced in upcoming legislative sessions.

Health care access for transgender, nonbinary, and two-spirit individuals is similarly impeded by medical professionals' lack of awareness of transgender-related health issues and cultural insensitivity to the transgender and nonbinary communities. For example, deadnaming and misgendering of transgender and nonbinary patients is common in health care contexts in both urban and rural areas. Therapists may also conflate body dysmorphia and gender dysphoria, even though medical treatments advised for one condition are contraindicated for the other.

Insurance limitations and exclusions for gender-affirming care also significantly impact transgender, nonbinary, and two-spirit people.

Participant Recommendations

- Increase competency training for all health care professionals regarding transgender, nonbinary, and two-spirit terminology and health needs.

Intersectionality with Other Identities

Systemic racism can present unique challenges that disproportionately impact LGBTQIAP2+ people from minoritized racial and ethnic communities. For example, in many border communities near reservations, Indigenous LGBTQIAP2+ people experience both racism and homophobia or transphobia, and many health care providers make assumptions based on stereotypes about Indigenous people (e.g., Indigenous people live in poverty and rely on government assistance programs). One Indigenous participant who works for the Child Ready Montana project illustrated how racism can make racial and ethnic minorities reluctant to seek health care in border communities:

> *"One of the visits we made a few weeks ago to certify a* [health care facility] *for the Child Ready project was in a border town. I look kind of generic* [i.e., less likely to be identified as Indigenous based solely on appearance]*, so they have no idea who I really am, but you could feel that border town tension in the room. If I'm feeling that tension, what does a patient of color feel when they walk into that facility?"*

Furthermore, the sexual and gender identities of LGTQIAP2+ people of color are frequently invalidated or viewed as ephemeral compared to White sexual and gender identities.

Many mainstream LGBTQIAP2+ community organizations have historically focused on White and middle-class needs, which marginalizes many racial and ethnic minorities and people with lower SES. These organizations also often do not account for cultural differences that affect inclusion and belonging; for example, many Native languages do not include words that directly translate to English pronouns (e.g., he/his, she/her), so many Indigenous LGBTQIAP2+ people dislike being asked about their preferred English pronouns. Many LGBTQIAP2+ events such as Pride are often less accessible to many LGBTQIAP2+ people with transportation difficulties, disabilities, and older adults.

Participant Recommendations

- Increase LGBTQIAP2+ and cultural competency training for health care providers, including training in how intersecting identities influence patient needs and health outcomes.
- Encourage LGBTQIAP2+ community organizations to hold events accessible to different age groups and people with disabilities, transportation difficulties, and other socioeconomic factors.

Challenges Facing LGBTQIAP2+ Youth and Young Adults

Participants highlighted that LGBTQIAP2+ youth and young adults – particularly transgender, nonbinary, and two-spirit youth – face unique challenges, particularly in more rural and socially conservative areas. The recent rise in bills that prohibit gender-affirming care for minors and participation in sports programs that match one's gender identity significantly increases anxiety among LGBTQIAP2+ youth, even in states such as Colorado that prohibit discrimination based on sexual orientation and gender identity. Multiple Region 8 states have passed similar bills (e.g., HB 11 in Utah, SB 46 in South Dakota), and their quick passage prevents the LGBTQIAP2+ community from responding to bills before they move to a vote. Participants described how recent bills such as Florida's Parental Rights in Education law (also known as the "Don't Say Gay" law) and the recent U.S. Supreme Court decision overturning Roe v. Wade further increases anxiety and feelings of isolation and uncertainty. One participant in South Dakota stated:

> *"Florida just passed the 'Don't Say Gay' bill and I know that is probably going to be spreading across the country. We're also extremely worried about the overturning of same-sex marriage* [rights]*. If the Supreme Court can overturn Roe v. Wade, I'm sure that they're going to be coming for other things.* [The Obergefell v. Hodges decision] *was never a law, it was a Supreme Court decision, so what is that going to look like, especially for our youth? Our youth are potentially able to see potentially healthy queer relationships, but if* [same-sex marriage rights] *get taken away, what is going to happen? Queer youth have really high rates of depression, anxiety, and suicide, and that is amplified among tribal communities.* […] *I don't know how to be living in this society right now, and I don't know how to tell our youth that it's okay because it's not."*

Mental Health

Participants noted that connection with a visible and inclusive LGBTQIAP2+ community can significantly improve mental health among LGBTQIAP2+ youth, including locating affirming health care providers, and providing peer support for coming out and transitioning. However, many LGBTQIAP2+ organizations are limited to more urban areas as well as colleges and universities, and most rural states have few if any PFLAG chapters or resources for LGBTQIAP2+ families. Some schools provide resources through gender and sexuality alliances (GSAs), but many rural schools also lack GSAs.

LGBTQIAP2+ youth are three times more likely to attempt suicide than their cisgender and heterosexual peers, particularly LGTQIAP2+ minors with non-accepting parents and liberal access to firearms. Financial dependence on parents, including parents' health insurance plans, may leave youth in the closet at home out of fear of rejection and loss of stable housing and food. Many LGBTQIAP2+ youth are unaware of relevant privacy and confidentiality protections for minors, and they may avoid seeking medical or mental health assistance out of fear of being outed to their parents. Similarly, many school boards may be unaware of student privacy rights, particularly that schools are not required to disclose student LGTQIAP2+ identities to parents, even when parents request this disclosure.

State and Local Child Welfare Systems

Many state and local child welfare agencies (e.g., child protective services agencies) lack clear guidance on the rights of LGBTQIAP2+ children within child welfare systems, and existing laws and guidance can leave LGBTQIAP2+ minors vulnerable. For example, while LGBTQIAP2+ children within foster care have the right to placements with people that have been *trained* on LGBTQIAP2+ issues, this right does not guarantee placement with an *affirming* foster care provider. In neglect and dependency cases, many state and local child welfare agencies and courts lack guidance on which parent or guardian has control over health care and legal decisions for transgender and nonbinary minors, which significantly impacts the ability of those minors to access gender-affirming health care and legal changes (e.g., name and gender marker changes).

Increased Polarization of School Boards, Curricula, and School Policies

Participants consistently highlighted the increased polarization and politicization of school board meetings, school curricula, public accommodations access within schools, and other school policies. Many school boards are increasingly dominated by socially conservative members without backgrounds in education, and these members often focus on excluding LGBTQIAP2+ material from school curricula, opposing public accommodations that match students' gender identity, and opposing curricula perceived as Critical Race Theory (CRT). One charter school in a socially conservative area of Colorado issued a written proclamation that federal and state nondiscrimination laws "violate natural law." Even in more socially liberal areas, school boards may be reluctant to include curricula on LGBTQIAP2+ issues due to fears of potential backlash from conservative parents. School board meetings are also increasingly acrimonious, with some participants describing physical violence at meetings or cancellation of meetings due to safety concerns.

The increased polarization around school policies and exclusion of LGBTQIAP2+ books and curricula negatively impacts the mental health of LGBTQIAP2+ youth, exacerbating a sense of isolation and uncertainty. LGBTQIAP2+ advocates have found some success in framing LGBTQIAP2-affirming policies and curricula as suicide prevention measures, but some policies (e.g., participation in sports that match a student's gender identity) remain deeply divisive in many school districts.

Participant Recommendations

- Encourage educators in rural areas to create opportunities for students to discuss LGBTQIAP2+ topics, including LGBTQIAP2+ mental health issues.
- Provide additional education and outreach to LGBTQIAP2+ youth and young adults regarding their rights, particularly privacy and patient confidentiality.
- Issue guidance for school districts on providing equal access to education for LGBTQIAP2+ students and federal protections for student privacy.
- Provide clear guidance to state and local child welfare agencies on the rights of LGBTQIAP2+ children within child welfare systems and those involved in dependency and neglect cases.