Testimony

of

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New York City Department of Health and Mental Hygiene

before the

New York City Council Committee on Mental Health, Developmental Disability, Alcoholism, Drug Abuse & Disability Services

on

Int. 1225

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Good morning, Chair Cohen and members of the Committee. I am Dr. Gary Belkin, Executive Deputy Commissioner of the Division of Mental Hygiene for the New York City Department of Health and Mental Hygiene. Thank you for the opportunity to testify today on the City's work to provide mental health services for Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) New Yorkers. I would like to thank you, Chair Cohen, for the support you and your fellow council members have shown to changing the culture of mental health in this city. I would like to also thank Council Member Torres, Council Member Johnson, Council Member Dromm, and the City Council LGBTQ Caucus for their leadership in championing civil rights in New York City and fighting to ensure that services are provided for all LGBTQ New Yorkers.

The LGBTQ population in New York City faces very real health disparities, particularly related to mental illness and substance use. LGBTQ high schoolers in New York City experience double the prevalence of feeling sad or hopeless in comparison to heterosexual youth (50% vs. 25%). A higher percentage of these LGBTQ youth, almost threefold, seriously considered attempting suicide (31% vs. 11%) or have attempted suicide (20% vs. 6%). LGBTQ youth are twice as likely to misuse both prescription and illicit drugs compared with heterosexual youth (16% vs. 8%).

From national data, we know that the mental health outcomes are far worse for transgender and gender non-conforming persons. In the 2015 U.S. Trans Survey, 39% of respondents reported currently experiencing serious psychological distress, compared to 5% of the U.S. population. Additionally, 40% of the nearly 28,000 respondents had attempted suicide, compared to 4.6% in the U.S. population.

It is a priority for this Administration to expand healthcare and social services to traditionally underserved communities, including LGBTQ New Yorkers. I would like to highlight some of our recent work in this area.

The Administration has created and expanded offices coordinating LGBTQ programming and input across City government. As part of this commitment, the City has formed LGBTQ offices within a number of city agencies, including the Department of Education, the Department of Health and Mental Hygiene, the Human Resources Administration (HRA), New York City Health + Hospitals, the Department of Homeless Services, and the Administration for Child Services (ACS). These units help coordinate LGBTQ related programing, policy, and outreach within and between City agencies. This is a marked expansion from 2014, when only one such position existed in City government.

Through a partnership with Councilmember Torres, the Department of Homeless Services recently announced the creation of a new shelter which will prioritize the needs of LGBTQ young people. This new shelter will be run by Project Renewal and is expected to open in the coming weeks, with screening for current residents underway. New shelter staff will have training on LGBTQ issues, and provide supportive services tailored to the needs of LGBTQ youth, including mental health, substance use programs and benefits access.

For the first time, the City has added funds dedicated to enhancing mental health services at Runaway and Homeless Youth Drop-In Centers, Crisis Shelters, and Transitional Independent

Living Programs. In Fiscal Year 2015, residential programs served more than 2,200 youth under age 21, nearly 40% of whom identify as LGBTQ. These new services allow youth to receive psychiatric and psychosocial evaluations, help them apply for supportive housing, and provide access to life skill supports.

In 2015, HRA began an agency-wide initiative to train all of their 14,000 staff on LGBTQ and intersex basics. The training provides thorough background on many issues affecting LGBTQ and intersex people, including the general need for LGBTQ-affirming mental health providers, as well as the unique mental health needs associated with anti-LGBTQ violence, discrimination, and family rejection. In addition, as a result of the March 2015 settlement in a case called Lovely H. v. Eggleston, HRA has developed and piloted a new optional mental health screening to be offered to all new cash assistance clients. Paired with cognitive/learning disabilities screenings, these tools are designed to identify mental health needs that may require accommodation in service delivery. When fully implemented, these screenings will enable HRA workers to offer reasonable accommodations to people with mental illness or disabilities both at the benefit application and renewal stages

In addition, through supportive housing programs overseen by HRA, the City provides stable housing and as needed supportive services, including both mental and physical healthcare, alcohol and substance use programs and other social services including education and employment, to a variety of qualified populations living with serious mental illness, substance use disorders, disabilities, and/or HIV AIDS, as well as young adults who have left foster care, homeless single veterans, and medically frail individuals and individuals receiving nursing home care. Through supportive housing these vulnerable populations are able to address the multiple barriers they face when trying to obtain and maintain stable housing and live with independence and dignity.

The Department for the Aging (DFTA) has been conducting training for Case Management Agency (CMA) staff on "Working with LGBTQ" seniors since September 2008. Every new CMA hire attends training within their first two years. Realizing the need for a senior center focusing on the needs of the LGBTQ community, DFTA has also funded the first LGBTQ-dedicated senior center in the country – the SAGE Innovative Senior Center which opened in 2012. SAGE offers a range of social and cultural activities as well as health and wellness classes. In addition, SAGE provides a set of Title III-E services and LGBTQ seniors and their caregivers and family networks throughout the City, including counseling, support groups, and assistance accessing benefits.

Commissioners Bassett, Commissioner Banks, and Commissioner Carrion commented on proposed state regulations regarding Medicaid coverage of transition-related transgender care and services. As studies confirm, access to gender-affirming healthcare is essential for both physical and mental health. As agencies that play a role in the administration of health programs and services, it is vital that we support the rights of transgender people to get medically necessary care that has been shown to dramatically improve health and well-being. Additionally, the Department of Health provides support for four grassroots transgender-focused organizations to increase their capacity to address social exclusion and health inequities in order to broadly promote the well-being of transgender and gender non-conforming persons.

As this committee is well aware, mental health is a priority of this Administration. In November 2015, Mayor Bill de Blasio and First Lady Chirlane McCray launched ThriveNYC, a set of 54 initiatives – representing an investment of $850 million over four years – to address the mental health of our city. At the heart of each ThriveNYC initiative is a focus on destigmatizing mental illness, increasing access to services, and changing the way New Yorkers think and talk about mental health at home, in their communities and in the workplace.

This plan was developed over a year of going out into the community to get feedback from New Yorkers. During this process, we heard from hundreds of New Yorkers through 25 stakeholder focus groups, town halls in every borough, countless informal conversations, and meetings with our elected officials. We received critical feedback from communities across the city, including immigrant communities, faith-based organizations, and business leaders, representing over 250 organizations. Members from many LGBTQ organizations were invited to participate as well, including the Ali Forney Center, AIDS Center Queens, the Hetrick-Martin Institute, FIERCE, Covenant House, Gay Men's Health Crisis, Gay Men of African Descent, the LGBTQ Center, the Audre Lorde Project, and the Door. This critical feedback has informed the development and implementation of ThriveNYC.

ThriveNYC is meant to serve all New Yorkers, but I would like to highlight a few ways in which they provide support specific to the LGBTQ community:

- Our Mental Health First Aid initiative will train 250,000 New Yorkers in Mental Health First Aid and certify another 500 individuals as Mental Health First Aid instructors. The Gay Men's Health Crisis and the Hetrick-Martin Institute participated in the instructor program and now lead Mental Health First Aid training in their communities. We are working to increase the number of LGBTQ community organizations that receive trainings and encourage more of them to pursue instructor certification.

- NYC Well is our single point of access to counseling, support services and treatment referral. It is free, confidential, and available 24/7. NYC Well operators can connect individuals to over 100 LGBTQ resources for all ages.

- Our first cohort of 120 Mental Health Services Corps members are now embedded in primary care and behavioral health clinics across the city. Every corps members will complete a special populations training on LGBTQ issues during their three-year curriculum. One of our corps members is embedded at the Callen Lorde primary care center in Manhattan, the largest Federally Qualified Health Center in the city that provides services specifically targeted to LGBTQ New Yorkers.

- Thanks to the generous support of the City Council, the Department collaborates with the Hetrick-Martin Institute and key agencies to foster the Citywide LGBTQ Youth Initiative, which supports youth, their families, and youth service providers. This year the Institute will also provide training, capacity building, and technical assistance programs for school based health clinic staff and school mental health consultant program staff. These trainings will help staff guide their schools in a variety of topics around gender

identity and sexual orientation including, but not limited to: deconstructing gender, the importance of vocabulary, and LGBTQ policy impacts for schools. It will also provide case scenarios and actions plans for schools that surface challenges while serving LGBTQ youth.

But ThriveNYC is more than a collection of initiatives; it is a comprehensive strategy for reforming the behavioral health system for all New Yorkers. By taking a public health approach to mental health, we identify leading risks, health outcomes, and access to resources across society. This approach aims the spotlight on groups at highest risk, and calls us to design interventions accordingly. In this way ThriveNYC provides a framework for creating culturally competent services for LGBTQ New Yorkers of all ages.

As ThriveNYC continues to reform the City's mental health system, we are committed to engaging stakeholders from across the city to guide the development and implementation of our work. We have reinvigorated the Community Service Board (CSB), the advisory body required by law to advise the Department of Health in all areas related to the City's mental health and substance use treatment services. New appointees to the board represent a broad spectrum of communities, organizations and viewpoints to engage people whose voices have previously been underrepresented.

As part of efforts to revitalize the CSB, the board formed an LGBTQ subcommittee that will meet for the first time this month. This subcommittee is well poised to provide input to the Department's existing programming and policy work supporting LGBTQ populations, review and inform the development of the Department's annual mental health services plan that is presented to the State, and strengthen the Department's burgeoning efforts to collaboratively address the unique public health needs of the LGBTQ community.

Outside of specific new ThriveNYC initiatives, the Department of Health is making additional strides to address the mental health needs of LGBTQ New Yorkers. Including:

- Through contracts with service providers that deliver treatment, support services and health education such as:
    - The LGBTQ Center of New York which provides both individual and systems advocacy services for the LGBTQ community by offering direct and indirect support.
    - The Rainbow Heights Club which provides mental health services to LGBTQ individuals to support their recovery, develop or re-establish a sense of self-esteem and group affiliation, and support their reintegration into a meaningful role in the community.
    - The LGBTQ Service Center which has five programs that serve the LGBTQ population affected by substance use disorders, including adult outpatient treatment, peer support, and group and individual counseling prevention.
- Through partnerships with:

- The Department of Education to pilot a model called Out for Safe Spaces that helps school-based employees "come out" as visible allies for LGBTQ students. As part of the program, participating staff wear badges identifying themselves as allies in order to make school a safer, more welcoming place. This partnership also allows Community Schools to provide a variety of clinical and psycho-educational group work specific to LGBTQ youth, support for after school clubs, and training and professional development for staff to increase knowledge and awareness of LGBTQ issues.

- The New York State Office of Alcoholism and Substance Abuse Services to provide comprehensive substance use disorder treatment, including medication assisted treatment for opioid use disorder, to adolescents at the LGBTQ Center in Manhattan.

- And through expanding internal coordinating capacity to ensure that LGBTQ health issues are addressed across the Department of Health's portfolio. Currently within the Department we have six dedicated staff who work exclusively on LGBTQ health issues, joined by an additional twenty staff across the agency that form a working group to enhance the Department's overall programming, policy and data collecting on LGBTQ communities. I also want to highlight the Center for Health Equity's Gender Justice Initiative, which works to transform gender and power relations, norms and structures as a core strategy for challenging health inequality. Through this work, the Center builds capacity within the Department and with healthcare providers across the city to understand and address multiple barriers caused by race, ethnicity, poverty, gender identity, gender expression, sexual orientation, disability status and other factors. As with ThriveNYC, the work is informed by, and done in collaboration with, the community.

Intro. 1225

I would now like to address the legislation being discussed today. Intro 1225 would require the Department of Health to develop a comprehensive plan to address the mental health and substance use needs of LGBTQ New Yorkers. As I hope my testimony conveys, we are continually working to address the needs of all New Yorkers, including those communities that suffer mental health disparities, of which the LGBTQ community is especially prominent. We would be happy to work with the Council to determine how to best integrate the extensive planning and mental health development ongoing through ThriveNYC and partner efforts with feedback from the LGBTQ community, and look for ways to share these findings with the Council and the public at large.

We look forward to working with the Council to ensure that the behavioral health needs of LGBTQ New Yorkers are met through ThriveNYC and other programs funded through the Department.

Thank you again for the opportunity to testify. I am happy to take questions.

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Testimony of State Senator Brad Hoylman Before the New York City Council Committee on Mental Health, Developmental Disability, Alcoholism, Substance Abuse and Disability Services in Support of Proposed Resolutions Numbers 130-A and 613-A

January 10, 2017

Thank you for the opportunity to testify today in support of two proposed resolutions under your consideration, one of which (Res. No. 130-A) calls upon the State Legislature to pass and the Governor to sign legislation I sponsor in the New York State Senate designating so-called "conversion therapy" by mental health care professionals upon patients under 18 years of age as professional misconduct. The accompanying resolution (Res. No. 613-A) calls upon the American Psychological and American Psychiatric Associations to immediately pass resolutions declaring the practice of "conversion therapy" to be unethical. I want to thank Council Member Andrew Cohen, Chair of the Committee on Mental Health, Developmental Disability, Alcoholism, Substance Abuse and Disability Services, for hosting today's hearing. I also want to thank Council Member Daniel Dromm for his committed sponsorship of both resolutions.

On May 15, 2014, I held a public forum in New York City with Senator Michael Gianaris and Assemblymember Deborah Glick to address the practice of "conversion therapy." The forum brought together two dozen panelists including former subjects of conversion therapy, as well as representatives from leading mental health professional associations, legal experts, members of the clergy, and LGBT advocates. My office compiled the forum's main takeaways in a report titled *Protecting LGBT Youth from "Conversion Therapy" in New York State.*

First and foremost, we found that "conversion therapy" is unfortunately practiced in New York State, including by licensed mental health professionals, and is thus a real problem that warrants legislation. The subjects of "conversion therapy" at our forum reported that it was ineffective and degrading, resulting in numerous negative outcomes including depression and suicidal thoughts. We also learned that the unanimous consensus among major mental health professional associations including the American Psychological and American Psychiatric Associations corroborated the anecdotal evidence from subjects that the practice poses harmful and potentially life-

threatening risks, particularly to minors. The American Psychological Association, for instance, finds that "conversion therapy" victims face 8.9 times the rate of suicide ideation than the general population. Mental health professionals and legal experts agree that legislation prohibiting licensed mental health professionals from engaging in "conversion therapy" with minors is an appropriate and necessary use of New York State's ability to regulate professional conduct.

California, Oregon, Vermont, New Jersey, Illinois and the District of Columbia have now all passed legislation with bipartisan support banning this deleterious practice on minors. New York has also made strides. I was extremely grateful for Governor Cuomo's use of his executive authority in February 2016 to cut off state support for "conversion therapy" through a series of multi-agency regulations to ban public and private health care insurers from covering the practice and to prohibit mental health facilities under its jurisdiction across the state from conducting the practice on individuals under 18 years of age.

Nonetheless, conversion therapy remains legal in New York State. While admirable, Governor Cuomo's actions will only have a small impact on the scope of "conversion therapy," as most practitioners operate underground and do not openly apply for state support such as Medicaid reimbursements. My bill would go further than the Governor's actions by classifying the practice of sexual orientation change efforts upon minors as professional misconduct, which is punishable by the Board of Regents under the New York State Education Law. Penalties range from censure, to suspension or revocation of a license, to a civil penalty of up to $10,000. Only by making this bill a law will we finally see the end of this shameful practice in New York State, and thus I urge the adoption of Res. No. 130-A before you today.

Moreover, while the American Psychological and American Psychiatric Associations have already been instrumental in calling attention to the ineffective and disastrous effects of "conversion therapy," they can go further by classifying the practice as unethical and thus making health care providers who engage in the practice subject to professional sanctions.

The ascendancy of a stridently anti-LGBT federal administration heightens the need to take state and organizational action to curtail "conversion therapy" and signal support for LGBT youth. Incoming Vice President Mike Pence has openly supported the use of federal funding to treat people "seeking to change their sexual behavior," and the family of Secretary of Education nominee Betsy DeVos has given hundreds of thousands of dollars to advocacy groups that champion the practice. The election of Donald Trump has also ushered in a wave of hate crimes targeting the LGBT community. The Southern Poverty Law Center reported 867 hate incidents in the ten days following the election, eleven percent of which were anti-LGBT. Bringing "conversion therapy" to an end once and for all will send a positive message to LGBT youth amidst an otherwise hostile anti-LGBT climate, especially for transgender youth in the absence of the Gender Expression Non-Discrimination Act (GENDA).

I respectfully ask my colleagues in the City Council to support today's resolutions sponsored by Council Member Dromm. I appreciate your time and consideration, and thank you again for the opportunity to comment.

Protecting LGBT Youth from "Conversion Therapy" in New York State

A Report on the May 15, 2014 Public Forum

New York State Senator Brad Hoylman

Introduction

On May 15, 2014, a public forum was held in New York City on legislation carried by Senator Brad Hoylman (S.4917-B) and Assembly Member Deborah Glick (A.6983-B) that would prohibit licensed mental health professionals from engaging in so-called "conversion therapy" with minors.

Testimony was presented at the public forum by two dozen panelists, which included former subjects of conversion therapy, as well as representatives from leading mental health professional associations, legal experts, members of the clergy, and LGBT advocates. Written testimony was submitted by several others, all of which was been compiled and reviewed by legislative staff in preparation for this report.

Several common themes arose during the forum, underscoring the need for New York State to enact legislation barring licensed mental health professionals from engaging in the practice of "conversion therapy." Each of these findings is discussed more thoroughly below.

Key Findings

- "Conversion therapy" is practiced in New York State, including by licensed mental health professionals.
- The subjects of "conversion therapy" report that it was ineffective and degrading, and resulted in numerous negative outcomes including depression and suicidal thoughts.
- The unanimous consensus among major mental health professional association corroborates the anecdotal evidence shared by "conversion therapy" subjects: the practice is ineffective and poses harmful and potentially life-threatening risks, particularly to minors.
- Mental health professionals and legal experts agree that legislation prohibiting licensed mental health professionals from engaging in "conversion therapy" with minors is an appropriate and necessary use of New York State's ability to regulate professional conduct.

Frequently Asked Questions About S.4917-B/A.6983-B

What does the bill do?

The bill states that it is professional misconduct for certain health and mental health professionals licensed by New York State to practice sexual orientation change efforts on persons younger than 18 years old.

What are "sexual orientation change efforts"?

Sometimes referred to as "conversion therapy" or "reparative therapy," sexual orientation change efforts are practices that seek to change an individual's sexual orientation or gender identity, or that seek to eliminate or reduce sexual or romantic attractions or feelings towards individuals of the same sex.

They do not include counseling for a person seeking to transition from one gender to another, nor do they include counseling to prevent or address unlawful or unsafe conduct or sexual practices.

To whom does this bill apply?

The bill generally applies to New York State licensed psychologists, psychiatrists, social workers, mental health practitioners, and physicians.

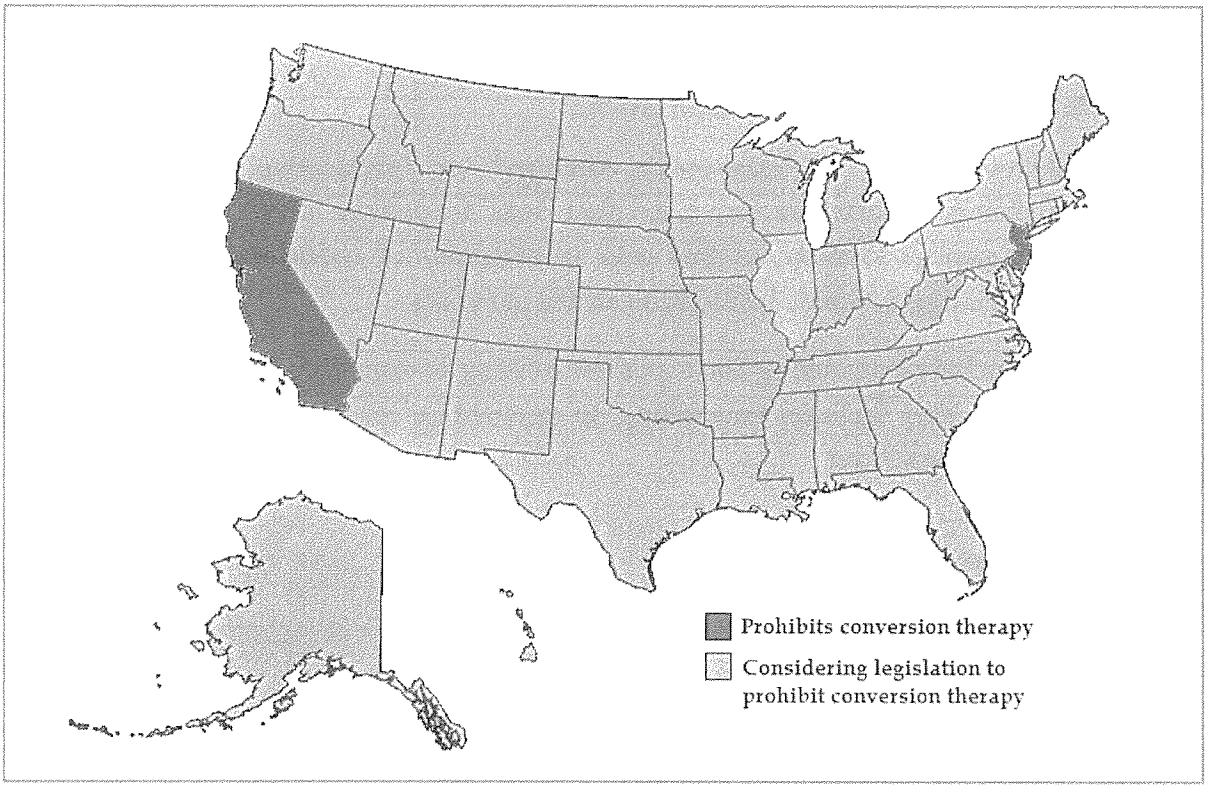
The bill does not apply to members of the clergy, parents, or anyone else who is not a New York State licensed mental health professional.

What is the penalty for practicing sexual orientation change efforts upon minors?

The bill classifies the practice of sexual orientation change efforts upon minors as professional misconduct, which is punishable by the Board of Regents under the New York State Education Law. Penalties range from censure, to suspension or revocation of a license, to a civil penalty of up to $10,000.

Have any other states passed similar laws?

California and New Jersey enacted substantively identical legislation in 2012 and 2013, respectively. In each instance the legislation was passed with bipartisan support. Similar bills have been introduced in the District of Columbia, Illinois, Maryland, Massachusetts, Minnesota, Ohio, Pennsylvania, Washington, and Virginia.



Is this legislation constitutional?

Yes. Substantively identical legislation has been upheld as a constitutional exercise of a state's power to regulate professional conduct by the United States Court of Appeals for the Ninth Circuit and the Federal District Court of New Jersey.

See Pickup v. Brown, 728 F.3d 1042 (9th Cir. 2013) and King v. Christie, 2013 U.S. Dist. LEXIS 160035 (D.N.J. 2013) for more information.

Discussion of Testimony

Personal Stories

Mathew Shurka, joined by his mother and sister, recounted the five years of "therapy" he was subjected to, starting at age 16. He was told that there was no such thing as homosexuality, and that men experienced sexual attraction towards other men because of a "void in their masculinity," a condition that his licensed therapist claimed could be corrected.

His therapist directed him to limit his interactions and conversations with his mother and sisters, and as a result, he barely spoke to them for two years. He was provided pornography and Viagra to aid him in pursuing heterosexual sexual encounters. After seeing four therapists over five years, Mathew, now 21 years old, ended the therapy and gradually came out as openly gay.

Another panelist, Mordechai Levovitz, spoke of being shamed by a licensed therapist whenever he would speak with a lisp, cross his legs, or hold his wrist in a certain way. Mordechai, who is now a social worker working with LGBT youth in the Orthodox Jewish community, reported that some of minors he works with who had been subjected to conversion therapy were shown pictures of AIDS patients, made to read aloud descriptions of anal cancer and other diseases, and directed to undress and touch their genitals in front of their therapists.

One panelist described how his therapist attached electrodes to his hands and genitals, shocking him with electricity when he displayed physiological signs of arousal.

Yet another panelist, Dean Dafis, described how his therapist attached electrodes to his hands and genitals, shocking him with electricity when he displayed physiological signs of arousal upon viewing homosexual pornography. His therapist was a licensed psychotherapist affiliated with an Ivy League university.

Mathew's mother, Jane Shurka, testified about her guilt for her role in facilitating her son's therapy. She felt that the fact that licensed mental health professionals offered "conversion therapy" lent the practice professional respectability and took advantage of her ignorance about sexual orientation. Jane, along with Mathew's sister, Melanie

Shurka, testified that had they known that "conversion therapy" was widely discredited, they would have advised Mathew not to undertake it.

David Dinielli, the Deputy Legal Director of the Southern Poverty Law Center, stated that Jane's experience was not uncommon. Parents, desperate to help their children, turn to people they perceive to be knowledgeable, particularly licensed and credentialed health and mental professionals. "Well-intentioned parents," Mr. Dinielli noted, "should not be duped by practitioners who choose to espouse beliefs about sexual orientation that directly conflict with the consensus views of all major mental health organizations."

Mental Health Professionals

The personal stories from the forum all shared two major similarities: the so-called "therapy" failed to alter the subjects' sexual orientation, and the subjects uniformly all experienced a combination of negative outcomes in the wake of the failed "therapy," including guilt and shame, frustration, disappointment, withdrawal from family, poor academic performance, drug abuse, depression, and suicidal thoughts.

The mental health professionals who testified at the forum said they were not surprised at these reports. For over 40 years, it has been the consensus in the health and mental health professions that homosexuality and bisexuality are not considered disorders or abnormalities. Dr. Dinelia Rosa, the President of the New York State Psychological Association, pointed out that no major mental health professional organization endorses sexual orientation change efforts, and virtually all of them have adopted official policy statements against the practice (see sidebar, right).

There is no evidence to suggest that sexual orientation change efforts are even successful. Dr. Jack Drescher, appearing on behalf of the New York State Psychiatric Association, noted that "it is the consensus of most professional organizations that sexual orientation change

The following professional organizations have issued statements or adopted policies against the practice of conversion therapy:

- American Academy of Child and Adolescent Psychiatry
- American Academy of Pediatrics
- American Counseling Association
- American Medical Association
- American Psychoanalytical Association
- American Psychological Association
- American Psychiatric Association
- American School Counselor Association
- National Association of Social Workers
- Pan American Health Organization

efforts are outside the mainstream of mental health practice. The theories upon which they are based have no scientific basis."

Mr. Dinielli, who is currently litigating a conversion therapy case in New Jersey on consumer fraud grounds, shared his experience from depositions of approximately 20 adult men who claimed to have successfully changed from gay to straight:

> "Once we put [these men] under oath, we learned that some of them have been able to reduce the frequency of their same-sex sexual encounters, but still occasionally [...] 'act out,' as it is called in the conversion therapy business. Some of them have been able to stop having sex with men, but still fantasize [about] it and have to keep pornography blocks on their computers and smartphones to avoid looking at gay porn. Some of them claim they are heterosexual but really have just become celibate. People who claim to be heterosexual as a result of [sexual orientation change efforts] may have a very different understanding of what that means than you or I likely do."

Several of the mental health experts who testified explained that sexual orientation change efforts can be extremely harmful.

Dr. Ariel Shidlo, the co-researcher of a landmark study of over 200 individuals who had experienced sexual orientation change efforts, explained: "When consumers of [sexual orientation change efforts] fail to change, they blame themselves and often experience depression and even suicidal ideation. [...] Failure is framed as the result of the client not trying hard enough, not of a defective and fraudulent intervention."

Conversion therapy is harmful because it presents the view that the sexual orientation of LGBT youth is a mental illness or disorder.

"Such efforts are potentially harmful because they present the view that the sexual orientation of LGBT youth is a mental illness or disorder," testified Dr. Rosa, "and they often frame the inability to change one's sexual orientation as a personal or moral failure."

Policy & Legal Experts

Assemblyman Tim Eustace, who sponsored similar legislation in New Jersey, spoke about the broad bipartisan support his bill had in the state legislature, noting that "protecting our children is not a partisan issue."

Assemblyman Eustace pointed out that opposition to his bill did not come from licensed mental health professionals nor mainstream religious groups. He said both groups recognized that the legislation did not curtail their rights to practice their professions nor their religions - a fact which was subsequently confirmed by federal court rulings in California and New Jersey.

Mr. Dinielli, who helped draft the original California legislation, explained: "The government has broad latitude to regulate the practice of licensed professions in order to ensure compliance with professional standards of competence and ethics, and to protect clients and the public," drawing an analogy to other professional standards imposed on physicians or attorneys.

Dr. Shidlo addressed the issue of whether the legislation could be construed as an infringement of free speech. He noted that "our society does not allow physicians to offer interventions based on fraud and pseudo-science just because we value freedom of speech and consumer choice. We outlaw 'snake oil' cures because we, as a society, believe that vulnerable patients who are in distress need to be protected from false and harmful interventions."

Echoing Dr. Shidlo and the federal court decisions in California and New Jersey, Mr. Dinielli testified that in many instances states regulate professional practice, even when the practice involves speech. "The state is well within its authority to prohibit this particular treatment," he asserted, "despite the fact that practitioners who attempt to change their patients' orientations use words, rather than surgery or pills."

David Castleman, an attorney and co-founder of Trevor Project NextGen, described the legal rationale for this legislation as "the state saying that it is professional misconduct when a licensed mental health professional practices this widely discredited and harmful treatment on a minor."

Further Information

For more information about the legislation to prohibit licensed mental health professionals from practicing sexual orientation change efforts on minors, please contact Burton Phillips, Counsel & Policy Director for Senator Brad Hoylman, at (518) 455-2451.

Acknowledgements

We wish to thank those who testified at the May 15, 2014 public forum, including **Rev. Pat Bumgardner**, Metropolitan Community Church of New York; **David Castleman**, Co-Founder, Trevor Project NextGen; **Jason Cianciotto**, Director of Public Policy Development, Gay Men's Health Crisis; **Dean Dafis**; **Dr. Jack Drescher**, New York State Psychiatric Association; **David Dinielli**, Deputy Legal Director, Southern Poverty Law Center; **the Honorable Tim Eustace**, New Jersey Assemblyman; **Jason Daniel Fair**, the Trevor Project; **Hayley Gorenberg**, Deputy Legal Director, Lambda Legal; **Rev. David Starbuck Gregory**, United Church of Christ; **Ryan Kendall**; **Thomas Krever**, Executive Director, Hetrick-Martin Institute; **Mordechai Levovitz**, Co-Executive Director, JQY; **Dr. Jack Levy**; **Dr. Andrew Livanis**, New York Association of School Psychologists; **Pastor Chad Tanaka Pack**, Middle Collegiate Church; **Dr. Dinelia Rosa**, President, New York State Psychological Association; **Jacob Rudolph**; **Maya Rupert**, Policy Director, National Center for Lesbian Rights; **Nathan Schaefer**, Executive Director, Empire State Pride Agenda; **Dr. Ariel Shidlo**, Research Institute Without Walls; **Jane Shurka**; **Mathew Shurka**; **Melanie Shurka**; and **Dr. Tamara Sullivan**, American Counseling Association-NY.

We would also like to thank **Senator Michael Gianaris** and **Assembly Member Deborah Glick** for co-hosting the public forum, and **Senator Bill Perkins** and **Council Member Ritchie Torres** for attending the forum and helping drive the conversation with their insightful questions.

Also, special thanks to **Burton Phillips**, Counsel & Policy Director for Senator Brad Hoylman, who assisted with the preparation of this report, **David Rozen**, Counsel for Senator Michael Gianaris, and New York State Senate staff member **Franci Schwartz** for her assistance in organizing the public forum.

***Cover photo**: Senator Michael Gianaris, Senator Brad Hoylman, and Assembly Member Deborah Glick at the May 15, 2014 public forum.*

January 10, 2017

Testimony in Support of Res 0130-2014 & Res 0613-2015 Barring Sexual Orientation Change "Therapy" for Minors

FOR THE RECORD

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My name is Jason Cianciotto and I am the Vice President of Policy, Advocacy, and Communications at Harlem United Community AIDS Center, which has been serving LGBT and other populations affected by HIV and AIDS in New York City for nearly 30 years. I testify today in support of two resolutions critical to reaching our goal of ending the AIDS epidemic in our city by 2020:

- **Resolution 0130-2014**, which designates as professional misconduct, engaging in sexual orientation change efforts by mental health care professionals upon patients under 18 years of age. (A.6983A/S.4917A)
- **Res 0613-2015**, which declares the practice of "curative therapy," also known as "reparative" or "conversion" therapy, or any attempt to change, alter, or "correct" a person's sexual orientation, to be unethical.

For nearly 15 years, I have been working as a researcher, policy analyst, and author focused on LGBT populations in the US, with a specialty at the intersection of public policy and LGBT youth. I am the co-author of *LGBT Youth in America's Schools*, published by the University of Michigan Press in 2012, and of the report, *Youth in the Crosshairs: The Third Wave of Ex-Gay Activism*, published in 2006. Throughout my career, the findings I have summarized from peer-reviewed research on LGBT youth are heartbreaking. For example:

- In a study of over 500 LGB youth in New York City, 72% reported that the first time they were verbally harassed because of their sexual orientation was at school.
- Nearly 30% of homeless youth in New York City ages 13 to 24 are gay or transgender. They become homeless at an average age of 14 and the majority are black or Hispanic.
- Among gay and bisexual New Yorkers, youth ages 13 to 29 are the only cohort to experience an *increase* in HIV incidence over the past decade.

The consequences to their physical and mental health and well-being are dire. LGBT youth are more likely to skip school, experience depression and report substance abuse. They are up to three times more likely to attempt suicide. Compared to 11% of high school students overall, 33% of LGBT youth in New York City attempted suicide.

It is critical to be clear that these negative outcomes for LGBT youth are not because of their sexual orientation or gender identity. Rather, they are linked to socio-cultural, familial, and faith-based environment in which these youth experience stigma, discrimination, and rejection, often from a very early age.

This is why these data have profound implications for public policy and what is perhaps the most noble and critical role of government: to protect its citizens, especially youth, from harm. That is what these resolutions are about: protecting vulnerable LGBT youth in New York City from being harmed by rejection and so-called "ex-gay" therapy provided by state-licensed mental health professionals.

Mordechai Levovitz was six when his parents first brought him to "ex-gay therapy." Because of behavior deemed gender-atypical — a limp wrist, lisp and love of Barbie dolls — he was diagnosed and treated for "pre-homosexuality" by a New York State-licensed therapist. Beginning at age 16, Matthew Shurka was advised by his state-licensed therapist to stop speaking to his mother and sisters, which lasted for two years. Dean Dafis' New York State-licensed therapist showed him gay pornography when he was 13 while shocking him with electrodes, initially taped to the palms of his hands and eventually to his scrotum. During a public forum in May 2015, my heart broke for these and the many other victims who testified in support of the predecessors to New York State bills A.6983A/S.4917A, which would prohibit state-licensed mental health professionals from providing so-called "ex-gay therapy" to minors.

We need only look to the 2016 Republican Party Platform, and to the life's work of several members of the forthcoming Trump administration, to see that the pernicious belief that homosexuality can and should be changed is alive and well. As Mordechai testified, minors are an easy target of the "ex-gay" industry, particularly those from anti-LGBT religious families, because they have no choice, no power, and no one to protect them.

These resolutions are an important part of a policy agenda necessary to ensure the health and well-being of LGBT youth and to ending AIDS in New York by 2020. As I summarized in my book, *LGBT Youth in America's Schools*, decades of research has documented that the experience of growing up LGBT in America includes verbal and physical harassment, bullying, and rejection from peers at school and families, often from a very young age. Youth see and hear anti-LGBT rhetoric from their parents, older siblings, and on television. "That's so gay" remains common lingo for rejecting and making fun of something bad. For a significant proportion of LGBT youth, growing up in this context has profound and sometimes deadly consequences for their mental and physical health.

This is why there is consensus among New York State and national medical, mental health, and child welfare professional associations that "ex-gay therapy" is scientifically unnecessary, ineffective, and dangerous, including the New York State Psychiatric Association, New York Association of School Psychologists, American Academy of Pediatrics, American Medical Association, and the American Psychological Association. In 2013, the American Psychiatric Association released a position statement stating it "does not believe that same-sex orientation should or needs to be changed, and efforts to do so represent a significant risk of harm by subjecting individuals to forms of treatment which have not been scientifically validated and by undermining self-esteem when sexual orientation fails to change."

In my report, *Youth in the Crosshairs: The Third Wave of Ex-gay Activism*, I show that, despite this consensus among these professional organizations, Mordechai's, Matt's, and Dean's experiences are not unique. Rather, they are just a few of many victims of a coordinated shift in the "ex-gay" movement from attempting to "cure" homosexuality in adults to purportedly treating "pre-homosexuality" in adolescents and children as young as five years old.

The research is clear that ex-gay programs do not convert someone from a homosexual to a heterosexual orientation. In a peer-reviewed study of 202 ex-gay therapy participants, only eight self-reported changing their sexual orientation. Of those eight, seven were providers of ex-gay therapy. Conversely the majority of "ex-gay" program participants reported psychological harm, including depression and suicidal ideation, social and interpersonal harm, which prevented them from forming long-term relationships, as well as spiritual harm that separated them from life-long connections to faith communities.

The long-term effects of this harm also creates the context for higher risk for HIV infection among LGBT youth and young adults. A study conducted by researchers at the Family Acceptance Project at San Francisco State University found that 34% of LGB participants were sent by their family to a therapist to change their sexual orientation when they were youth. They experienced significant family rejection and were 3.4 times more likely to report unprotected sex with a casual partner at the time of last intercourse and 1.5 times more likely to report having had an STD than youth who came from more accepting families. This research helps shed light on the stigma, family rejection, and homophobia that drives the HIV epidemic among LGBT youth, as well as other harmful physical and mental health outcomes. In fact, among gay and bisexual men in New York, youth ages 13 to 29 are the only demographic that experienced an increase in HIV incidence in the past decade.

New York City has the opportunity to ensure that mental health practitioners operating under the privilege of a state license are prevented from providing treatment that is not only scientifically discredited and unnecessary, but also harmful to LGBT youth and their families. This is not only critical to their overall health and well-being, but also to the City's investment in and vision to end the AIDS epidemic by 2020.

For more information:

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Testimony to the Committee on Mental Health of the New York City Council

Delivered in person on January 10, 2017
by Thomas Weber, Director of Care Management

Councilmembers, on behalf of SAGE – Services and Advocacy for GLBT Elders – thank you for holding this Committee hearing on how the city can better serve the mental health needs of lesbian, gay, bisexual, transgender and questioning people.

My name is Thomas Weber, and I am the Director of Care Management at SAGE. SAGE is the country's first and largest organization dedicated to improving the lives of LGBT older adults. Founded right here in NYC in 1978, SAGE has provided comprehensive social services and programs to HIV positive & LGBT older people for nearly four decades, including through our five LGBT-welcoming senior centers across the city, which have been funded through the Council.

SAGE's services are so important to LGBT older adults. LGBT elders face compounded challenges of aging: They are twice as likely to live alone; half as likely to be partnered; half as likely to have close relatives to call for help; and more than four times more likely to have no children to help them. As a result of these thin support networks, many LGBT older people have nobody to rely on. In fact, nearly 25% of LGBT older adults have no one to call in case of an emergency.

LGBT older people are more likely to face discrimination around their sexual orientation and gender identity when accessing health care, social services or mainstream senior centers – yet they are among the most in need of care as they have few places to turn.

All of this leads to severe isolation among LGBT older people – already a concern among all seniors. Deepened experiences of isolation puts LGBT older people at greater risk for physical and mental health issues.

Depression is the most prevalent mental health problem among all older adults. Recent CDC Behavioral Risk Factor Surveillance data indicated that among adults age 50 or older, 7.7% reported current depression and 15.7% reported a lifetime diagnosis of depression. Also, according to the National Council on Alcoholism and Drug Dependence, by the year 2020, the number of persons needing treatment for drug abuse and addiction will double among persons aged 50 or older.

LGBT elders disproportionately grapple with mental health issues. According to a 2011 national health study of LGBT people, more than half of the respondents have been told by a doctor that they have depression; 39 percent have seriously thought of suicide; and 53 percent feel isolated from others. This is starkly higher than the general population. Further, when compared to their cisgender, heterosexual peers, LGBT populations have higher rates of tobacco, alcohol, and other drug use.

These statistics mirror SAGE's experience working directly with LGBT older people. What we have seen in the last year is a dramatic rise in the demonstrated need for mental health services among LGBT older adults in New York City. In the past year, SAGE has administered 269 depression, alcohol and drug screenings, far exceeding the 175 screenings funded through the NYC Geriatric Mental Health Initiative. Of those, 20% were referred for mental health treatment – a staggeringly high number.

Here in New York City, geriatric mental health services are limited – and these services are even scarcer for LGBT older adults as mainstream providers typically lack LGBT cultural competence.

For SAGE, NYC's Geriatric Mental Health Initiative is the only dedicated source of mental health funding. SAGE – and many aging providers in New York City – rely upon these funds to provide these life-saving services. And SAGE's services offered through this program comprise the only LGBT-dedicated mental health program for our city's LGBT elder pioneers.

Aside from the Geriatric Mental Health Initiative, SAGE does not receive any New York City funding to support the mental health needs of LGBT older people. SAGE does not receive – nor is SAGE qualified for – a DFTA baselined case management grant because those are awarded geographically, and cover mass areas. Organizations like SAGE that serve special populations and draw their clients from across the city, are not eligible for grants of that size that would require us to serve all older adults within a certain area, thus taking us outside of our mission of serving LGBT older people. One unfortunate consequence of the way in which case management grants are distributed is that SAGE – and many other organizations – are ineligible for Thrive NYC funds, which are being awarded only to baselined DFTA care management programs.

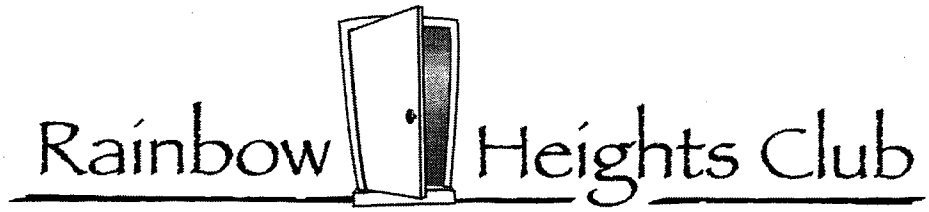
It has become strikingly clear that these resources are not enough, and immediate additional resources, such as mental health training, professionalized staff and opportunities to screen for mental illness and substance abuse are required to address this compounding need.

This is why SAGE strongly supports this legislation, which would require the Office of Health and Mental Hygiene to develop a culturally competent plan for serving the mental health needs of LGBT people, including the needs of LGBTQ elders over age 65.

Thank you for this opportunity to provide some testimony and recommendations on the mental health needs of LGBT older adults. With the new administration in Washington, we at SAGE are doubling down on our commitment to serve our vulnerable LGBT elders and we are grateful for our partnership with the New York City Council.

We hope that the Mental Health Committee and other members of the City Council will support this legislation and deepen its support to meet the needs of LGBT older adults who are most at risk, and prioritize their need to age in place safely, and with culturally competent mental health services.

Thank you to the City Council for your continued commitment to our city's LGBT elders.



A project of Heights-Hill Mental Health Service South Beach Psychiatric Center Community Advisory Board, Inc.
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TESTIMONY in support of Int. 1225
for City Council hearing on January 10, 2017, 1 pm

Christian Huygen, Ph.D., Executive Director, Rainbow Heights Club
christianhuygen@rainbowheights.org 718 852 5212

My name is Dr. Christian Huygen. I'm a licensed clinical psychologist, and for the past 14 years I have served as executive director of Rainbow Heights Club. We provide LGBTQ affirming mental health support to adults who are living with mental illness.

I support Introduction 1225 because the needs of LGBTQ people living with mental illness are not currently being met. This costs the public mental health system millions of dollars every year.

I have some estimates for you. They're not specific numbers because until recently, no government agency anywhere in the United States was asking people about their sexual orientation or gender identity. Invisible populations don't get their needs met. I thank Danny Dromm and the other city councilmembers who supported legislation to ensure that going forward, New York City agencies will collect this information, and I thank Mayor de Blasio for signing it into law.

It's estimated that 11,000 LGBTQ adults right here in New York City are currently living with serious mental illness. And they experience significant disparities. In New York City, LGBT people are twice as likely to experience depression as non-LGBT people are, and the burden is even greater if you're Black or Latino. One third of LGBTQ New Yorkers say they have difficulty accessing mental health services that meet their needs, and again, LGBTQ people of color have an even harder time finding care.[1]

Some people might feel that we don't need legislation because we have community input. Last year, a new mental health plan called ThriveNYC was developed, with an enormous amount of community input. This $850 million initiative was subtitled "a mental health roadmap for all." But it has virtually nothing to say about how LGBTQ people's mental health needs should be addressed.

There are two references to LGBTQ people in the entire report, and no suggestions or commitments about meeting their needs. This unacceptable result demonstrates the need for legislative prompting. *(over)*

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[1] Frazer, M. Somjen. (2009) LGBT Health and Human Services Needs in New York State. Empire State Pride Agenda Foundation: Albany, NY. https://gaycenter.org/thenetwork#reports accessed on January 6, 2017.

LGBTQ affirming mental health care will save New York City millions of dollars every year. Over the past 14 years, Rainbow Heights Club's affirming services have kept 90% of our clients out of the hospital and in the community every year. A one year psychiatric hospitalization costs New York taxpayers over $300,000, so the potential savings are enormous.

Institutionalized marginalization and discrimination of many kinds cause enormous barriers for people who are seeking to access mental health care, including LGBTQ people. The system needs a plan to meet their needs.

To end on a positive note, I recently spoke with Dr. Myla Harrison at DOHMH about my concerns, and we had a very productive conversation. I thank her for that.

Int. 1225 is an important means of ensuring that LGBTQ people's needs are taken into account, resulting in better outcomes and better cost containment.

Thank you very much for your consideration of this testimony. I would be happy to answer any questions that you may have.

###

Christian Huygen, Ph.D., Executive Director, Rainbow Heights Club
christianhuygen@rainbowheights.org 718 852 5212

Data:

- The Archives of General Psychiatry suggests that one in three with HIV may suffer with depression
- Studies show that people who do not know that they are HIV-positive are more likely to engage in risk behaviors associated with HIV transmission;
- Research has revealed that some gay men described engaging in unsafe sex when depressed because they were less concerned about the consequences.
- 8.3% of NYC high school students reported having attempted suicide within the past 12 months;
- The rate of attempted suicide was 32% among NYC youth who have been bullied on school grounds in the past 12 months and identified as lesbian, gay, bisexual or were not sure of their sexual identity.
- 1 in 3 transgender youth in NYC have seriously thought about taking their lives, and 2 in 5 report having made a suicide attempt in the past 12 months.
- NYC LGB youth, and youth who were not sure of their sexual identity, attempted suicide at significantly higher rates in comparison to heterosexual youth.
- Nationally, LGB youth who experience rejection at home are 8.4 times as likely to have attempted suicide as LGB peers who reported no or low levels of family rejection. (Bullets 4 – 8, NYC Department of Health Website)
- Krieger and Sidney (1997)[20] found that 50% of Whites compared with 33% of Blacks reported discrimination based on sexual orientation. On the other hand, in a study of HIV-positive gay men in New York City, Siegel and Epstein (1996)[21] found that African-American and Puerto Rican men had significantly more gay-related minority stressors than Caucasian men.
- Research on Black and Latino LGB individuals has shown that they often confront homophobia in their racial/ethnic communities and alienation from their racial/ethnic identity in the LGB community (Diaz, Ayala, Bein, Jenne, & Marin, 2001; Espin, 1993; Loiacano, 1993)[22-23]
- Members of racial/ethnic minority groups have a lower lifetime risk for mental disorders than do Whites [3-5], but paradoxically lesbian, gay, and bisexual individuals of racial/ethnic minority backgrounds may be at an increased for risk of suicide attempts relative to Whites [5,6].
- Lifetime suicide attempt rates in LGB population range from 10% to 40% [7,15] compared with 0.4% to 5.1% [2] in the heterosexual population.
- According to the minority stress model[16] the excess prejudice, stigma, and discrimination encountered by sexual minority individuals lead to increased mental health problems in this population and the resulting increased risk of suicide.
- Researchers—primarily looking within LGB samples—have described additional risk factors related to minority stress, prejudice, stigma, and discrimination, including gender-atypical behavior [14,17], family rejection[15], and early age of self-labeling.

o In New York:

  - 17% transgender were refused medical care due to their gender identity/expression
  - 5.36% were HIV positive, compared to the general population rate of 0.6%
  - 29% postponed needed medical care, when they were sick or injured, due to discrimination
  - Only 52% of transgender respondents had employer-based health insurance, compared to 59% of the general U.S. population at the time of the survey.
  - 36% reported attempting suicide at some point in their life, 22 times the rate of the general population of 1.6%[26].

Sources/Citations on page 4.

1) Res. No. 1225

The draft of this legislation addresses a much needed demographic, to ensure that it's incorporated into the City's THRIVENYC program, which fails to address the mental health needs of LGBT peoples of color in the city; it is deficient in the following areas and should be modified to include:

- mental health needs to be separated from substance abuse
- a person with a mental health issue is not always visible/apparent
- legislation should be modified, that there are many LGBT peoples of color along the age spectrum with mental health issues ; it is not confined to teenagers and elders.
- all aspects of law enforcement needs to incorporate mental care and training in the public response, and law enforcement needs to be regularly screened for mental issues, similar to retraining and fire arm recertification
- to provide mental health screenings for those peoples of color, especially if LGBT, who are arrested, including mental health clinicians on call at precincts;
- to mandate that all immigrants detained for immigration violations be mental health screened;
- to mandate that mental health screening and referral must accompany all HIV-positive diagnoses and treatment regimens
- mandate that all teaching facilities – education and medical in the City – provide mental health screening and cultural competency training for students; a survey of medical training institutions revealed that less than 5% of the overall curriculum is devoted to cultural competency
- develop programs/initiatives to encourage mental health clinicians to accept Medicaid/Medicare for those in our communities who cannot afford or do not have sufficient insurance coverage; this includes increasing the percentage Medicaid/Medicare reimburses, and a reduction in the volume of paper work required of mental health clinicians
- mandate that mental health professionals, if in a public/clinic setting, should have a manageable client/patient case load;
- mandate that all healthcare providers – private, clinic or public – provide mental health screenings and referrals to mental health professionals – according to the State Office of Mental Health, nearly two-thirds of 1,585 New York clinicians surveyed reported little or no specialized training in suicide-specific interventions.
- require that the Department of Health and Mental Hygiene, through the Coroner's Office and Medical Examiner, establish and keep records of the sexual orientation of cases of self- inflicted/-caused deaths
- to mandate that religious institutions/organizations, registered as non-profits, who receive any government funding, especially for HIV prevention, and who, if any practice or preach homophobia, bigotry or any form of discrimination, should have their funding suspended, pending a review and or terminated;

A national and local issue in the LGBTQ community, is the detrimental effects of conversion therapy on the mental health of LGBTQ; which bring us to requiring your support on:

2) Res. No 130-A and Res. No. 613- A

These resolutions set a protective measure for the prevention of any mental health professional operating in New York State/City from causing harm through conversion/reparative therapy. Moreover, it sends a clear message to other institutions within the state, which may be religiously affiliated or non-mental healthcare related, that the harm this practice causes the community, should be stopped.

In its continuing efforts as a beacon of progressive policy, the City needs to use its collective voice to call on the APA to declare that conversion/reparative therapy damages lives and families, even if under religious cover.

We realize the need to protect the most marginalized in our City and to send a clear message of the values that the NY City Council cares about, I ask you to sincerely support the legislative measure and two resolutions.

We restate the resolutions: **Res. No. 1225; Res. No 130-A; and Res. No. 613-A**

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Mental Health Facts
MULTICULTURAL

Fact: Mental health affects everyone regardless of culture, race, ethnicity, gender or sexual orientation.

1 in every 5 adults in America experience a mental illness.

Nearly 1 in 25 (10 million) adults in America live with a serious mental illness.

One-half of all chronic mental illness begins by the age of 14; three-quarters by the age of 24.

Prevalence of Adult Mental Illness by Race

Hispanic adults living with a mental health condition.

White adults living with a mental health condition.

Black adults living with a mental health condition.

Asian adults living with a mental health condition.

AI/AN* adults living with a mental health condition.

*American Indian/Alaska Native

LGBTQ Community

2X

LGBTQ individuals are 2 or more times more likely as straight individuals to have a mental health condition.

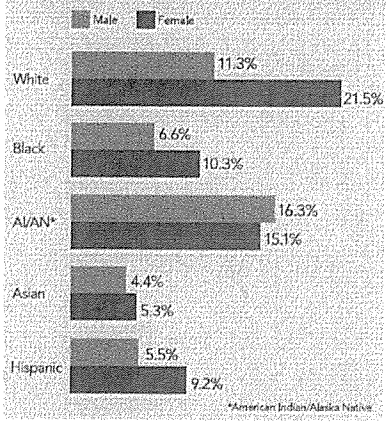
11%

11% of transgender individuals reported being denied care by mental health clinics due to bias or discrimination.

2-3X

Lesbian, gay, bisexual, transgender and questioning (LGBTQ) youth are 2 to 3 times more likely to attempt suicide than straight youth.

Use of Mental Health Services among Adults (2008-2012)



*American Indian/Alaska Native

Critical Issues Faced by Multicultural Communities

- ✓ Less access to treatment
- ✓ Less likely to receive treatment
- ✓ Poorer quality of care
- ✓ Higher levels of stigma
- ✓ Culturally insensitive health care system
- ✓ Racism, bias, homophobia or discrimination in treatment settings
- ✓ Language barriers
- ✓ Lower rates of health insurance

Ways to Get Help

Talk with your doctor

Connect with other individuals and families

Learn more about mental illness

Visit NAMI.org

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Facebook.com/NAMI
Twitter.com/NAMICommunicate

NAMI
National Alliance on Mental Illness
www.nami.org

THE TREVOR PROJECT
saving young lives

New York City Council

Committee on Mental Health, Developmental Disability, Alcoholism, Substance Abuse and Disability Services

January 10, 2017

Int. 1225-2016, LGBT Mental Health Bill testimony

Steve Mendelsohn
Interim Executive Director
The Trevor Project

Good afternoon Chairman Cohen and members of the committee. My name is Steve Mendelsohn and I am the Interim Executive Director of The Trevor Project, the leading national organization providing crisis intervention and suicide prevention services to LGBTQ youth. I am here today in support of Int. 1225-2016, the LGBT Mental Health Bill. Thank you Councilman Torres for bringing forth this important piece of legislation. Today I will focus my remarks on how to improve the bill by including a focus on suicide prevention.

The LGBT Mental Health Bill rightly tasks the Department of Health and Mental Hygiene (DOHMH) with developing a comprehensive plan to address the needs of LGBTQ youth and older adults. Given that LGBTQ youth have significant mental health disparities, there is great need for such a plan. Suicide is an important aspect of mental health that is too often neglected even within the mental health profession. Some may even be surprised to find out that the majority of graduate schools for social work and psychology related degrees do not require courses on suicide assessment or treatment even though suicide is the second leading cause of death among young people ages 10 to 24.[i] While developing the plan to address the mental health needs of the LGBTQ community, the bill requires DOHMH to "consult not-for-profit organizations with expertise in providing social and mental health services" to the LGBTQ community. We urge the committee to amend this language to also specifically state that it include "not-for-profit *suicide prevention* organizations" among the

list of consultants to address the often present gap in suicide education or training of mental health providers.

Just a few months ago the country received a major wake-up call when the Centers for Disease Control released the results of the 2015 nationwide Youth Risk Behavior Survey (YRBS), which includes data from New York City's local YRBS study. This is a survey of young people *which for the first time ever* included a nationally representative sample of lesbian, gay, and bisexual youth (LGB), and the results were shocking. LGB youth seriously contemplate suicide at almost *three times* the rate of heterosexual youth; and LGB youth are almost *five times* as likely to have actually attempted suicide. Another factor to consider is that, LGB youth's attempts were almost *five times* as likely to require medical treatment than heterosexual youth.[ii] In sum, significantly more LGB people think about suicide, make a suicide attempt, and those attempts are more deadly than heterosexual youth. Additionally, nearly *half of all transgender youth have seriously considered attempting suicide*, and approximately a quarter have attempted.[iii] These alarming statistics speak to the severe need for tailored plans and policies to meet the mental health needs of this highly vulnerable group.

Over the last several years, almost 10,000 LGBTQ young people in New York have utilized Trevor's suicide prevention services, including: calling or texting the Trevor Lifeline; going online through TrevorChat.org to seek help digitally; and engaging with other youth through TrevorSpace, a unique and monitored social media platform that allows young LGBTQ youth to connect with other youth who may be dealing with similar struggles. Given

that youth spend a large part of their time in school, these statistics indicate a need for schools to implement plans to appropriately address suicide prevention, intervention and postvention. We are aware that the New York City school system has these types of policies; however, they are not specific to the LGBTQ community. We strongly suggest that the LGBT Mental Health Bill require schools to develop these tailored policies. Major cities and states nationwide have begun to recognize this need and have acted. Just last year the District of Columbia and the state of California passed laws requiring schools to develop and implement policies to address suicide that *specifically* focus on the needs of several elevated-risk populations -- including LGBTQ youth.[iv,v] We anticipate the 2017 legislative season will see even more states passing similar legislation. Fortunately, The Trevor Project in partnership with the American Foundation for Suicide Prevention and others have published a model school district policy on suicide prevention that is based on research and provides sample language that school districts can use to draft their own policies.[vi] This is a free and existing resource to help reduce any barriers that might exist for schools to be able to develop these types of plans. New York City LGBTQ youth would benefit tremendously from having educators and administrators who can recognize and act on the warning signs of suicide.

Far too often, LGBTQ people young and old who are already in crisis run into a lack of understanding or support from the very systems that are supposed to support them. Passing this bill will help enable these systems to respond to the unique needs of this population. Unfortunately this bill is very much needed because the city's ThriveNYC

initiative to address mental health does not specifically speak to the needs of the LGBTQ community, as others today are discussing. In rectifying this, it is critical that this bill be amended to add suicide prevention organizations to the list of groups tasked with developing a plan and for schools to be written into the bill to require LGBTQ inclusive suicide prevention policies. We know that one supportive adult can reduce a young person's risk of suicide, and the passage of this bill will significantly add to that pool of supportive adults. Thank you again Councilman Torres for introducing and holding a hearing on this bill, we look forward to working with you and others to ensure LGBTQ youth receive the culturally competent treatment they deserve.

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[i] *CDC, NCIPC. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2015) {2016 Dec. 1}. Available from:www.cdc.gov/ncipc/wisqars.*

[ii] *CDC. (2016). Sexual Identity, Sex of Sexual Contacts, and Health-Risk Behaviors Among Students in Grades 9-12: Youth Risk Behavior Surveillance. Atlanta, GA: U.S. Department of Health and Human Services.*

[iii] Grossman, A. H. & D'Augelli, A. R. (2007). Transgender youth and life-threatening behaviors. *Suicide and Life Threatening Behavior 37*(5), 527-527. Retrieved from http://transformingfamily.org/pdfs/Transgender%20Youth%20and%20Life%20Threatening%20Behaviors.pdf

[iv] DC A21-0374 & CA AB 2246

[v] At-risk populations specifically mentioned in the DC or CA legislation include: homeless youth; youth in out-of-home settings such as foster care; American Indian/Alaska Native youth; youth bereaved by suicide; youth with substance use or mental health disorders; and youth living with medical conditions and disabilities

[vi] Available at http://www.thetrevorproject.org/pages/modelschoolpolicy

THE CENTER

Testimony of

Emily Contillo

Government Relations Coordinator

The Lesbian, Gay, Bisexual & Transgender Community Center

In response to the

New York City Council's Committee on Mental Health Hearing

On Int. 1225

Submitted on January 10, 2017

To the

New York City Council

Committee on Mental Health

250 Broadway, Committee Room

New York, NY 10007

THE CENTER

Thank you for the opportunity to provide testimony on Council Member Torres's bill, Int. 1225. My name is Emily Contillo, and I am the Government Relations Coordinator at The Lesbian, Gay, Bisexual, and Transgender Community Center (commonly known as The Center). The Center was founded in 1983 and is visited each week by 6,000 unique individuals from across all five boroughs.

I sought input from both clients and counselors at The Center on the issue Int. 1225 seeks to address: the lack of city-funded mental health services available to the LGBT community. As mental health can be a difficult topic to speak about firsthand, I have combined their input and expertise into the testimony I deliver today.

Counselors at The Center say that they observe two main issues when assessing mental health services made available to the LGBT community. First, there are significant gaps in services. These gaps include free, long-term counseling, services designed for the aggressor in a same-sex relationship that is dealing with domestic violence, and bereavement counseling for individuals who have lost a spouse of the same gender. The Center provides as much service in-house as possible, but there is a consensus among staff that there is a general lack of city programs to which we can refer clients for longer-term care. To maintain the trust of our clients, we are hesitant to refer individuals to programs which we either know to lack knowledge of the LGBT-community, or where clients have experienced cultural-competency problems in the past.

The second main barrier our community encounters when attempting to access mental health services is: what do we mean when we say LGBT-affirming? Our counselors have worked with clients who previously sought help in an environment that was advertised as being knowledgeable and inclusive of their identities, only to ultimately conclude that the mental health professional was not really comfortable with their sexual orientation or gender identity. While these slights may be imperceivable to others, if an individual is misgendered during intake, or there is no box to check that allows the person to identify themselves, the relationship between counselor and client is

already damaged. The Center's own intake process is influenced by these nuances, and our counselors are trained to leave the questions as open as possible to allow individuals to identify how he, she or they choose.

This concept of cultural competency is key to an effective and inclusive mental health campaign by the City. It means more than a general knowledge of the existence of the LGBT community, but rather that mental health professionals are trained and able to work specifically within this community, affirming and embracing their clients' full identity. There are certainly New York City-based professionals who seek out these trainings and continue their education throughout their professional lives, but without a clear directory of who they are and what their cultural-competency entails, organizations like The Center are understandably hesitant to refer clients to them. The Center's own counseling services are built around the concept of seeing, supporting, and treating the whole person, which includes creating space for them to explore and share their gender identity and sexual orientation. Our intake process is deliberately open-ended and does not rely on leading questions, allowing the client to feel seen and heard.

When an LGBT person is not able to access identity-affirming mental health services, the cost to that individual is significant. Often these are people who have also experienced both personal and community-based trauma, who are already at risk of isolation. The act of seeking care that instead leaves one feeling judged or misunderstood leaves lasting damage, and risks making that person less likely to pursue care in the future. For this reason, many people seek help in an environment in which they have already been made to feel welcome, seen, and understood. As an example, this experience informs the way The Center approaches youth treatment. We work to create an environment, including drop-in spaces, where LGBTQ young people can come and build a sense of community and self-worth. Once that trust has been established, they are much more likely to reach out to our counselors to discuss the bullying, suicidal tendencies, or substance use issues that may make up their daily reality.

THE CENTER

The Center would like to commend Council Member Ritchie Torres for shining a spotlight on this issue. We encourage passage of Int. 1225 and think that a city-wide closer look at LGBT mental health services can only be a good thing. The Center would be honored to continue to provide guidance and expertise on these issues.

HETRICK-MARTIN INSTITUTE

EMPOWERMENT, EDUCATION & ADVOCACY FOR LGBTQ YOUTH

Testimony Prepared for the New York City Council's Committee on Mental Health, Developmental Disability, Alcoholism, Substance Abuse and Disability Services on mental health needs of lesbian, gay, bisexual, transgender and questioning people

Presented by:

Lillian Rivera, MPH

Director of Advocacy & Capacity Building, Hetrick-Martin Institute

Tuesday, January 10, 2017

My name is Lillian Rivera and I am the Director of Advocacy and Capacity Building at the Hetrick-Martin Institute (HMI), the nation's largest and oldest lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth serving organization. HMI provides mental health services to thousands of LGBTQ youth from all five boroughs and we have done so since the early 80's. I thank the chair and the committee for their keen leadership in moving towards addressing the mental health and wellness of the LGBTQ community in New York City.

For well over 2 decades we have been keenly aware of the disparities experienced by LGBTQ youth in terms of their mental health and emotional well-being. HMI's founders were pioneers in the field of research on LGBTQ youth and mental health. From their work we learned that there were differences in their transition to adulthood from their heterosexual peers. In an article published in 1988 Hetrick and Martin wrote:

> ...isolation, family violence, educational issues, emotional stresses, shelter, and sexual abuse are the main concerns of youth entering the program. If not resolved, the social,

cognitive, and social isolation may extend into adulthood, and anxiety, depressive symptoms, alienation, self-hatred, and demoralization may result. In a non-threatening supportive environment that provides accurate information and appropriate peer and adult role models, many of the concerns are alleviated and internalized negative attitudes are either modified or prevented from developing.

Our founders knew that the young people were experiencing a different world than their heterosexual and cisgender peers. A world that often deems them as abnormal and a world that would allow parents to reject and throw them to the streets. Our founders also knew that these disparities were all caused by external influences and not due to a unique predisposition to mental health illnesses. And here we are over 20 years later and our nation has still not sufficiently responded to a health crisis that is caused by factors beyond the control of this population-LGBT youth. New York City has the opportunity to lead this country in how we care for our young people who continue to have three times higher suicide attempt rates than their straight peers due to the toxic environment that tells them their innate nature is wrong. New York City can set the bar on how we prioritize those who have been rejected by their families of origin who will have eight times greater rates of suicide attempts.

For me this issue is personal. This issue not only about legislation or regulatory policies; it is about life or death. I have seen too many young people in pain, a pain so great that they could not go on any farther on their journey. I know this pain all too well. I live with depression everyday but the difference is that I have always had the resources to get the best treatment. Today I thrive with depression and every young person deserves the right to as well. That only

happens due to being in care with competent LGBTQ affirming mental health professionals that can celebrate the existence of every young person and the gifts they bring to our world. Hetrick-Martin Institute supports a law that would require the development of a plan for serving the mental health needs of LGBTQ people and we support the ban of reparative therapy. We would encourage the development of a plan in consultation with community providers that have extensive experience in working with the community. We encourage forward thinking that seeks to create organizational and systemic standards of care that set a high threshold of service delivery and a professional development plan for staff that moves beyond "cultural competence" and seeks to achieve fluency. It takes a village to raise a child that requires that all members do their part - and are provided the tools to do so. We recognize that not all LGBTQ youth have that village and applaud Councilmember Torres for helping New York City create the foundation that will support LGBT youth as they so justly deserve.

Thank you.

Testimony of Diana Christian
Chief Policy Advisor
Community Healthcare Network
Hearing before the New York City Council Committee on Mental Health, Developmental Disability, Alcoholism, Substance Abuse and Disability Services
RE: Int. 1225- Requiring the DOHMH to develop a plan for serving the mental health needs of LGBTQ individuals.
Res. 0130 – Designates as professional misconduct, engaging in sexual orientation change efforts by mental health care professionals upon patients under 18 years of age.
Res. 0613 – Declaring the practice of "curative therapy," also known as "reparative" or "conversion" therapy, or any attempt to change, alter, or "correct" a person's sexual orientation, to be unethical.
New York City Council Chambers
Tuesday, January 10, 2017

Thank you Chairperson Cohen and members of the Committee for the opportunity to speak this afternoon, and particular thanks to Council members Torres and Drumm for introducing this important legislation. My name is Diana Christian and I am the Chief Policy Advisor at Community Healthcare Network. CHN is a network of 11 Federally Qualified Health Centers, plus two mobile medical vans and a school-based health center. We provide affordable primary care, dental, behavioral health and social services for 85,000 New Yorkers annually in four boroughs.

On behalf of CHN, we fully support the New York City Council in passing the bills before you, and would like to testify specifically on Int. 1225- requiring the DOHMH to develop a plan for serving the mental health needs of LGBTQ individuals. We are encouraged by the strides that the city is making to properly address the unique needs of LGBTQ New Yorkers, and urge the Council to recognize how critical it is for the city to work in partnership with existing community organizations when developing physical or mental health plans. We very much support the provision of the bill requiring the DOHMH to develop the plan in consultation with not-for-profit organizations with expertise, and in particular, federally qualified health centers. At CHN, we provide both one-on-one behavioral health services, as well as group counseling. The group settings for LGBTQ communities are tremendous, and we have found them to result in an increase in medical visits, return rates, and proactivity in healthcare.

There are a few issues I would like to address here, the first being the backbone of a plan like this – there are simply not enough behavioral health providers in New York City that serve low-income individuals – LGBTQ or otherwise. Organizations like ours struggle tremendously to identify and hire mental health professionals – and for most community providers, wait lists are often weeks or months before there is an opening for an appointment. There is no shortage of desire for services, but neither the city nor the state is creating incentives or support for mental health professionals to go into serving these populations. Also, current city plans, such as ThriveNYC, work outside the existing framework of community providers.

As a provider of comprehensive health care services in underserved communities for over three decades, CHN has extensive experience serving the LGBTQ community. In order for us and others to provide better care, there needs to be increased support, with both money and resources, towards training for all providers and healthcare staff in LGBTQ specific competencies. Few providers have even baseline familiarity with issues specific to the LGBTQ population, much less expertise. Nearly one-third (30.7%) of respondents in a recent NYS LGBTQ Health & Human Services needs assessment reported not enough LGBT-trained health professionals as a barrier to health care. Receiving medical care in a setting which is not culturally sensitive to LGBTQ individuals can cause additional trauma and result in avoidance of care. Cultural competency with LGBTQ individuals should exist at all levels – from the front desk staff to providers.

Additionally, there is a long history of LGBTQ communities being pathologized by the medical community. Mental health concerns endorsed by a patient should not be automatically assumed to be related their gender identity- as is often assumed with untrained providers. We must also examine how social determinants impact mental health needs. For example, people that have experienced violence against them – at home or socially, been kicked out of their homes or

school system, or other instances, have mental health needs that do not solely rest on their gender identity. In the same HHS needs assessment, nearly one in five (17.7%) LGBT respondents had been homeless at some point in their lives. We have found this to be particularly true for our transgender patients in the Bronx. It is far too common for them to have been rejected by loved ones and been victims of abuse and discrimination from family, friends and others in the community.

Circumstances often have additional layers of complexity for LGBTQ youth. The Centers for Disease Control and Prevention (CDC) recently reported, in the most comprehensive study to date, which does not yet include the option to identify as transgender or non-binary, that 8% of the high-school population identifies as lesbian, gay, or bisexual (LGB). In New York City, that equals 80,000 individuals. It also found staggering statistics on the substantially higher levels of harassment and physical and sexual abuse that LGB youth face compared to those who identify as straight, such as, 42.8% of LGB youth have considered suicide in the last year, compared to 14.8% of straight individuals, and 29.4% of which attempted suicide, compared to 6.4% of straight youth. They also face much higher levels of bullying, skipping school out of fear of safety, being forced to have unwanted sexual intercourse, and sexual violence. According to a NYS transgender discrimination survey, 75% of transgender and gender non-conforming (TGNC) students in grades K-12 reported high rates of harassment, 35% reported physical assault, 12% reported sexual violence, and 14% reported that harassment was so severe it led to their leaving school.

For the transgender community, seeking mental health services is often not a choice; rather, they are mandatory to attaining transition surgery. Medicaid requires two letters – one from a psychiatrist and one from a therapist. This is mandated therapy with providers that may not be trained to be sensitive in LGBT services – thus forcing patients into a system which can ultimately lead to further trauma and negative health outcomes. Transgender patients at CHN are often afraid to see a mental health therapist due to past negative situations – including being asked their "real" name, or personal questions about genitalia. Unfortunately, it is not uncommon for providers to be curious about the individual's gender dysphoria more than their mental status.

Finally, these services are still too expensive for many New Yorkers. Despite progress, many LGBTQ individuals are still fired from their job or lack spousal or parental support. This results in a community of people that are unemployed or underemployed and cannot afford services. At CHN we have a sliding fee scale for individuals with no health insurance, which allows individuals to pay $40 or $50 out-of-pocket to see one of our providers. This is still a tremendous amount for many individuals, especially youth if they are not supported by their parents.

On the two remaining bills, other states have shown leadership in these areas, and as New York prides itself on our progressiveness, it is time for us to take the steps to eliminate all forms of unwanted provider intervention in gender identity. Rather, we must solely support exploration of gender identity and be affirming of an individual's right to exist without stigma or bias. Further, conversion therapy or curative therapy has been rejected by the American Psychological Association (APA) and has been demonstrated to be harmful to patients. It is medically proven that children are born with their gender identity. It is how they feel, and how they express. They know what gender they are, regardless of what they are born with. Forcing them into oppressing

their gender identity overwhelmingly results in negative health outcomes, including depression, anxiety, suicide, and others. Sexual orientation is not different.

In closing, I strongly encourage the New York City Council to pass these three bills before you.

Additional: CHN Patient Examples

Patient 1: Patient is a 42 year old HIV positive transgender woman. Patient was recruited through an outreach event in May of 2015. Patient is an event organizer and social event planner at different clubs throughout Queens. Patient showed interest in transferring care to Community Healthcare Network based on her needs and the comprehensive services we offer to the LGBT community.

Patient has a long history of trauma inflicted by her older brothers. Patient was raised by her mother who had an alcohol problem. Her father died when patient was very young. Patient continues to mourn the death of her father. Patient suffers from trauma inflicted by her brothers for being transgendered.

After Program Manager completed a psychosocial assessment, patient was referred for behavioral services due to her traumas; patient is ambivalent to trust others. Patient was diagnosed with PTSD (Post Traumatic Stress Disorder). Her employment requires her to be around individuals that may be drinking alcohol. She reported often feeling nervous around individuals who are drinking often placing her job in jeopardy because she had to leave the establishment to compose herself. Both service provider and patient felt that therapy would be beneficial.

For the past year patient attends weekly therapy sessions and is compliant with all appointments. Patient continues to be virally suppressed. Patient has also engaged in support groups offered at the clinic. Patient recently obtained legal status, she was very happy with the news. Patient has shown improvement in mood and motivation for life. During reassessment, patient talked about her desire to work to improve his emotional health.

Patient 2: Patient is a 30 year old, newly diagnosed HIV Positive. Patient was referred by AVP (Anti-Violence Project) where patient is receiving legal assistance against ex-partner for domestic abuse to Community Healthcare Network. Patient is interested in primary care, hormone treatment, mental health and support group. Patient has history of suicidal ideation, attempted once prior to coming to the program. Patient also has experienced traumatic events, molestation.

Patient began receiving care at Community Healthcare Network, became virally suppressed, engaged in support groups, and attends weekly therapy visits. She is currently on medication to help with depression. She is actively working to obtain legal status, recently granted permission to work, and received her name change. Patient is currently in a relationship, she states she feels more confident expressing her needs due to her therapy session and support from friends that attend the group. Overall patient is doing better.

CALLEN LORDE
COMMUNITY HEALTH CENTER

The Coalition for Behavioral Health

TESTIMONY BEFORE THE NEW YORK CITY COUNCIL'S

Committee on Mental Health, Developmental Disability, Alcoholism, Substance Abuse and Disability Services

January 10, 2017

By David A. Guggenheim, PsyD

Good Afternoon. Thank you for the opportunity to provide testimony in support of Intro. 1225, as well as both resolutions that are being considered today. My name is David Guggenheim, and I am the Chief Mental Health Officer for **Callen-Lorde Community Health Center**. Callen Lorde is pleased to be a member of The Coalition for Behavioral Health, who joins us in today's testimony.

Callen-Lorde is a growing federally-qualified health center (FQHC) with a mission to reach lesbian, gay, bisexual and transgender communities and people living with HIV in addition to its geographic service areas. As a vital part of the dynamic healthcare infrastructure in New York City

(NYC), Callen-Lorde provided a patient-centered medical home for 16,643 patients, who made just under 100,000 visits in 2015.

Callen-Lorde provides behavioral health services to the LGBTQ community and every day we see mental health issues that are specific to our population. Last year alone, we saw over 2,000 of our medical patients who were in need of mental health services, and we estimate that the actual need is much greater than this.

The Coalition for Behavioral Health, Inc. (The Coalition) is the umbrella advocacy and training organization of New York's behavioral health community, representing over 140 non-profit community-based agencies that serve more than 450,000 consumers. Our members serve the entire continuum of behavioral health care in every neighborhood of New York City, and communities in Long Island, Westchester, Rockland, and Orange counties. Coalition members provide access to the range of outpatient mental health and substance use services, supportive housing, crisis intervention, peer support services, employment readiness, Personalized Recovery Oriented Services (PROS), Club Houses, education and nutritional services, as well as many other supports that promote recovery. The Coalition also trains on average 500 human services providers monthly on cutting edge and proven clinical and best business practices through generous support from the New York State Office of Mental Health, New York City Department of Health and Mental Hygiene, the New York City Council, and in conjunction with foundations and leaders from the behavioral health sector.

There's a significant body of researching showing disparities that exist in the health of LGBTQ folks —higher rates of anxiety, depression, post-traumatic stress disorder, substance use, and

suicide. But these mental health issues cannot be separated from the high cost, chronic and debilitating medical conditions that are associated with trauma and depression – such as higher rates of cardiovascular disease, asthma, uncontrolled diabetes, and certain types of cancer. There is a deep-rooted connection between trauma and chronic health conditions, which shows just how important mental health intervention can be for those who face trauma. A single incident of trauma can deeply affect the body and affect cardiovascular, immune system, brain and other bodily functioning. One study showed that "the development of future medical disease are *exponentially* greater following exposure to trauma."

The LGBTQ community faces stigmatization and discrimination on a daily basis, especially those with limited financial resources. Half of limited income LGBT New Yorkers reported some form of violence – including domestic violence, sexual assault, parental abuse, crime, workplace violence and trafficking. And it's not just incidents like the Pulse Nightclub shooting that deeply wound our community and our sense of safety. Of all LGBTQ folks, about a quarter have experienced at least one hate crime. LGBTQ persons are more likely to be the victims of hate crimes than any other minority group in the country. But violence and discrimination are just one piece of the puzzle. Many grow up in environments that are not accepting of LGBTQ folks – 42% of youth report living in a community where being LGBTQ-identified is not accepted. Adults face similar struggles in their communities and workplaces - 21% of LGBT employees report having been discriminated against in hiring practices, in their ability to be promoted and in pay difference and 78% of transgender employees report workplace discrimination. And one study showed that employers given resumes with clues, such as LGBT activism, on a resume were 23% less likely to respond.

As I mentioned, the resulting impacts on mental health are real – and sometimes fatal. LGBTQ people raised in homes that are high in terms of rejection measures are over 8 times more likely to attempt suicide than those raised in homes rated as low in rejection. Studies have shown that for every instance of physical or verbal abuse or harassment, individuals are 2.5 times more likely to engage in self-harm behaviors, such as cutting. Lesbian and bisexual women are twice as likely to have attempted suicide in their lifetime and gay and bisexual men are four times more likely. Almost half of people who identify as transgender have had at least one suicide attempt in their lifetime.

Every day we hear stories from our patients who face incredible odds – some of whom have experienced severe trauma – from older adults who have watched friends die of AIDS inaction, to younger patients who grow up in communities and homes where their first bullies are parents. While progress is heartening, it's inexcusable for us to ignore homophobia and transphobia that exist both overtly and institutionally, still even here in New York City. The least we can do to support the LGBTQ community is to support those who face incredible odds and seek treatment because of it. A clear path to mental health services should include a plan that integrates trauma into whole-person healthcare. Primary care should include screening for trauma and other mental health symptoms and LGBT patients should have easy, integrated access to mental health services with clinicians who are culturally competent and trained to provide LGBTQ-sensitive and affirming care. If we are going to address mental health needs, we need to be certain that the care we provide is specific to the needs of the community as well as the best care possible. It is essential that this committee and the New York City Council support a resolution to designate as professional misconduct any form of sexual orientation change efforts by mental health

professionals. Not only is the practice unethical, it can lead to fatal consequences – people who have gone through conversion therapy are 8.9 times more likely to experience suicidal thoughts and 5.9 times more likely to experience depression than their peers. They are also 3 times more likely to use drugs.

Lesbian, gay, bisexual, transgender, queer and questioning people face stigma and discrimination that deeply affects their overall health and leaves communities harmed. Not only will a plan to treat the unique needs of the LGBTQ community help improve the population's health and outcomes, it can help reduce the disease burden of chronic illness and decrease suicide rates. Through mental health programs tailored to meet the needs of LGBTQ people, we will increase the quality of care we provide and build stronger and healthier communities.

Thank you again for inviting Callen-Lorde and The Coalition for Behavioral Health to participate in this important hearing. I'm happy to answer any questions.

FOR MORE INFORMATION, PLEASE CONTACT DAVID GUGGENHIEM AT DGUGGENHEIM@CALLEN-LORDE.ORG OR KIMBERLEIGH J. SMITH, OUR SENIOR DIRECTOR FOR COMMUNITY HEALTH PLANNING AND POLICY AT KMITH@CALLEN-LORDE.ORG.

CHRISTY PARQUE, MSW, PRESIDENT & CEO, THE COALITION FOR BEHAVIORAL HEALTH AT CPARQUE@COALITIONNY.ORG

AMIDA CARE

ABOVE AND BEYOND FOR YOU

Committee on Mental Health, Developmental Disability, Alcoholism, Substance Abuse and Disability Services

Tuesday 10, January 2017

Re: Hearing on Int. 1225-2016, Res 0130-2014 and Res 0613-2015

Good afternoon

Thank you for this opportunity to testify. My name is Lyndel Urbano, and I am the Director of Public Policy and Government Relations at Amida Care. Amida Care thanks City Council for supporting our efforts to bring people living with HIV into care through our Member engagement teams, and for your continued support with launching our Peer Workforce pilot.

Amida Care is a citywide not-for-profit health plan that specializes in providing comprehensive health coverage and coordinated care to New Yorkers with chronic conditions, including HIV and behavioral health disorders. We are the largest Medicaid special needs health plan (SNP) in New York. Established in 2003 by several non-profit community-based health organizations in New York City, Amida Care developed a highly effective, specialized model of care to provide individualized attention and support to people with HIV/AIDS and other complex health issues. We serve the five boroughs of New York City. With our understanding of the range of issues that affect New Yorkers, we are able to deliver expert care to New York populations with the greatest need.

Amida Care fully supports passage of Int. 1225 and its intent to create a culturally competent mental health plan for addressing the mental health needs of LGBT people. The bill lays the foundation for a coordinated roadmap that could produce a comprehensive plan from all stakeholders. The inclusion of non-profit organizations with expertise working to address the mental health needs of LGBT people in the creation of the plan would be critical for the creation of a culturally sensitive plan. We also appreciate that bill provides clear direction for planning that considers often underserved populations including LGBT youth and the homeless. Further, we support the call for mental health planning that facilitates HIV prevention and supportive communities through peer networks.

Amida Care would welcome the opportunity to work with the Department of Health to create a health care strategy that encompasses the needs of New Yorkers living with HIV.

We also support Resolutions 0130 and 0613. These resolutions are important because they promote measures that would prevent the damaging and unethical practice of mental health professionals engaging in efforts to change sexual orientation. These resolutions support actions

that will prevent potential trauma and guilt resulting from attempts to change an intrinsic aspect of identity. According to the American Academy of Child and Adolescent Psychiatry there is no evidence that sexual orientation can be altered through therapy. There is also no medically valid basis for attempting to prevent homosexuality and the effects carry the risk of significant harm.

Thank you for the opportunity to express our support for these important actions that would address the mental health needs and wellbeing of lesbian, gay, bisexual, transgender an questioning people.

NEW YORK COUNTY PSYCHIATRIC SOCIETY
A District Branch of the American Psychiatric Association
1001 AVENUE OF THE AMERICAS, 11TH FLOOR
NEW YORK, NEW YORK 10018
TEL. (212) 685-9633 ◆ FAX (212) 685-9179

FOR THE RECORD

January 10, 2017

RE: Resolution Number 613

Dear Chairman Cohen and Members of the Committee on Mental Health, Developmental Disability, Alcoholism, Substance Abuse and Disability Services,

On behalf of the New York County Psychiatric Society ("NYCPS"), we thank you for the opportunity to address Resolution Number 613 "calling on the American Psychological and American Psychiatric Associations to immediately pass resolutions declaring the practice of "curative therapy," also known as "reparative" or "conversion" therapy, or any attempt to change, alter, or "correct" a person's sexual orientation, to be unethical." NYCPS is very pleased that the Committee has come together today to hold a hearing on such an important mental health issue.

NYCPS is a non-profit membership association of psychiatrists in Manhattan and Staten Island founded in 1955. For more than fifty years, NYCPS has been dedicated to improving the field of psychiatry and the psychiatric treatment and care of people with mental illness and with over 1,800 members, is the largest district branch of the American Psychiatric Association. As such, we would like to submit to you the official position statements of the APA regarding "reparative" or conversion therapy.

The American Psychiatric Association put out its first position statement regarding reparative therapy in 1998 stating that it "opposes any psychiatric treatment, such as reparative or conversion therapy which is based upon the assumption that homosexuality per se is a mental disorder or based upon the a priori assumption that the patient should change his/her sexual homosexual orientation." APA augmented their position with another statement in 2000. After noting the lack of "scientifically rigorous" studies on the efficacy or harm of reparative therapy, APA recommended that "ethical practitioners refrain from attempts to change individuals' sexual orientation, keeping in mind the medical dictum to First, do no harm." In the most recent position statement from 2013, APA states it "does not believe that same-sex orientation should or needs to be changed, and efforts to do so represent a significant risk of harm by subjecting individuals to forms of treatment which have not been scientifically validated and by undermining self-esteem when sexual orientation fails to change." We have attached all three position statement for your reference.

Once again, NYCPS is encouraged by the City Council's attention to this issue. We stand ready to be a resource to the Council wherever we are needed.

Respectfully submitted on behalf of the New York County Psychiatric Society,

Daniel Safin, M.D.
NYCPS President

Kenneth Ashley, M.D.
Chair of the NYCPS Committee on LGBT Issues

Position Statement on Issues Related to Homosexuality

Approved by the Board of Trustees, December 2013
Approved by the Assembly, November 2013

"Policy documents are approved by the APA Assembly and Board of Trustees...These are...position statements that define APA official policy on specific subjects..." – *APA Operations Manual.*

While recognizing that the scientific understanding is incomplete and often distorted because of societal stigma, the American Psychiatric Association holds the following positions regarding same-sex attraction and associated issues. It is the American Psychiatric Association's position that same-sex attraction, whether expressed in action, fantasy, or identity, implies no impairment per se in judgment, stability, reliability, or general social or vocational capabilities. The American Psychiatric Association believes that the causes of sexual orientation (whether homosexual or heterosexual) are not known at this time and likely are multifactorial including biological and behavioral roots which may vary between different individuals and may even vary over time. The American Psychiatric Association does not believe that same-sex orientation should or needs to be changed, and efforts to do so represent a significant risk of harm by subjecting individuals to forms of treatment which have not been scientifically validated and by undermining self-esteem when sexual orientation fails to change. No credible evidence exists that any mental health intervention can reliably and safely change sexual orientation; nor, from a mental health perspective does sexual orientation need to be changed.

The American Psychiatric Association opposes discrimination against individuals with same-sex attraction whether it be in education, employment, military service, immigration and naturalization status, housing, income, government services, retirement benefits, ability to inherit property, rights of survivorship, spousal rights, family status, and access to health services. The American Psychiatric Association recognizes that such discriminations, as well as societal, religious, and family stigma, may adversely affect the mental health of individuals with same-sex attraction necessitating intervention by mental health professionals, for which, the American Psychiatric Association supports the provision of adequate mental health resources to provide that intervention. The American Psychiatric Association supports same-sex marriage as being advantageous to the mental health of same-sex couples and supports legal recognition of the right for same-sex couples to marry, adopt and co-parent.

Authors:
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NOTE: This statement combines into one document APA policies previously expressed in twelve separate position statements adopted between 1973 and 2011.

APA Document Reference No. 200001

Therapies Focused on Attempts to Change Sexual Orientation (Reparative or Conversion Therapies)
COPP POSITION STATEMENT

Approved by the Board of Trustees, March 2000
Approved by the Assembly, May 2000

"Policy documents are approved by the APA Assembly and Board of Trustees...These are ... position statements that define APA official policy on specific subjects..." -- *APA Operations Manual.*

Preamble

In December of 1998, the Board of Trustees issued a position statement that the American Psychiatric Association opposes any psychiatric treatment, such as "reparative" or conversion therapy, which is based upon the assumption that homosexuality per se is a mental disorder or based upon the a priori assumption that a patient should change his/her sexual homosexual orientation (Appendix 1). In doing so, the APA joined many other professional organizations that either oppose or are critical of "reparative" therapies, including the American Academy of Pediatrics, the American Medical Association, the American Psychological Association, The American Counseling Association, and the National Association of Social Workers (1).

The following Position Statement expands and elaborates upon the statement issued by the Board of Trustees in order to further address public and professional concerns about therapies designed to change a patient's sexual orientation or sexual identity. It augments rather than replaces the 1998 statement.

Position Statement

In the past, defining homosexuality as an illness buttressed society's moral opprobrium of same-sex relationships (2). In the current social climate, claiming homosexuality is a mental disorder stems from efforts to discredit the growing social acceptance of homosexuality as a normal variant of human sexuality. Consequently, the issue of changing sexual orientation has become highly politicized. The integration of gays and lesbians into the mainstream of American society is opposed by those who fear that such an integration is morally wrong and harmful to the social fabric. The political and moral debates surrounding this issue have obscured the scientific data by calling into question the motives and even the character of individuals on both sides of the issue. This document attempts to shed some light on this heated issue.

The validity, efficacy and ethics of clinical attempts to change an individual's sexual orientation have been challenged (3,4,5,6). To date, there are no scientifically rigorous outcome studies to determine either the actual efficacy or harm of "reparative" treatments. There is sparse scientific data about selection criteria, risks versus benefits of the treatment, and long-term outcomes of "reparative" therapies. The literature consists of anecdotal reports of individuals who have claimed to change, people who claim that attempts to change were harmful to them, and others who claimed to have changed and then later recanted those claims (7,8,9).

Even though there are little data about patients, it is still possible to evaluate the theories which rationalize the conduct of "reparative" and conversion therapies. Firstly, they are at odds with the scientific position of the American Psychiatric Association which has maintained, since 1973, that homosexuality per se, is not a mental disorder. The theories of "reparative" therapists define homosexuality as either a developmental arrest, a severe

The American Psychiatric Association is a national medical specialty society, founded in 1844, whose 40,000 physician members specialize in the diagnosis and treatment of mental and emotional illnesses and substance use disorders.

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form of psychopathology, or some combination of both (10-15). In recent years, noted practitioners of "reparative" therapy have openly integrated older psychoanalytic theories that pathologize homosexuality with traditional religious beliefs condemning homosexuality (16,17,18).

The earliest scientific criticisms of the early theories and religious beliefs informing "reparative" or conversion therapies came primarily from sexology researchers (19-27). Later, criticisms emerged from psychoanalytic sources as well (28-39). There has also been an increasing body of religious thought arguing against traditional, biblical interpretations that condemn homosexuality and which underlie religious types of "reparative" therapy (40-46).

Recommendations:

1. APA affirms its 1973 position that homosexuality per se is not a diagnosable mental disorder. Recent publicized efforts to repathologize homosexuality by claiming that it can be cured are often guided not by rigorous scientific or psychiatric research, but sometimes by religious and political forces opposed to full civil rights for gay men and lesbians. APA recommends that the APA respond quickly and appropriately as a scientific organization when claims that homosexuality is a curable illness are made by political or religious groups.

2. As a general principle, a therapist should not determine the goal of treatment either coercively or through subtle influence. Psychotherapeutic modalities to convert or "repair" homosexuality are based on developmental theories whose scientific validity is questionable. Furthermore, anecdotal reports of "cures" are counterbalanced by anecdotal claims of psychological harm. In the last four decades, "reparative" therapists have not produced any rigorous scientific research to substantiate their claims of cure. Until there is such research available, APA recommends that ethical practitioners refrain from attempts to change individuals' sexual orientation, keeping in mind the medical dictum to First, do no harm.

3. The "reparative" therapy literature uses theories that make it difficult to formulate scientific selection criteria for their treatment modality. This literature not only ignores the impact of social stigma in motivating efforts to cure homosexuality, it is a literature that actively stigmatizes homosexuality as well. "Reparative" therapy literature also tends to overstate the treatment's accomplishments while neglecting any potential risks to patients. APA encourages and supports research in the NIMH and the academic research community to further determine "reparative" therapy's risks versus its benefits.

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Appendix 1

APA Position Statement on Psychiatric Treatment and Sexual Orientation
December 11, 1998

The Board of Trustees of the American Psychiatric Association removed homosexuality from the DSM in 1973 after reviewing the evidence that it was not a mental disorder. In 1987, ego-dystonic homosexuality was not included in the DSM-III-R after a similar review.

The American Psychiatric Association does not currently have a formal position statement on treatments that attempt to change a persons sexual orientation, also known as reparative or conversion therapy. There is an APA 1997 Fact Sheet on Homosexual and Bisexual Issues which states that there is no published scientific evidence supporting the efficacy of reparative therapy as a treatment to change ones sexual orientation.

The potential risks of reparative therapy are great, including depression, anxiety and self-destructive behavior, since therapist alignment with societal prejudices against homosexuality may reinforce self-hatred already experienced by the patient. Many patients who have undergone reparative therapy relate that they were inaccurately told that homosexuals are lonely, unhappy individuals who never achieve acceptance or satisfaction. The possibility that the person might achieve happiness and satisfying interpersonal relationships as a gay man or lesbian is not presented, nor are alternative approaches to dealing the effects of societal stigmatization discussed. The APA recognizes that in the course of ongoing psychiatric treatment there may be appropriate clinical indications for attempting to change sexual behaviors.

Several major professional organizations including the American Psychological Association, the National Association of Social Workers and the American Academy of Pediatrics have all made statements against reparative therapy because of concerns for the harm caused to patients. The American Psychiatric Association has already taken clear stands against discrimination, prejudice and unethical treatment on a variety of issues including discrimination on the basis of sexual orientation.

Therefore, the American Psychiatric Association opposes any psychiatric treatment, such as reparative or conversion therapy which is based upon the assumption that homosexuality per se is a mental disorder or based upon the a priori assumption that the patient should change his/her sexual homosexual orientation.

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NYASP
NY Association of School Psychologists

FOR THE RECORD

Testimony of Dr. Andrew Livanis

New York Association of School Psychologists

Good Afternoon Chairman Cohen and members of the New York City Council Committee on Mental Health, Developmental Disability, Alcoholism, Substance Abuse and Disability Services. My name is Dr. Andrew Livanis and I am the President of the New York Association of School Psychologists.

I am pleased to offer these brief remarks on behalf of the New York Association of School Psychologists, which supports the New York City Council's efforts to prohibit mental health professionals from engaging in sexual orientation change therapy with a patient under the age of eighteen years.

Sexual orientation change therapy with youth creates a perception that there is something wrong or "disordered" within the individual. Among numerous documents, the National Association of School Psychologists' *Safe Schools for Transgender and Gender Diverse Students* position statement acknowledges that neither having a transgender identity, nor being perceived as gender diverse is a disorder, and that efforts to change a person's gender identity are ineffective, harmful, and discriminatory. Indeed, not only are school psychologists banned from doing harm, they are obliged to advocate for the needs of LGBTQ youth.

Efforts to change sexual orientation have been shown to cause harm and do not adhere to NYASP or NASP policies regarding supporting youth in developing their identity. School psychologists agree with the Pan American Health Organization's statement which indicates that while every expression of homophobia is regrettable, harm caused by health professionals as a result of ignorance, prejudice, or intolerance are absolutely unacceptable and must be avoided by all means. Not only is it fundamentally important that every person who uses health services be treated with dignity and respect; it is also critical to prevent the application of theories and models that view homosexuality as a "deviation" or a choice that can be modified through "will power" or supposed "therapeutic support".

School psychologists are often the first mental health professional that youth encounter when faced with life challenges. LGBTQ or other gender diverse youth are often faced with additional difficulties beyond those of their heterosexual peers. School psychologists play a critical role in supporting all youth.

Therefore, the New York Association of School Psychologists would welcome further conversation with the New York City Council regarding non-discriminatory and effective therapeutic interventions for LGBTQ youth who may need support in coping with life challenges, as well as supporting the development of resiliency strategies. In addition to these comments, I have provided a support memo for New York State Bills S.4917B/A.6983B from the New York Association of School Psychologists and three resources on LGBTQ and Gender Diverse Youth from the National Association of School Psychologists.

Thank you.

NASP
NATIONAL ASSOCIATION OF School Psychologists

Position Statement

Safe Schools for Transgender and Gender Diverse Students

The National Association of School Psychologists (NASP) supports efforts to ensure that schools are safe and inclusive learning environments for all students, family members, and school staff, including those who are transgender or gender diverse. NASP respects a person's right to express gender identity, and the right to modify gender expression when necessary for individual well-being. In addition, NASP supports all students' right to explore and question their gender identity. NASP is committed to a policy of nondiscrimination and the promotion of equal opportunity, fairness, justice, and respect for all persons (NASP, 2012).

NASP acknowledges that neither having a transgender identity nor being perceived as gender diverse is a disorder, and that efforts to change a person's gender identity are ineffective, harmful, and discriminatory. NASP works to ensure that settings in which school psychologists work are safe and welcoming and provide equal opportunity to all persons regardless of actual or perceived characteristics, including gender, gender identity, gender expression, sexual orientation, and any other personal identity or distinguishing characteristics (NASP, 2010). A glossary of terms may be found at the end of the statement.

NEEDS OF TRANSGENDER STUDENTS

In many communities, it is dangerous to be gender nonconforming or to be known as transgender. Many children, youth, and adults blend with their chosen gender, and are safe to the extent that their transgender status is hidden. Data concerning school-age transgender youth are limited, but what data are available suggest that more action by school officials is needed to ensure schools are settings in which students can thrive.

Because transgender youth are so hidden, it would be easy to believe that these students are extremely rare. It is extremely difficult to estimate the prevalence of transgender students in school (Meier & Labuski, 2013). One of the few large districts to gather data is San Francisco. In 2011, 0.5% of San Francisco high school students self-identified as transgender on the annual Youth Risk Behavioral Survey (Timothy Kordic, personal communication, December 20, 2013). The prevalence of self-identified transgender adults has been estimated as 0.3% of the U.S. general population (Gates, 2011).

The experiences that transgender students have at school appear to have effects on their well-being as adults. Toomey, Ryan, Diaz, Card, and Russell (2010) showed that while gender nonconformity alone had no direct effect on these outcomes, the *victimization* experienced at school associated with gender nonconformity had a lasting impact and put these children at risk for negative mental health outcomes in adulthood. Harassment and assault lead to anxiety about school, leading to missing days of school. Nearly half (46%) of transgender students reported missing at least one school day in the previous month because they felt unsafe (Greytak, Kosciw, & Diaz, 2009).

Research suggests that gender diverse children are at higher risk of physical, emotional, and sexual abuse and are at higher risk of posttraumatic stress disorder (PTSD) in adulthood, with about a third of the higher risk of PTSD accounted for by being abused as a child (Roberts, Rosario, Corliss, Koenen, & Austin, 2012). Coming out to family members often results in physical assault and expulsion from the family home (Ray, 2006). In one study, more than half of transgender youth reported initial parental reaction to coming out as negative or very negative (Grossman, D'Augelli, & Frank, 2011). Young adults who experience low family acceptance of identity are more likely to be at risk for depressive symptoms, substance use, and suicidal ideation and attempts (Ryan, Russell, Huebner, Diaz, & Sanchez, 2010). In addition to longitudinal outcome risks, transgender youth face immediate challenges during their school-age years. Transgender youth are often desperate to transition. However, even if they have medical insurance, the healthcare procedures necessary to transition are explicitly excluded from most health insurance plans. Psychotherapy for gender dysphoria is often excluded. Transgender youth may take hormones obtained on the street or through the internet without medical supervision, and take excessive doses. They may seek silicone injections at "pumping parties," resulting in severe disfigurement or death.

Despite these challenges, many transgender youth are resilient, and there are a number of factors that may help them guard against the worst outcomes. Resilience in children and youth appears to depend on personal characteristics like being outgoing, resourceful, and having a positive self-concept. In addition, social relationships, such as having an emotional bond with at least one adult over a period of time, and having a supportive community are associated with resilience (Werner, 1995). Specifically for transgender and gender diverse children, attention has been focused on *family acceptance* and *school acceptance.* LGBT youth from families rated high in acceptance (e.g., they discuss their child's gender identity or sexual orientation openly, integrate their child's LGBT friends into family activities, express appreciation for their child's clothing choices even if the clothing was gender nonconforming) reported better self-esteem, better health, lower levels of depression, lower rates of substance abuse, lower rates of suicide attempts, and lower rates of risky sexual behavior (Ryan, Russell, Huebner, Diaz, & Sanchez, 2010). These findings suggest that similar acceptance in school environments is recommended.

CONSIDERATIONS FOR PARENTS, PHYSICIANS, AND SCHOOLS

To adequately support their child's growth, parents must allow their child's personality to unfold while simultaneously protecting them from harm (Ehrensaft, 2011). Families go through a developmental process in accepting a transgender or gender diverse child. Much depends on a parent's beliefs and understanding of child development and of gender. Some children have unexpected gender behavior at an early age, which persists in spite of parent attempts to divert the child to gender conforming behavior. Parents may be embarrassed or ashamed of their child's behavior, depending on conformity pressures coming from extended family members, neighbors, clergy, daycare providers, and others. Parents may fear the future for their child, as well as their own future as they are judged by other adults. The parent who is the same sex as the child may question his or her own effectiveness as a role model. Children and youth are more likely to have successful outcomes if parents work to create safe and supportive spaces for their child within the home, require others to respect their child, and express love for their child (Brill & Pepper, 2008).

The World Professional Association for Transgender Health (WPATH) *Standards of Care* for the psychiatric, psychological, medical, and surgical management of gender transition note that "Treatment aimed at trying to change a person's gender identity and expression to become more congruent with sex

assigned at birth has been attempted in the past without success. Such treatment is no longer considered ethical" (Coleman, et al., 2011, p. 175).

Some students arrive at kindergarten already living in their asserted gender, while others express a desire to make a gender transition later in elementary or in secondary school. The majority of gender diverse children under age 9 who assert that they are a different gender than assigned at birth do not persist in asserting that gender in adolescence and early adulthood. By comparison, the majority of youth age 11 and older asserting a gender different than assigned at birth persist in that identity throughout adolescence and adulthood (Steensma, Biemond, de Boer, & Cohen-Kettenis, 2011). For children under age 9, only reversible social transitions are recommended (e.g., clothing, hair styles, activity preferences). For children age 11 or older, other treatments may be appropriate. A reversible medical treatment involving the administration of a gonadotropin-releasing hormone agonist (GnRH) in early puberty can put puberty on hold for several years, allowing the child time to mature and be ready for permanent changes. After puberty, youth can make more informed decisions regarding long-term treatment (Delemarre-van de Waal & Cohen-Kettenis, 2006; Spack et al., 2012).

Educational persistence of transgender and gender diverse students may depend on their sense of safety and belonging in the school environment. Title IX of the Education Amendment Act of 1972 prohibits harassment of students on the basis of gender expression. Schools have a duty to ensure that gender diverse and transgender students are included in all school infrastructure. For example, providing gender-neutral bathroom options and avoiding the use of gender segregation in practices such as school uniforms, school dances, and extracurricular activities are structural ways to provide safer school environments (Toomey et al., 2010). The presence of a Gay–Straight Alliance (GSA) in school can lead to greater feelings of safety and of belonging, better attendance, and lower rates of harassment. (Toomey, Ryan, Diaz, & Russell, 2011).

Comprehensive antiharassment policies that include protections for transgender and gender diverse students are helpful for all students. Adult intervention is helpful when homophobic or transphobic statements are heard (Case & Meier, 2014). Written policies and procedures addressing the needs of transgender and gender diverse students are helpful for staff and administrators and all students and families (e.g., Gay, Lesbian, and Straight Education Network/National Center for Transgender Equality, 2011; Massachusetts DOESE, 2012).

ROLE OF THE SCHOOL PSYCHOLOGIST

The school psychologist should be in tune with the needs of students and staff, and can provide evidence-based information about transgender issues. The school psychologist should be welcoming and supportive of transgender and gender diverse staff and parents, and he or she should be able to foster a climate of acceptance and security for all (Case & Meier, 2014). A student's transgender status or history must be kept confidential and within the student's control. In all cases school psychologists must be sensitive to the needs and welfare of all individuals at their school sites, including transgender and gender diverse students and staff. School psychologists must advocate for the civil rights of all students, including those who are transgender or gender diverse. This can be accomplished by:

- Advocating for gender neutral spaces and helping establish safe zones for transgender students
- Seeking additional training or supervision as needed regarding issues affecting transgender and gender diverse people

- Modeling acceptance and respect
- Providing staff training to increase awareness regarding transgender issues in the schools
- Responding to bullying, intimidation, and other harassment, whether perpetrated by students or staff
- Minimizing bias by using phrasing and pronouns that are not gender specific and by avoiding gender stereotypes
- Providing counseling and attending to the social–emotional needs of transgender and gender diverse students in school
- Acquiring and providing information on community agencies that provide services and supports to the transgender community
- Supporting or contributing to research regarding best practices for integrating transgender and gender diverse students in school

Gender diverse and transgender students might be referred to a school psychologist due to school victimization or bullying, suicidal ideation or attempts, nonsuicidal self-injury, sexual orientation instead of gender issues, social anxiety, and/or autism spectrum symptoms. School psychologists should be aware of resources for these children and their families. Transgender and gender diverse students may benefit from learning healthy coping skills and building resilience, but interventions for associated social–emotional problems should not attempt to enforce gender stereotypical behavior.

NASP's *Principles for Professional Ethics* (NASP, 2010) include provisions that pertain to gender diverse and transgender individuals, including the following:

- *Standard I.2.6:* School psychologists respect the right of privacy of students, parents, and colleagues with regard to sexual orientation, gender identity, or transgender status. They do not share information about the sexual orientation, gender identity, or transgender status of a student (including minors), parent, or school employee with anyone without that individual's permission.
- *Standard II.1.2:* Practitioners are obligated to pursue knowledge and understanding of the diverse cultural, linguistic, and experiential backgrounds of students, families, and other clients. When knowledge and understanding of diversity characteristics are essential to ensure competent assessment, intervention, or consultation, school psychologists have or obtain the training or supervision necessary to provide effective services, or they make appropriate referrals.
- *Principle I.3:* In their words and actions, school psychologists promote fairness and justice. They use their expertise to cultivate school climates that are safe and welcoming to all persons regardless of actual or perceived characteristics, including race, ethnicity, color, religion, ancestry, national origin, immigration status, socioeconomic status, primary language, gender, sexual orientation, gender identity, gender expression, disability, or any other distinguishing characteristic.

School psychologists should encourage schools to develop and implement policies and procedures to prevent harassment of gender diverse and transgender students in order to promote safe schools for all students. School psychologists can provide education about gender expression and LGBT issues to teachers, administrators, students, and staff (Toomey et al., 2010). School psychologists should encourage the formation of support or social groups for gender diverse and transgender students (Goodenow, Szalacha, & Westheimer, 2006; Toomey et al., 2010). School psychologists can work with teachers and administrators to serve as mentors for these students. Being accepted by even just one coach, teacher, or administrator can serve as a protective factor against negative psychosocial outcomes for these youth.

GLOSSARY

Language is evolving rapidly. Some terms that were considered acceptable in the past may be offensive in the present. Some previously offensive terms have been reclaimed by newer generations. We have attempted to use currently acceptable terms in this glossary. A glossary that is frequently updated is the *Media Reference Guide* available online from the Gay and Lesbian Alliance Against Defamation (GLAAD, 2010).

- **Asserted Gender.** The gender a person declares to be, verbally, nonverbally, covertly, or overtly. A transgender person's gender is usually affirmed insistently, consistently, and persistently over years. In transgender people, there is a difference between birth-assigned gender and affirmed gender. In *cisgender* people, affirmed gender aligns with birth-assigned gender. Depending on ecological safety, gender affirmation may be nonverbal and covert, or it may be a verbal declaration ("coming out") in a safe place.
- **Cisgender.** A person whose sex assigned at birth matches current gender identity. The opposite of *transgender.* "Nontransgender" is sometimes used, but implies that being transgender is not a normal variant of human difference.
- **Gender.** *Gender* implies the psychological, behavioral, social, and cultural aspects of being male or female (VandenBos, 2007). Gender refers to the socially constructed roles, behaviors, activities, and attributes that a given society considers appropriate for boys and men or for girls and women (APA, 2011). While sex is a biological construct, gender is a social construct. As most people's sex and gender align, the two terms are sometimes used interchangeably.
- **Gender Assignment.** *Gender assignment* is the classification of an infant at birth as either male or female (VandenBos, 2007); this assignment of a legal gender (sex) to a child triggers a variety of social events and developmental tasks related to gender role.
- **Gender Constancy.** *Gender constancy* is a child's emerging sense of the permanence of being a boy or a girl (VandenBos, 2007), an understanding that occurs in stages but is mostly complete by age 7. School entry presents greater pressure to conform to gender expectations. At this age, some children with a gender identity incongruent with their birth-assigned sex may experience distress if they are not permitted to express and be witnessed as their gender. At clinically significant levels, this is called *gender dysphoria* (VandenBos, 2007).
- **Gender Dysphoria.** Discontent with the physical or social aspects of one's own sex (VandenBos, 2007). The degree of distress can vary from mild to severe, and can be life long, although not all transgender people experience gender dysphoria. The child with gender dysphoria may demonstrate symptoms of depression, anxiety, self-harm, or oppositionality (APA, 2013).
- **Gender Diverse.** Someone is *gender diverse* if his or her *gender expression* does not match what is culturally expected for the sex assigned at birth (Gender Equity Resource Center, n.d.). Individuals may dress or act in ways that others believe are not feminine enough or not masculine enough. Gender expression has become one aspect of diversity in human resource practice and in civil rights law, including nondiscrimination laws. Gender diverse implies that all humans express gender, and that no gender expression is inherently better than another. Gender diverse is an alternative term for *gender nonconformity,* which implies that gender diverse people are violating rules for gender expression; it is also an alternative for *gender variant,* which implies difference from a norm. Other respectful terms for gender diversity include *gender creative* and *gender expansive.*
- **Gender Expression.** *Gender expression* refers to how a person represents or expresses gender identity to others, often through behavior, clothing, hairstyles, voice, or body characteristics

(NCTE, May 2009). Gender expression is visible, while gender identity is not. Being gender diverse means having an unexpected gender expression; being transgender means having an unexpected gender identity. Some transgender people do not appear gender diverse. Some people with diverse gender expression are happy with their sex assigned at birth and have no desire or intention to transition genders.

- **Gender Identity.** *Gender identity* is a person's internal sense of being male, female, both, or neither (APA 2011). This sense of maleness or femaleness typically develops from a combination of biological and psychic influences (VandenBos, 2007). Shortly after children begin to speak, most are able to state whether they are a boy or a girl, and this identity is stable and resistant to change. Gender identity typically forms between 2 and 5 years of age. For most people, gender identity is consistent with sex assigned at birth.
- **Genderqueer.** A person who defies or does not accept stereotypical gender roles and may choose to live outside expected gender norms may self-identify as *genderqueer.* (Center for Excellence in Transgender Health, April, 2011). Genderqueer people may or may not avail themselves of hormonal or surgical treatments.
- **Sex.** The term sex refers to a person's biological characteristics, including chromosomes, hormones, and anatomy (VandenBos, 2007).
- **Sexual Orientation.** A person's gender identity is distinct from sexual orientation. *Sexual orientation* refers to an enduring pattern of emotional, romantic, and/or sexual attractions to men, women, both sexes, transgender people, no one, or all genders (APA, 2008; VandenBos, 2007). A transgender adult may be attracted to women, to men, to both women and men (bisexual), to no one (asexual), and/or to other transgender people. One's sexual orientation identity label is typically derived from gender identity, and not birth assigned sex. For example, a female-to-male transgender man who is primarily attracted to other men is likely to self-identify as gay. A male-to-female transgender woman who is primarily attracted to men is likely to identify as straight. Transgender people are more likely to also identify as LGBQ than cisgender people.
- **Trans.** shorthand term for a variety of transgender identities. Also, trans people or transpeople (Center for Excellence in Transgender Health, April 2011). Because there are a variety of disputes about the terms *transgender* and *transsexual, trans* is seen as a more widely accepted and respectful term than transgender. There are other terms which are more universally perceived as offensive, such as "tranny." See the GLAAD *Media Reference Guide* (2010) for terms that are universally offensive.
- **Transgender.** *Transgender* refers to having a gender identity that differs from culturally determined gender roles and biological sex (VandenBos, 2007). It is an umbrella term which includes diverse identities and includes persons identifying as female-to-male, male-to-female, two-spirit, genderqueer, and other terms (APA, 2011). The transgender umbrella includes those assigned female at birth who are or who wish to be living as men (*transgender men*), and those assigned male at birth who are or who wish to be living as women (*transgender women*). Many transgender people appear indistinguishable from *cisgender* people. They may or may not desire body modifications to express their asserted gender. Body modifications may be temporary (e.g., shaving, changing hair style, binding, using hormone blockers) or permanent (e.g., hormones, electrolysis, surgeries; APA, 2011). Medical assistance can help transgender people live more comfortable lives as they may be better able to blend in as their affirmed gender. Transgender women typically identify as *women,* and transgender men typically identify as *men.*
- **Transition.** The process of changing gender expression from that of one gender to another is called *transition* (APA, 2011). *Social transition* may include changes in clothing, grooming, pronouns, names, and identity documents. Children, adolescents, and adults may undergo social transition at

any time. *Medical transition* may include hormones and surgeries. Surgeries are only available after age 18, after at least one year of living persistently and consistently as the desired gender. Youth who have lived persistently in their preferred gender and who have reached Tanner Stage 2 for their birth sex (around age 12 for female-born youth and about 14 for male-born youth) may be eligible for medication that can suppress puberty until they reach age 16 or older when they may be eligible to be treated with hormones appropriate to their desired gender, saving much of the expense, pain, and cost of medical transition for adults.

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Potential Follow-up questions

1. What are some different ways that school psychologist work with LGBTQ youth?

Just as with any young person who is struggling with life issues, school psychologists work with LGBTQ youth who are experiencing difficulties by addressing their social and emotional needs. At times, individual therapeutic interventions are provided to address issues related to anxiety, depression, trauma, and other mental health problems. Other times, school psychologists may run group counseling sessions around specific issues or to build skills. In addition, school psychologists consult with school staff and families on ways to support LGBTQ youth.

However, school psychologists also work with LGBTQ youth to help them build resiliency skills to face life's challenges. These resiliency skills include managing emotions, taking care of self both physically and emotionally, and connecting with support systems.

2. School psychologists don't provide therapy to students so how would this legislation apply?

As I mentioned in my testimony, school psychologists are often the first and sometimes the only mental health professional that youth encounter. School psychologists engage in therapeutic interventions with many young people, including LGBTQ youth and their families. We believe that school psychologists have an ethical duty to provide non-discriminatory therapeutic procedures.

3. What recommendations would you have regarding this legislation?

As stated in my testimony, because school psychologists have an ethical duty to engage in non-discriminatory practices, we believe that this legislation should apply to all mental health professionals, including school psychologists.

4. Are you aware of any school psychologists who engage in sexual orientation change therapy or similar procedures?

NYASP is unaware of any school psychologists who engage in this practice. However, we would be concerned about any school psychologist who may work in a setting that views homosexuality as something that can or should be changed.

NYASP
NY Association of School Psychologists

Memo in Support of S.4917B/A.6983B

The New York Association of School Psychologists (NYASP), which represents the profession of school psychology and the thousands of school psychologists who work with children and youth in New York, supports the New York State Legislatures' efforts to prohibit mental health professionals from engaging in sexual orientation change efforts with a patient under the age of eighteen years.

Sexual orientation change efforts with youth create a perception that there is something wrong or "disordered" within the individual. Among numerous documents, the National Association of School Psychologists' (NASP) *Safe Schools for Transgender and Gender Diverse Students* position statement acknowledges that neither having a transgender identity, nor being perceived as gender diverse is a disorder, and that efforts to change a person's gender identity are ineffective, harmful, and discriminatory (NASP, 2014). Indeed, not only are school psychologists banned from doing harm, they are obliged to advocate for the needs of LGBTQ youth. The *NASP Standards for Graduate Preparation of School Psychologists* (2010) describes critical experiences and competencies needed by school psychology degree candidates in order to be prepared for a career in school psychology. These standards state:

> School psychologists ensure that their knowledge, skills, and professional practices reflect understanding and respect for human diversity and promote effective services, advocacy, and social justice for all children, families, and schools.

NYASP supports the recommendations of NASP. According to NASP's 2011 position statement on *Lesbian, Gay, Bisexual, Transgender, and Questioning Youth*, "school psychologists are ethically obligated to ensure that all students have an equal opportunity for the development and expression of their personal identity in a school climate that is safe, accepting, and respectful of all persons and free from discrimination, harassment, violence, and abuse." Efforts to change sexual orientation have been shown to cause harm and do not adhere to NASP policies regarding supporting youth in developing their identity (NASP, 2011, 2014). Additionally, the American Psychological Association (APA) and NASP's 1993 joint resolution on lesbian, gay and bisexual youths in schools specifically states the practice of psychology "promotes the individual's development of personal identity including the sexual orientation of all individuals."

APA and NASP resolved that best psychological practices promote "an understanding and acceptance of self." Therefore, school psychologists have the obligation to develop and evaluate interventions that foster nondiscriminatory environments, lower risk for HIV infection, and decrease self-injurious behaviors in lesbian, gay, and bisexual youth. Research upon the effects

of "reparative therapy" on youth indicate that at best, such therapies are ineffective and at worst, such therapies may and do result in increased suicide rates, depression, and anxiety for LGBTQ youth (APA, 2009). According to the Pan American Health Organization position statement on "conversion therapies," while every expression of homophobia is regrettable, harms caused by health professionals as a result of ignorance, prejudice, or intolerance are absolutely unacceptable and must be avoided by all means. Not only is it fundamentally important that every person who uses health services be treated with dignity and respect; it is also critical to prevent the application of theories and models that view homosexuality as a "deviation" or a choice that can be modified through "will power" or supposed "therapeutic support".

School psychologists are often the first mental health professional that youth encounter when faced with life challenges. Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) or other gender diverse youth are often faced with additional difficulties beyond those of their heterosexual peers. School psychologists play a critical role in supporting all youth.

Therefore, the New York Association of School Psychologists would welcome further conversation with legislators regarding non-discriminatory and effective therapeutic interventions for LGBTQ youth who may need support in coping with life challenges, as well as supporting the development of resiliency strategies.

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NASP
NATIONAL ASSOCIATION OF School Psychologists

Position Statement

Lesbian, Gay, Bisexual, Transgender, and Questioning Youth

The National Association of School Psychologists (NASP) supports that all youth have equal opportunities to participate in and benefit from educational and mental health services within schools regardless of sexual orientation, gender identity, or gender expression. Harassment, lack of equal support, and other discriminatory practices toward lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth violate their rights to receive equal educational opportunities, regardless of whether the discrimination takes the form of direct harassment of individuals or is directed at the entire group through hostile statements or biases. Failure to address discriminatory actions in the school setting compromises student development and achievement. NASP believes that school psychologists are ethically obligated to ensure that all students have an equal opportunity for the development and expression of their personal identity in a school climate that is safe, accepting, and respectful of all persons and free from discrimination, harassment, violence, and abuse. To achieve this goal, education and advocacy must be used to reduce discrimination and harassment against LGBTQ youth by students and staff and promote positive social–emotional and educational development.

When compared to youth who are heterosexual, youth who identify as LGBTQ or those who are gender nonconforming are more likely targeted for harassment and discrimination. For example, when over 7,000 LGBTQ students nationwide were surveyed regarding their school experiences, 84% reported being verbally harassed, 40% reported being physically harassed, and 18% reported being physically assaulted at school within the past year based on actual or perceived sexual orientation (Kosciw, Greytak, Diaz, & Bartkiewicz, 2010). Of the students who reported harassment experiences to school staff, one third said no subsequent school action was taken. Additionally, LGBTQ students were four times more likely than heterosexual students to report skipping at least one day of school in the previous month because they felt unsafe or uncomfortable. While LGBTQ youth appear to experience higher levels of mental health and academic difficulties, school-based social situations like victimization and lack of support are frequently related to these heightened risk levels (Bontempo & D'Augelli., 2002; Goodenow, Szalacha, & Westheimer, 2006).

Whereas members of other minority groups likely share their unique identity with family members and a visible community, LGBTQ youth may have few to no opportunities to learn coping strategies related to dealing with anti-LGBTQ sentiments and behaviors from a family support network (Ryan & Futterman, 1998). Additionally, LGBTQ youth are at an increased risk for emotional and physical rejection by their families and may become homeless as a result of disclosing their sexual orientation or gender identity (Rivers & D'Augelli, 2001). Concealing one's LGBTQ identity may increase a youth's risk for anxiety, depression, hostility, demoralization, guilt, shame, social avoidance, isolation, and impaired relationships (Pachankis, 2007).

CREATING SAFE SCHOOLS FOR LGBTQ YOUTH

Individual and systems-level advocacy, education, and specific intervention efforts are needed to create safe and supportive schools for LGBTQ youth. These should include, but not be limited to, the following strategies.

Establish and enforce comprehensive nondiscrimination and antibullying policies that include LGBTQ issues. Many schools already have nondiscrimination policies, but these may not include reference to sexual orientation, gender identity, or gender expression. Explicitly including these characteristics in policy statements gives legitimacy to LGBTQ concerns and keeps schools accountable for enforcing nondiscrimination and antibullying standards. Explicit policies also support staff who may fear repercussions for openly intervening and advocating for LGBTQ youth.

Educate students and staff. NASP supports educating students and staff about LGBTQ youth and their needs through professional development about the range of normal human diversity that includes sexual orientation, gender identity, and gender expression. Professional development training can lead to immediate and maintained improvements in students' and educators' motivation to interrupt harassing remarks and increased awareness of LGBTQ issues and resources (Greytak & Kosciw, 2010). NASP also supports the provision of information and training about relevant research, the risks experienced by these youth, effective strategies for addressing harassment and discrimination directed toward any student, and improving the school climate (e.g., inservices, staff development, policy development, research briefs, and program implementation). In addition, creating an educational context that includes the broad array of human diversity can help demystify sexual orientation and gender identity, along with promoting a positive self-concept for LGBTQ youth. This can include infusing issues pertaining to sexual orientation and gender identity into the curriculum, which may decrease feelings of isolation and promote a more positive self-concept. Curricula may include presenting theories about the development of sexual orientation or gender identity in a science class; reading works of famous gay, lesbian, bisexual, or transgender authors in a literature class; discussing the LGBTQ rights movement in historical context with other civil rights movements in a social studies class; or including LGBTQ demographic statistics in math exercises. In addition, including LGBTQ issues in health education can increase decision-making skills for all youth, by preparing them to make positive choices and reducing unsafe behavior.

Intervene directly with perpetrators. As with any instance of school violence, harassment and discrimination against LGBTQ youth, or any gender nonconforming youth, should be addressed both through applying consequences and educating the perpetrator. Education should be provided to the perpetrator to help prevent future aggression. Interventions should emphasize that discrimination and harassment must be addressed regardless of the status of the perpetrator. Youth, teachers, support staff, and administrators must be educated to make policies effective.

Provide intervention and support for those students targeted for harassment and intimidation and those exploring their sexuality or gender identity. Up to one fourth of adolescents may question their sexual orientation or gender identity (Hollander, 2000). School personnel should make no assumptions about youth who may be questioning, but provide opportunities for students to develop healthy identities. In addition to sexual orientation, gender identity, and gender expression, other diversity characteristics (e.g., gender, ethnicity, socioeconomic status) may add additional challenges or serve as strengths toward positive mental health and academic development and should be considered.

Counseling and other supports should be made available for students who have been targets of harassment, for those who are questioning their sexual orientation or gender identity, for those who are perceived as LGBTQ by peers or others, and for those who may become targets of harassment in the future by disclosing their status as LGBTQ (e.g., Gay-Straight Alliance). Interventions should focus on strategies that allow students to experience safety and respect in the school environment, including empowerment of students to address harassment of students who are LBGTQ.

Promote societal and familial attitudes and behaviors that affirm the dignity and rights within educational environments of LGBTQ youth. Schools should promote awareness, acceptance, and accommodation of LGBTQ students and their needs in fair ways. Schools can promote attitudes that affirm the dignity and rights of LGBTQ youth by becoming aware of and eliminating biases from their own practice. They can model nondiscriminatory practice by providing services to all students regardless of sexual orientation, gender identity/expression, or other minority status. School psychologists can promote and model affirming attitudes, use language that is nondiscriminatory and inclusive, and educate students and staff. Moreover, schools can function as powerful agents of change when they actively address slurs and openly confront discrimination, and they can address the actions or statements of other school staff or administrators who neglect the needs of LGBTQ youth or who actively discriminate against them. School psychologists can provide information, expert opinions, and evidence-based strategies to ensure that effective policies and practices are adopted and enforced, increasing the acceptance and tolerance of differences in the school environment by supporting development of student groups that promote understanding and acceptance of human diversity. Gay-straight alliances (GSAs) have a positive impact on school climate (Kosciw, Diaz, Greytak, & Bartkiewicz, 2010) and should be supported by school psychologists. Students who reported having GSAs in their schools were less likely to feel unsafe, less likely to miss school, and were more likely to feel that they belonged at their school than students in school with no such clubs (Kosciw, et al.). Schools should also be informed about programs in the community that facilitate and support healthy development of LGBTQ youth and support their families, and be prepared to advise parents, school personnel, and youth about these resources.

Recognize strengths and resilience. While much of the research has focused on negative factors impacting the development of LGBTQ youth, there are strengths as well. Savin-Williams (2009) posits a developmental trajectory that can impact a student positively or negatively with regard to psychosocial and educational domains. Further review of the research indicates that LGBTQ youth are capable of developing methods to keep themselves safe and find support from their environment. School psychologists should work to identify and build strengths and resilience in LGBTQ youth.

ROLE OF THE SCHOOL PSYCHOLOGIST

School psychologists can function as role models of ethical practice and inform staff and students that they are available to all students regardless of sexual orientation or gender identity. School psychologists can address issues of sexual orientation and gender identity in inservice training with teachers and programming for parents, actively counter discriminatory practices, and utilize NASP and other resources to advocate for LGBTQ youth. On an individual level, in counseling sessions, school psychologists can be mindful that sexual orientation, gender identity, and gender expression encompass a broad spectrum, and that many students question their sexual orientation and gender identity or are gender nonconforming. School psychologists are also in a position to educate students about a number of issues related to high risk behaviors that are especially frequent among gay, lesbian, bisexual,

transgender, and questioning youth, creating a more inclusive and healthier environment for both the school population in general and LGBTQ youth in particular.

SUMMARY

NASP recognizes that students who identify as LGBTQ, or those who are gender nonconforming, may be at risk for experiencing harassment and discrimination, as well as risk factors for social, emotional, and academic problems related to psychosocial stressors (Bontempo & D'Augelli, 2002; D'Augelli, 2006; Ryan & Futterman 1998). A successful program to address these issues educates both those who discriminate and those who are discriminated against because of sexual orientation, gender identity, or gender nonconformity. School psychologists can participate in education and advocacy on a number of levels by promoting nondiscrimination policies; conducting school-wide inservice training; actively addressing discrimination and neglect of student needs; sharing information about human diversity and evidence-based practices to address student needs; and modeling ethical practice through accepting and affirming attitudes, language, and behaviors in daily interactions with all students and staff. In addition, school psychologists can provide intervention to individual students. Any program designed to address the needs of LGBTQ youth should also include efforts to educate and support parents and the community through collecting information about services and establishing involvement with other organizations committed to equal opportunity for education and mental health services for all youth. Schools can only be truly safe when every student, regardless of sexual orientation, gender identity, and gender expression is assured of access to an education without fear of harassment, discrimination, or violence.

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CONVERSION THERAPY IS DAMAGING AND DANGEROUS FOR YOUTH

WHAT IS CONVERSION THERAPY?

"Conversion therapy (CT) also called reparative therapy refers to efforts to change an individual's sexual orientation, gender identity, or gender expression" (SAMHSA, 2015 p.66).

"When I came out to my parents, they found me a conversion therapist who told me transgender people were sick and belonged in mental hospitals. He forced me to throw away all my girl's clothes as part of my treatment, but, having to dress as a male sent me into complete despair, hopelessness, and depression" (SAMHSA, 2015, p.44).

We must rely on retrospective studies to understand the dangers of CT because it is unethical for researchers and mental health professionals to provide a treatment that is known to be harmful. **CT has been shown to worsen internalized homophobia, interrupt healthy identity development, increase depression, anxiety, self-hatred, and self-destructive behaviors, and create mistrust of metal health professionals** (Halpert, 2000).

Empirical Retrospective Experience Tells Us:

- Individuals who claim tp change their orientation struggle with their homosexuality their whole life (Weis et al. 2010).
- During CT, Therapists mentioned that the LGBT idenity is bacd, sick or inferior and to increse spiritual and religioius proctice (Flentje et al. 2013).
- Clients of CT rated their experience as being very destructive and not beneficial (Jones, 2003).
- Minors undergoing CT reported higher sexual identity distress and lower self esteem (Dehlin, 2014).

"It is nearly impossible to describe walking into a therapist's office after surviving conversion therapy. The problem is that we need help from a system we have only known to hurt us. Hearing that I would be okay and that my new therapist could help me learn to cope with the pain of my conversion therapy experience was like getting a second chance at life" (SAMHSA, 2015, p.50).

Major health, mental health, and educational organizations recognize the dangers of CT and support its ban.

-American Academy of Pediatrics

-American Association of School Administrators

-American Counseling Association
-American Federation of Teachers

-American Psychological Association

-American School Health Association

-Interfaith Alliance Foundation
-National Association of School Psychologists

-National Association of Secondary School Principals

-National Association of Social Workers

-National Education Association
-School Social Work Association of America

"I'd be brainwashed day after day after day, with them telling me about what hell was like and how I was going to be there...and they began to 'heal' my relationship with my parents by trying to prove that my father was distant and my mother was overbearing. They were trying to show that I had this brokenness sexually and they were using my [drug] abuse against me" (Price, 2014).

NASP

NATIONAL ASSOCIATION OF School Psychologists

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January 10, 2017

New York City Council
250 Broadway
Committee Room, 14th Fl.
New York, NY 10007

**Committee on Mental Health, Developmental Disability,
Alcoholism, Substance Abuse and Disability Services
Int. No 1225, Res 130-A & 613A**

To Whom It May Concern:

As the founder of Aces NYC, the group for asexual and aromantic people in the greater New York City area, I implore the New York City Council to include explicitly asexual people when considering the LGBT community in Introduction No 1225, Resolution 130-A, & 613A, for the following two reasons:

First, asexuality is a separate and valid sexual orientation, that is not considered a disorder. The DSM V specifies in the diagnosis for FSIAD:

"**If a lifelong lack of sexual desire is better explained by one's self-identification as 'asexual,' then a diagnosis of female sexual interest/arousal disorder would not be made.**"

The current language specifying gay, lesbian, and bisexual in resolutions 130-A and 613-A and specifying gay, lesbian, bisexual, transgender and questioning in Introduction 1225 create a loophole where asexual people could be interpreted as not protected by these proposals.

Second, the LGBT community at large does not cover the needs of LGBT people who are additionally asexual. As the contact person for Aces NYC, an entirely volunteer organization, I have an increasing number of people reaching out to me for help with mental health services. The number of people reaching out to me to explore the intersection between gender identity, gender dysphoria, and asexuality continues to grow. This shows that there is a lack within current LGBT mental health options for people grappling with gender identity and dysphoria to discuss asexuality, and that

asexuality needs to be called out separately from gay, lesbian, bisexual, and transgender services.

Other resolutions from the New York City Council have included asexuality, such as Introductions 251-A, 551-A, 552-A and Resolution 472. Adding asexuality to Introduction No 1225, Resolution 130-A, & 613A, would keep policies consistent and inclusive.

Thank you for your consideration,

Caroline (Bauer) McClave

Founder
Aces NYC

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. 130-A, 613-A

☒ in favor ☐ in opposition

Date: 1/10/17

(PLEASE PRINT)

Name: Jared Odessky (State Sen. Hoylman)

Address: 322 8th Ave, Suite 1700, NY, NY

I represent: State Sen. Brad Hoylman

Address: 322 8th Ave, Suite 1700, NY, NY

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 1225-2016 Res. No. _____

☑ in favor ☐ in opposition

Date: JAN 10, 2017

(PLEASE PRINT)

Name: Steven Mendelsohn

Address: 100 Riverside Drive, 13E NYC 10024

I represent: The Trevor Project

Address: 575 8th Ave, 5th NYC 10018

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 225 Res. No. 130 & 613

☑ in favor ☑ in opposition

Date: _____

(PLEASE PRINT)

Name: ANTOINE CRAIGWELL

Address: P.O. Box 284 NY NY 10032

I represent: DBGM, Inc.

Address: same as above

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 1225 Res. No. _____

☑ in favor ☐ in opposition

Date: 1/10/17

(PLEASE PRINT)

Name: Diana Christian

Address: 160 Madison Ave, 5th Floor

I represent: Community Healthcare Network

Address: 160 Madison Ave, 5th Floor

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Appearance Card

I intend to appear and speak on Int. No. 1225 Res. No. _____

☒ in favor ☐ in opposition

Date: 1/10/2017

(PLEASE PRINT)

Name: LYNDEL URBANO

Address: 14 Penn Plaza

I represent: AMIDA CARE

Address: NY, NY

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THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 1225 Res. No. _____

☒ in favor ☐ in opposition

Date: 1-10-17

(PLEASE PRINT)

Name: Tom Weber

Address: ~~SA~~

I represent: SNGE

Address: _____

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THE CITY OF NEW YORK

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☒ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: EMILY CONTILLO

Address: _____

I represent: The Center

Address: 205 W 13th Street, NY

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THE CITY OF NEW YORK

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☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: DAVID BERMAN

Address: 123 WILLIAM ST

I represent: COALITION FOR BEHAVIORAL HEALTH

Address: _____

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THE CITY OF NEW YORK

Appearance Card

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☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Andrea Gentile

Address: 446 W 33rd St

I represent: GMHC

Address: 446 W 33rd St

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Date: _____

(PLEASE PRINT)

Name: LILLIAN RIVERA

Address: 2 ASTOR PLACE

I represent: HETRICK-MARTIN INSTITUTE

Address: 2 ASTOR PLACE

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THE CITY OF NEW YORK

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☑ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: David Guggcheim

Address: 350 West 19th

I represent: Callen-Lorde

Address: Same

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THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 1/10/17

(PLEASE PRINT)

Name: Gary Belkin

Address: [illegible]

I represent: _____

Address: _____

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THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 1225 Res. No. _____

☐ in favor ☐ in opposition

Date: 1/10/17

(PLEASE PRINT)

Name: Elana Redfield

Address: _____

I represent: Human Resources Administration

Address: 4 World Trade

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THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 1225 Res. No. _____

☒ in favor ☐ in opposition

Date: 1-10-2017

(PLEASE PRINT)

Name: Christian Huygen

Address: 3721 80th St. #1-C Jackson Hts NY 11372

I represent: Rainbow Heights Club

Address: 25 Flatbush Ave 3rd Fl. BKNY 11217

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