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The Current Status of Sociopolitical and Legal Issues Faced by Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning Youth

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Abstract

Background: Adolescents today have unprecedented and uninterrupted access to news and current events through broadcast and social media. Lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQ) adolescents may be especially cognizant of media and public discourse pertaining to law and policy changes affecting the legal rights of their communities. The minority stress framework explains how sociopolitical discourse impacts mental health among sexual and gender minority youths.

Objectives: This paper identifies and describes contemporary sociopolitical and legal issues that may impact LGBTQ adolescents' mental health.

Methods: Authors describe the minority stress framework as applied to gender and sexual identity and explore key sociopolitical and legal topics relevant to LGBTQ adolescents, including employment; medical care bans; health insurance coverage; conversion therapy; religious exemptions in health care; housing rights; and rights in schools and school districts, including participation in sports.

Results: LGBTQ youth experience rejection, prejudice, and discrimination directly through adverse legislative or administrative action and more pervasively through the dominant cultural beliefs and sociopolitical messaging that such developments manifest.

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CONFLICT OF INTEREST

The authors declare no conflict of interest, financial or otherwise.

Conclusion: Mental health clinicians who are aware of legal issues and sociopolitical debate pertinent to LGBTQ rights are better prepared to address their significant impact on LGBTQ adolescents' mental health.

Keywords

LGBTQ; youth; adolescent; gender; sexual orientation; minority stress; discrimination; legal; politics; affirming care; policy; school; trans ban; housing; health insurance coverage; personal belief exemption; conversion therapy; Title IX; Title VII

1. INTRODUCTION

More than ever before, youths have unfettered access to broadcast and social media. Around 90% of teenagers report using the internet at least several times per day, and 45% report they are online "almost constantly" (Pew Research Center, 2018). One large survey study showed that lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQ) youth spend even more time online than their cisgender [1] heterosexual peers (GLSEN, CiPHR, & CCRC, 2013). Data also suggest that LGBTQ youth use the internet for civic participation at very high rates (88%) and at rates about twice that of their cisgender heterosexual peers (GLSEN *et al.*, 2013). Thus, LGBTQ youth are often keenly aware of legal and political developments reported in the news and may be particularly attuned to media related to their continually evolving legal rights and apparent standing in society.

Research on health outcomes among LGBTQ youth consistently documents widespread mental and physical health disparities (*e.g.*, Gonzales & Henning-Smith, 2017). LGBTQ youth experience elevated rates of suicide attempts, substance use, and sexual risk behaviors, as compared to cisgender heterosexual peers (Kann *et al.*, 2016; Human Rights Campaign, 2012). These concerning outcomes stem from chronic, pervasive experiences of social stigma, rejection, victimization, and discrimination.

Over two decades of rigorous scientific inquiry illustrates that mental health among LGBTQ youth is directly and indirectly affected by laws pertaining to LGBTQ civil rights. For example, in states that legalized same-sex marriage before the United States Supreme Court required it, the rate of suicide attempts among sexual minority high school students —and high school students overall—subsequently declined (Raifman, Moscoe, Austin, & McConnell, 2017). Legal developments affecting civil rights often garner significant media exposure and instigate discussion about perceptions of LGBTQ populations more generally. LGBTQ youth may experience such developments on both a practical level (*e.g.*, by gaining the right to marry the partner of their choice) and psychologically (*e.g.* by internalizing messages that they are worthy of rights). Legal changes amounting to an expression of public affirmation and support for LGBTQ rights and identity may promote a more positive self-image and a sense of safety among LGBTQ youths, while publicity regarding the restriction or loss of civil rights among the LGBTQ community may contribute to feelings

[1]The term cisgender refers to gender identity that matches sex assigned at birth.

of stigma, hopelessness, internalized homophobia, and poor self-image (Woodford, Paceley, Kulick, & Hong, 2015; Bauermeister, 2014).

For clinicians treating youth, it is prudent to stay informed about legal and civil rights matters that contribute to stress experienced by LGBTQ patients. In this article, we report on key issues that affect LGBTQ youth, including employment; medical care bans; health insurance coverage; conversion therapy; religious exemptions in health care; housing rights; and rights in schools and school districts, including participation in sports.

2. MINORITY STRESS FRAMEWORK

Mental health disparities among sexual and gender minorities are well documented in the extant literature. Known disparities include higher rates of substance use, depression, anxiety, self-harm and suicidality compared to heterosexual and cisgender counterparts (Gonzales & Henning-Smith, 2017). However, no credible scientific evidence suggests that individuals with diverse sexual and gender identities have an inherent predisposition for psychopathology (Bailey, Vasey, Diamond, Breedlove, 2016). More than two decades of robust research shows that these disparities are attributable to the chronic stress stemming from experiences of stigma and discrimination on the basis of sexual orientation and gender identity (Cochran, 2001), also referred to in the academic literature as “minority stress.”

Meyer’s (1995, 2003) minority stress framework is an extension of social stress theory (Crocker, Major, & Steele, 1998; Link & Phelan, 2001) and was developed out of the early body of research that connected experiences of discrimination and stigma with increased psychological distress (*e.g.*, Markowitz, 1998). The minority stress model contextualizes health disparities among LGBTQ individuals within a sociopolitical climate that is characterized by exposure to rejection, stigma, prejudice, and discrimination—including legal or structural inequalities—as a result of socially marginalized identity. Minority stressors affecting sexual and gender diverse individuals are chronic, socially embedded, and unique to these populations (*i.e.*, are above and beyond typical stressors experienced by similarly situated, non-stigmatized groups) (Meyer, 2003; Hatzenbuehler & Pachankis, 2016). Such stressors include both explicit and less conspicuous experiences of discrimination, the persistent expectation of stigma, internal and external pressure to conceal one’s identity in anticipation of negative reactions, and internalized negativity towards one’s own identity as a result—all of which are connected to poorer mental health outcomes (Hatzenbuehler, 2009). Minority stress functions to disrupt cognitive (*e.g.*, rumination), affective (*e.g.*, low mood), interpersonal (*e.g.*, isolation), and physiological (*e.g.*, hyper-vigilance, high stress reactivity) processes, collectively harming the overall health of sexual and gender diverse communities (Hatzenbuehler & Pachankis, 2016).

Within this framework, Meyer (2003) distinguishes between proximal and distal stressors. Proximal stressors are subjective events that rely on individual perceptions such as internalized heterosexism and homophobia, expectations of stigma, and concealment of one’s identity. Distal stressors refer to objective environmental conditions, such as structural stigma, that do not depend on individual perceptions. Hatzenbuehler (2016) defines structural stigma, also referred to as institutionalized discrimination, as “societal-

level conditions, cultural norms, and institutional policies that constrain the opportunities, resources, and wellbeing of the stigmatized." This form of discrimination often stems from stereotypic beliefs held by the majority and infused into federal, state, and local policies and laws, resulting in self-perpetuating socio-structural inequalities that disadvantage the minority group. Common examples are laws (discussed herein) that fail to protect sexual and gender minorities and thus legally allow for discrimination in employment, housing, and other key areas of life. Proximal stressors function to mediate the effects of such distal stressors at the macro-level, thus helping explain the connection between the noted health disparities and the sociopolitical and legal context (Brewster *et al.*, 2013; Dyar *et al.*, 2018; Velez *et al.*, 2017).

While the distal stressor of an adverse legal environment has a profound effect upon all LGBTQ communities (Hatzenbuehler, 2009), youths—who are heavily dependent on and influenced by the support (or lack thereof) at home and at school—are especially vulnerable. The literature clearly indicates how the immediate social environment—family, peers, and school—greatly affects the outcomes of sexual and gender diverse youth (Newcomb *et al.*, 2019; Hatzenbuehler, 2011). For example, the more contexts in which gender diverse youth are referred to by their chosen name (*e.g.*, teachers at school, parents at home, doctors in medical settings, *etc.*), the lower their suicidal ideation, suicidal behaviors, and depression (Russell, Pollitt, Li, & Grossman, 2018). Although structural stigma and discrimination at the federal, state, and local level have been the subjects of comparatively less empirical research, a growing body of work illustrates such distal stressors play a critical role in shaping the health outcomes of LGBTQ youth, as well (Hatzenbuehler, 2017; Hatzenbuehler & Link, 2014; Hatzenbuehler, 2014).

The detrimental impact of distal minority stressors on LGBTQ populations, generally, is evident from studies showing higher rates of psychiatric disorders and psychological distress among sexual minority adults living in states that banned same-sex marriage before it was federally recognized (Rostosky, Riggle, Horne, & Miller, 2009), as well as those living in states that do not protect LGBTQ people from employment discrimination or hate crimes (Hatzenbuehler, Keyes, & Hasin, 2009). Given that the positive psychological effects of the legalization of same-sex marriage noted in the literature are not dependent on partnership status, same-sex marriage policies likely have broader impact on sexual minority communities beyond the direct benefits of entering into legal marriage (Hatzenbuehler *et al.*, 2012). Furthermore, while initial studies on structural stigma, institutionalized discrimination, and the broader legal context surveyed adult participants, studies focused on youth samples have yielded similar findings (*e.g.*, Raifman *et al.*, 2017).

For example, researchers observed suicide attempts among public high school students before and after law recognizing same-sex marriage passed in 32 states and compared suicide attempts among high school students in 15 other states where same-sex marriage remained illegal using data from the nationally-representative Centers for Disease Control and Prevention (CDC) Youth Risk Behavior Surveillance System from 1999 to 2015. Results showed that state-level same-sex marriage laws were associated with a significant reduction in suicide attempts among LGB students, providing specific evidence of the impact of laws on mental health outcomes for sexual minority youth (Raifman *et al.*,

2017). Likewise, studies show that LGBTQ youth living in states with lower structural stigma and institutionalized discrimination are less likely to use substances such as cigarettes, marijuana, and other illicit drugs (Hatzenbuehler, Jun, Corliss, & Austin, 2014; Hatzenbuehler, Jun, Corliss, & Austin, 2015).

As this line of research demonstrates, the legal environment is a strong objective factor that is not often self-reported but may nevertheless have a profound impact on the mental health of LGBTQ youth. Simply put, well-publicized laws and policies send loud and easily internalized messages to youth: either that they are equal, valued, and deserving of protection, or that they are not. Practitioners should be aware of such societal messaging and how it may affect their LGBTQ patients. Accordingly, the sections below summarize key areas in which extant and proposed laws and regulations may affect the lives and mental well-being of young LGBTQ patients.

3. SOCIOPOLITICAL AND LEGAL ISSUES

3.1. Employment

Legal protections for LGBTQ adults and teens in the workplace have been the subject of legal and political controversy for decades. At the national level, Title VII of the Civil Rights Act of 1964 (Title VII) protects historically persecuted minorities in every state from discrimination in important employment decisions such as hiring, firing, compensation, or promotion. Drafted during the Civil Rights era, the law as written prohibits covered employers from providing differential treatment to employees on the basis of their sex, race, color, national origin, or religion. Although studies show that LGBTQ people are frequent targets of workplace discrimination and earn, as a group, significantly lower income than Americans overall, neither Title VII nor any other federal legislation explicitly protects LGBTQ individuals from being fired for coming out or suffering any different manner of discrimination at work. And efforts to enact legislation formally adding sexual orientation and gender identity as protected classes under Title VII—previously called the Employment Non-Discrimination Act (ENDA), and most recently the Equality Act—have been stymied in Congress since 1994.

Thus, until recently, whether LGBTQ people had a right to work without discrimination depended entirely on where they lived. As of 2020, twenty-one (mostly coastal) states and the District of Columbia have enacted laws expressly prohibiting workplace discrimination on the basis of sexual orientation, gender identity, and gender expression within their borders. Thirty states provide no such protections, and three of these (Arkansas, Tennessee, and North Carolina) have even passed legislation specifically prohibiting the enactment of any LGBTQ-specific anti-discrimination laws in the future. Meanwhile, federal courts in various jurisdictions were increasingly taking the position that federal and state laws prohibiting workplace discrimination “on the basis of sex,” only, necessarily included discrimination on the basis of sexual orientation or gender identity, as well. Yet, without any national consensus on this issue, whether an LGBTQ person could benefit from such rulings was still dependent on the state in which they lived.

In April 2019, the U.S. Supreme Court announced that it would hear appeals from three cases on precisely these issue: *Zarda v. Altitude Express*, in which the Second Circuit agreed that Title VII already prohibits employment discrimination based on sexual orientation; *Bostock v. Clayton County*, in which the Eleventh Circuit came to the opposite conclusion; and *Equal Employment Opportunity Commission v. R.G. & G.R. Harris Funeral Homes*, in which the Sixth Circuit ruled that firing an employee for coming out as transgender is sex-based discrimination prohibited by Title VII (collectively "*Bostock*"). On June 15, 2020, the Supreme Court issued a landmark ruling in which it agreed with the majority of lower federal courts that Title VII's prohibition of discrimination "because of sex" inherently extends to discrimination on the basis of one's gender identity, gender expression, and sexual orientation, as well. Thus, while efforts to enact the Equality Act are still ongoing for various reasons, such legislation is no longer necessary to extend Title VII's vital workplace discrimination protections to LGBTQ individuals nationwide.

The impact of the Supreme Court's ruling in *Bostock* will not likely be limited to employment issues alone. Because numerous other state and federal statutes use the same construction of "because of" or "based on sex" to prohibit discrimination in other essential areas, such as access to housing, education, and essential goods and services, the Court's interpretation of such language needs not be limited to Title VII, but will most likely extend to other similar contexts in which it arises, as well.

3.2. Medical Care Bans

Following the 2020 election, conservative legislators in numerous states introduced bans on gender affirming care for transgender youth. In fact, this torrent of care bans is one of the most significant and detrimental sociopolitical issues currently affecting LGBTQ youth. This year alone, 22 states (Alabama, Arizona, Arkansas, Florida, Georgia, Indiana, Iowa, Kansas, Kentucky, Louisiana, Mississippi, Missouri, Montana, New Hampshire, North Carolina, North Dakota, Oklahoma, South Carolina, Tennessee, Texas, Utah, West Virginia) introduced legislation to ban medical care for transgender youth (Movement Advancement Project, 2021a). Arkansas became the first state to pass such legislation in April 2021. Arkansas House Bill 1570 prohibits any health care provider in the state from delivering gender affirming care to patients under 19 years of age and from referring them for gender affirming care. The bill additionally prohibits insurance plans from covering affirming health care for minors and allows insurers to decline coverage for adults as well.

Several other states have advanced similar bills during their most recent legislative sessions. Depending on the state, penalties for medical providers delivering affirming care include criminal charges, licensure revocation, fines, and/or civil action (Movement Advancement Project, 2021a). Proposed legislation in seven states additionally threatens parents with criminal charges for obtaining affirming care, including child abuse (Movement Advancement Project, 2021a).

Bans on medical care for transgender youth contradict standards of care for medical treatments such as "puberty blockers" (gonadotropin-releasing hormone agonists) for pre-pubertal youth and hormone therapies for adolescents, which are interventions supported

by mainstream medical associations, including the American Academy of Pediatrics, the American Medical Association, and the Endocrine Society.

3.3. Health Insurance Coverage

During the Obama Administration, LGBTQ patients generally gained increased access to health care under the 2010 Affordable Care Act. The Health Care Rights Law, or Section 1557 of the Affordable Care Act, prohibited discrimination based on sex (as well as race, color, national origin, age or disability) in "any health program or activity" that receives federal financial assistance. [2] This law applies to most health care facilities, most health insurance companies, and to both state and federally administered Health Insurance Marketplaces (including all plans offered in those marketplaces). In May 2016, the Obama Administration issued a regulation clarifying that the law prohibits "discrimination on the basis of gender identity" (U.S. Department of Health and Human Services, 2016).

Several states and private healthcare providers subsequently challenged this regulation in the U.S. District Court for the Northern District of Texas, arguing that it would force doctors and insurers to provide gender reassignment procedures regardless of their religious opposition in purported contravention of extant law. In December 2016, after President Obama left office, the court issued an order stopping the federal government from enforcing the regulation while the case proceeds, which the Trump administration elected not to appeal. The subject is currently subject to ongoing litigation; however, the legal backdrop has changed significantly in light of the U.S. Supreme Court's 2020 holding in *Bostock v. Clayton County* that a federal statue prohibiting discrimination "on the basis of sex" inherently prohibits discrimination on the basis of sexual orientation or gender identity, as well. While *Bostock* concerned employment discrimination under Title VII and not healthcare discrimination under Section 1557, a number of federal anti-discrimination statutes—including Section 1557—employ the same language.

During the Trump Administration, the Office for Civil Rights of the Department of Health and Human Services generally refrained from taking any action to respond to discrimination claims among transgender patients. However, in May 2021, the Office for Civil Rights of the Department of Health and Human Services under President Biden announced that it would, in fact, interpret Section 1557 to bar discrimination on the basis of sexual orientation and gender identity, consistent with the Supreme Court's ruling in *Bostock.*

Meanwhile, state laws generally dictate coverage provided through private health insurance plans and vary widely in their protections for LGBTQ patients. Sixteen states (California, Colorado, Delaware, Hawaii, Illinois, Maine, Michigan, Minnesota, Nevada, New Hampshire, New York, Oregon, Rhode Island, Vermont, Washington, and Wisconsin), the District of Columbia, and Puerto Rico explicitly prohibit discrimination based on both sexual orientation and gender identity (Movement Advancement Project, 2021b). These sixteen states, the District of Columbia, and eight additional states explicitly ban transgender health exclusions within health insurance policies (Movement Advancement Project, 2021b).

[2]Updates on regulations pertaining to Section 1557 may be found online through the Health and Human Services Office for Civil Rights at https://www.hhs.gov/civil-rights/for-individuals/section-1557/index.html.

Approximately half of the states still have no laws in place regarding LGBTQ-inclusive private health insurance policies (Movement Advancement Project, 2021b).

Laws pertaining to Medicaid funding also vary by state. About half of the states specify that Medicaid covers transgender health care, including transition-related care (Movement Advancement Project, 2021b). On the other hand, ten states (Arkansas, Arizona, Georgia, Missouri, Nebraska, Ohio, Tennessee, Texas, West Virginia, and Wyoming) explicitly prohibit Medicaid funds from covering transgender health care. In multiple states, coverage of transgender health care is the subject of ongoing litigation and existing coverage for Medicaid-funded services remains uncertain.

3.4. Religious Exemptions in Health Care

LGBTQ patients frequently report worse health care experiences than heterosexual cisgender peers. Transgender patients, in particular, report the highest rates of discrimination by health care providers (see, *e.g.*, Kull, 2010; James *et al.*, 2016). In a national survey of 4,916 LGBTQ-identified respondents, 56% of LGB and 70% of transgender respondents reported at least one incident of discrimination while seeing a health care provider (Kull, 2010). Experiences reported included refusal of care, providers refusing to touch them or using excessive precautions, the use of harsh language, being blamed for their health status, and providers being physically rough. In another independent large national survey of transgender adults, 33% of respondents reported having at least one negative experience with a health care provider (James *et al.*, 2016). Given the frequency of negative experiences encountered by LGBTQ patients in health care, it is not surprising that many would not disclose particular aspects of their identities to providers.

Rather than encourage providers to correct these disparities, recent legal developments stand to make them worse. In January 2018, the Department of Health and Human Services (HHS) established a new branch within its Office of Civil Rights (OCR) called the “Conscience and Religious Freedom Division.” The division broadly aimed to expand the rights of hospital and health care providers to refuse services based on religious and moral beliefs. Under President Trump’s order, in May 2019 HHS issued the “Final Conscience Regulation,” which was designed to expand the OCR’s authority to enforce numerous federal “conscience protection” laws and, more generally, to expand their scope and impact. Over the objection of critics who believed it would only encourage discrimination against LGBTQ patients, the “Final Conscience Regulation” increased the number of applicable federal “conscience protection” statutes from 3 to 25.

In November 2019, before the rule could take effect, a federal court in New York vacated the “Final Conscience Regulation” on grounds both substantive and procedural. Since then, however, a number of Republican-controlled state legislatures have moved to enact legislation designed to accomplish the same purpose. Ohio, for example, recently enacted a provision buried within its two-year budget bill that will allow any medical professional, including doctors, nurses, lab technicians, and even insurance providers “the freedom to decline to perform, participate in, or pay for any health care service which violates the practitioner’s, institution’s, or payer’s conscience as informed by the moral, ethical, or religious beliefs.” Arkansas, Montana, and South Dakota have enacted similar legislation.

The impact of "conscience protection" statutes and regulations on health care systems, providers, and LGBTQ patients remains to be seen. Certainly, they will draw legal challenges to the extent they may conflict with federal non-discrimination provisions as they are now to be interpreted under *Bostock*. But assuming such laws continue to be implemented, they are very likely to adversely affect LGBTQ patients (including youth) across the country, especially in areas where fewer providers and/or affordable services are available. Under such laws, providers could decline to see patients entirely and/or refuse to provide specific services such as hormone therapy, in-vitro fertilization and other fertility treatments, care for HIV and AIDS, or preventative care such as sexual health screening and pre-exposure prophylaxis (PrEP) medication. These services are particularly important for LGBTQ youth, given the health disparities discussed earlier.

3.5. Conversion Therapy

Western medical communities have long pathologized LGBTQ identities, a problem that continues to this day. Physicians in the 19th century searched for biological causes of same-sex attraction and gender expression outside of the accepted binary, often by studying bodies postmortem. In the early 20th century, psychoanalytic theorists varied in their conceptualization of homosexuality, with some explaining same-sex attraction as a form of arrested sexual development (*e.g.* Sigmund Freud) or an overt pathological development that could perhaps be cured. These theories ultimately led to the invention of conversion therapy, which continues to be practiced in current day despite a marked lack of evidence supporting its safety or efficacy and numerous studies showing it is harmful (American Psychological Association [APA], 2009; Finnerty, Kocet, Lutes, & Yates, 2017; Dehlin, Galliher, Bradshaw, Hyde, & Crowell, 2015).

Conversion therapy, also sometimes referred to as reparative, aversion, or reorientation therapy or as sexual orientation change efforts (SOCE), refers to techniques that aim to change LGBTQ individuals' sexuality, gender identity, and/or gender expression (APA, 2009). In cases of same-sex attraction, the treatment usually focuses on reducing or eliminating same-sex attraction. In cases of transgender or gender diverse identities, treatment focuses on making the individual identify with the sex assigned at birth (typically listed on a birth certificate). Techniques vary among individual providers and have changed over time. According to the National Center for Lesbian Rights, the most common form of conversion therapy in present day is talk therapy (2018).

There is no credible or mainstream medical or mental health association that supports the use of conversion therapy. Conversion therapy, in its many forms, continues to lack any scientific evidence supporting its use and has been consistently shown to have detrimental effects on mental health, including on rates of suicidality (*e.g.*, APA, 2009; James *et al.*, 2016). Many major medical and psychological organizations, including the American Psychological Association, the American Psychiatric Association, the American Academy of Child & Adolescent Psychiatry, the American Academy of Pediatrics, the American College of Physicians, and the American Medical Association, all expressly oppose the practice of conversion therapy for this reason. Despite the medical and mental health communities' opposition, conversion therapy legally continues to be performed around the

country. The Williams Institute estimates that almost 700,000 US adults have received conversion therapy, with half of them receiving it before age 18 (Mallory, Brown, & Conron, 2018).

In 2012, California became the first state to pass a conversion therapy ban for youth under 18, prohibiting therapists licensed by the state to engage in practices that attempt to change a minor's sexuality or gender identity. Currently, only twenty states (California, Colorado, Connecticut, Delaware, Hawaii, Illinois, Maine, Maryland, Massachusetts, Nevada, New Hampshire, New Jersey, New Mexico, New York, Oregon, Rhode Island, Utah, Vermont, Virginia, and Washington) and the District of Columbia have laws that ban conversion therapy for minors (Movement Advancement Project, 2021c). There is no federal law addressing this issue. Bills that would have prohibited conversion therapy on a national level have been introduced into the U.S. House and Senate (*e.g.*, The Therapeutic Fraud Prevention Act), but have not been passed.

It is important to understand that state-level bans, where they exist, generally apply to licensed mental health providers only. While a few states have passed laws applying to any provider who collects payment in return for conversion therapy, state bans do not apply to religious or spiritual advisors or, in most states, to unlicensed practitioners—*i.e.*, the groups most likely to practice conversion therapy in the first place. Instead, states that ban the practice typically rely on state licensing boards to discipline licensed providers who practice conversion therapy on minors. While several states also consider conversion therapy to be an unfair business practice inviting other civil remedies, most provide no other mechanism to deter the practice among unlicensed practitioners.

3.6. Housing

The 2015 U.S. Transgender Survey revealed that almost a quarter of transgender American adults had experienced housing discrimination within the last year and one-third had experienced homelessness at some time (James *et al.*, 2016). In another survey, 19% of transgender individuals reported being refused a house or apartment because of their gender identity; 11% reported being evicted due to their gender identity; and 19% reported being homeless at some point in their lives because of their gender identity (Grant *et al.*, 2011).

Nevertheless, most state and federal laws still fail to explicitly protect transgender (or LGB) communities from discrimination in private housing. Similar to Title VII, the Fair Housing Act ("FHA") prohibits property owners in every state from refusing to sell or rent a dwelling, or offering to sell or rent a dwelling on different terms, to any person based on that person's race, color, religion, sex, familial status, or national original. As of the time of writing, no published court opinion has addressed whether the FHA's prohibition of sex-based discrimination includes anti-transgender discrimination, although two federal courts in 2017 and 2018 ruled that it covered discrimination based on sexual orientation under the same reasoning employed in Title VII cases. Thus, the Supreme Court's ruling on Title VII will likely impact the ongoing evolution of cases interpreting analogous language of the FHA, as well.

In the absence of clear federal guidance, twenty-one states and the District of Columbia (*i.e.*, the same localities with LGBTQ-inclusive anti-employment discrimination laws on their books) have enacted their own laws explicitly prohibiting LGBTQ discrimination in the private housing market. The remainder (and majority) of states have not, though most do have laws prohibiting housing discrimination based on sex, the interpretation of which may hinge on the Supreme Court's ruling in *Bostock*.

Laws and regulations governing access to public housing have been similarly tumultuous. This is of particular concern to transgender and gender diverse youth, who are at substantial risk of housing instability due to family rejection and other social stigma, including discrimination in the employment and private housing markets discussed above.[3] Indeed, according to a 2012 study conducted by the Williams Institute, 40% of homeless youth serviced by agencies now identify as LGBTQ, with most of these respondents reportedly losing their homes due to family rejection (70%) and/or abuse (54%) (Durso & Gates, 2012). And, once homeless, studies indicate that LGBTQ youths continue to experience significant rates of discrimination and harassment by staff and residents at homeless shelters. Seventy person of transgender individuals who stayed in a shelter within the last year reported harassment, assault, or being kicked out due to their gender identity (James *et al.*, 2016).

In 2012, the Department of Housing and Urban Development (HUD), which administers affordable housing programs and is charged with investigating unlawful housing discrimination, attempted to address some of these issues by imposing an "Equal Access Rule" on housing providers that receive federal funding. The Equal Access Rule comprises a series of regulations that require equal access to HUD programs such as affordable housing, homeless shelters, and federally insured mortgages without regard to the applicant's actual or perceived sexual orientation or gender identity. As amended in 2016, these regulations also explicitly require federally-funded emergency shelters with shared sleeping quarters and bathing facilities to house applicants in accordance with their stated gender identity, regardless of the gender shown on their identity documents.

Under the Trump Administration, however, HUD threatened to roll back these protections. On May 22, 2019, just one day after new HUD Secretary Ben Carson told Congress he anticipated no changes to the Equal Access Rule, HUD announced a proposed rule change that would have permitted providers of single-sex or sex-segregated shelters to "consider a range of factors" when determining admission to facilities, including not only the applicant's stated gender identity but, among other things, "privacy, safety,…religious beliefs,…[and] the individual's sex as reflected in official government documents" (U.S. Department of Housing and Urban Development, 2019). The proposed rule did not provide any guidance or limitation on how these factors should be balanced but appeared to return substantial discretion to shelter providers to deny transgender people access to shelter matching their stated gender identity on a range of ill-defined grounds that may include a shelter provider's or resident's religious opposition to transgender identity. The rule, had it been enacted,

[3]Housing instability among LGBTQ youth is further exacerbated by many state policies concerning foster care and adoption. In 11 states, state-licensed foster and adoption agencies are explicitly permitted to refuse, on religious grounds, to place children with LGBTQ people and same-sex couples. An additional 18 states have no anti-discrimination protections in foster care. (Movement Advancement Project, 2021f).

therefore stood to put significant numbers of transgender youth—and particularly those residing in more conservative areas—at greater risk.

In April 2021, the Biden Administration formally withdrew the Trump Administration's proposed rule change and reaffirmed HUD's commitment to equal access to public housing, shelters, and related services regardless of gender identity.

3.7. Rights in Schools and School Districts

As conceptualized by the minority stress framework, social environments greatly influence the mental health of LGBTQ youth. Studies have suggested that family and school connectedness (Saewyc *et al.*, 2009) and school safety (Eisenberg & Resnick, 2006) are associated with better mental health in sexual minority youth. School involvement and school connectedness are similarly associated with decreased risk behaviors, including substance use, among sexual minority youth (Ethier, Harper, & Dittus, 2018). Peer victimization, on the other hand, is a well-established individual level risk factor for suicide attempts among sexual minority youth (Garofalo, Wolf, Kessel, Palfrey, & DuRant, 1998; Russell & Joyner, 2001). The Gay, Lesbian & Straight Education Network (GLSEN), which has conducted a biennial National School Climate Survey since 1999 to better understand school-based risk and protective factors for LGBTQ students, consistently finds that the vast majority of LGBTQ students experience verbal harassment at school and discriminatory policies or practices (2020).

Thus, it is evident in both the existing school literature on LGBTQ youth mental health and the minority stress framework that school environment plays a key role in mental health. Numerous components of the school environment may influence LGBTQ students' experience, including school policies around facility access, access to sports, LGBTQ-inclusive curricula, and anti-harassment and anti-bullying measures. Such components are largely dictated by a patchwork of uncoordinated and, in some cases, inconsistent laws and policies implemented at the federal, state, and local school district levels, with the federal government frequently vacillating on the degree to which it should standardize local policies.

At the federal level, much debate has centered on Title IX and the definition of the word "sex." Title IX is a federal civil rights law passed as part of the Education Amendments of 1972. It states that: "No person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any education program or activity receiving Federal financial assistance." It was designed to prohibit sex discrimination in programs and activities that receive funding from the Department of Education.

Under President Obama, the Education Department's Office for Civil Rights and the Department of Justice issued guidance to schools to apply Title IX protections to transgender students targeted for their gender identity (U.S. Department of Justice, 2016). It also noted that schools may continue their implementation of sex-segregated restrooms, locker rooms, and other facilities but that transgender students "must be allowed to participate in such activities and access such facilities consistent with their gender identity."

One of the Trump Administration's first official and highly publicized acts was to revoke the Obama Administration guidelines applying Title IX to transgender students. In March 2017, Trump's Department of Education Secretary, Betsy DeVos, publicly announced by letter to all school districts that the Department—whose interpretations of Title IX are not binding but often afforded deference by schools and courts around the country—considered Title IX's use of the term "sex" to mean biological sex, only. The letter further noted that states and local school districts would carry the "primary role" in establishing educational policy (U.S. Department of Justice, 2017). This sharp reversal in federal guidance on Title IX created confusion for many schools, school districts, parents, and LGBTQ students and further promoted discriminatory restrictions for transgender students.

One of the first and most well-known cases involving the rights of students to use school bathrooms aligned with their gender identity is that of Gavin Grimm, a transgender high school student who sued the Gloucester County School Board in Virginia in July 2015. The school argued that Mr. Grimm's "biological gender" was female and that allowing him to use the boys' bathroom would endanger the privacy rights of other students. After years of litigation throughout the Obama and Trump Administrations, the U.S. Court of Appeals for the Fourth Circuit ruled in favor of Mr. Grimm in August 2020, holding that Title IX does, in fact, prohibit schools in receipt of public funding from treating transgender students who identify as male differently from other boys in terms of which restroom facilities they are permitted to use, and that the Gloucester County School Board had run afoul of that rule here. The U.S. Supreme Court declined to hear the case.

In reaction to cases like Mr. Grimm's, a number of state and local legislatures passed or proposed legislation explicitly prohibiting people from using public or commercial bathroom facilities other than those designated for their sex assigned at birth. These so-called "bathroom bills" became a lightning rod for the national debate surrounding transgender rights and a magnet for virulent anti-trans sentiment in the media. Indeed, the "trans bathroom debate" even took center stage in the Supreme Court's oral argument on Title VII cases that ostensibly had nothing to do with bathrooms. However, since the beginning of the Biden Administration, conservatives have largely shifted their focus to transgender students in sports, in addition to the aforementioned bans on affirming care for youth.

State-based legislation to ban transgender youth from school sports focuses mainly on students in K-12 programs. The laws fundamentally contend that transgender students should not play on sports teams consistent with their gender identity. Political and social rhetoric has largely focused on transgender girls, with proponents of the bans promoting gender stereotypes, scare tactics, and unfounded claims that transgender girls have a physical advantage over cisgender women. To date, nine states have banned transgender students from participating in sports that match their gender identity, with Idaho being the first (Movement Advancement Project, 2021d). To complicate matters further, state high school athletic associations have been releasing their own policies pertaining to transgender youth, which vary widely from state-to-state. Whether such laws and policies violate Title IX when carried out by recipients of federal funding will undoubtedly be one of the next hot-button LGBTQ issues taken up by the courts.

Other state laws vary by state and directly affect LGBTQ students and school climates, as well. For example, four states (Louisiana, Mississippi, Oklahoma, and Texas) explicitly forbid discussion of LGBTQ identities in public school sex education (Movement Advancement Project, 2021e). These laws are often colloquially referred to as "no promotion of homosexuality," or "no promo homo" laws and, more recently, as "Don't Say Gay" laws. These laws are generally vague and have been applied to various school settings, including classroom curricula, student organizations, and school events.

Given that students spend the majority of their time in school settings, it is unsurprising that sexual and gender diverse students in these states experience poorer outcomes, including greater harassment and assault at school, as well as higher rates of substance use (Parent, Arriaga, Gobble, & Wille, 2018; Kull, Kosciw, Greytak, 2015). Because they inherently result in insufficient sex education, these "no promo homo" laws also contribute to higher rates of pregnancy, sexually transmitted diseases, and, overall, higher risk sexual behaviors among sexual and gender diverse youth (Ybarra, Rosario, Saewyc, & Goodenow, 2016). As a corollary, more LGBTQ-inclusive curricula are associated with a greater sense of school safety, less identity-based victimization, and overall more positive health and academic outcomes (Gegenfurtner & Gebhardt, 2017; Snapp, McGuire, Sinclair, Gabrion, & Russell, 2015).

While most of the extant research on structural stigma focuses on the state level, a growing body of literature highlights the importance of local school-based policies. Though most public districts have anti-bullying policies, many lack specifications for sexual orientation or gender identity, particularly in rural locations (Kull *et al.*, 2015). School-based protections, including nondiscrimination and anti-bullying school policies that specifically defend sexual minority students, are significantly associated with fewer suicide attempts, even when controlling for sociodemographic variables and other risk factors (*e.g.*, peer victimization) previously associated with suicide attempts (Hatzenbuehler, 2011; Hatzenbuehler & Keyes, 2013). Data also suggest that student outcomes are similarly as poor for students in schools with policies that do not specifically include sexual orientation or gender identity as they are for youth attending schools with no anti-bullying policy at all (Kull *et al.*, 2015). Thus, the explicit enumeration of sexual and gender minority youth in anti-bullying policies appears to be key in improving youth outcomes.

When such policies do exist, they positively impact the overall school climate. For example, LGBTQ students in schools with inclusive policies reported a greater sense of safety, a greater sense of belonging, less victimization based on sexual orientation or gender identity/expression, lower rates of other forms of harassment, better response and support from staff when reporting incidents, and greater comfort with staff (Kull *et al.*, 2015). These findings are also supported by longitudinal research that shows improvement in school climate (and subsequent decrease in school victimization) through acceptance of sexual and gender minority youth over the past 20 years, *via* improvement in school policies and protections (O'Malley, Olsen, Vivolo-Kantor, Kann, & Milligan, 2017). Relatedly, sexual and gender diverse youth who live in areas with more comprehensive school protections report fewer suicidal thoughts than their counterparts in states and cities with fewer protections (Hatzenbuehler, Birkett, van Wagenen, & Meyer, 2014).

CONCLUSION

Anti-LGBTQ legislation and sociopolitical rhetoric create minority stress among LGBTQ youth. LGBTQ youth experience many social stressors, such as the obstruction of health care services, bans on transgender youth in sports, and discrimination in housing. These harmful experiences of discrimination, prejudice, marginalization, and stigmatization additionally impact internal psychological functioning around self-perception, self-regard, and personal agency. LGBTQ youths undoubtedly benefit from working with knowledgeable providers who are informed about sociopolitical stressors in various sectors, including in employment, health care, housing, and schools. Providers can additionally support LGBTQ youth by engaging in advocacy efforts to block anti-LGBTQ legislation within their communities.

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