# Literature Review: An Overview of BIPOC LGBTQ+ Youth Mental Health

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## Abstract

Black, Indigenous, and Persons of Color (BIPOC) youth who identify as lesbian, gay, bisexual, transgender and/or queer (LGBTQ+) face many barriers in accessing mental health support. BIPOC LGBTQ+ youth are at a significantly greater risk for suicidality, depression, bullying, and victimization than heterosexual and cisgender peers. Minority stress theory and intersectionality are theoretical frameworks applied to understand the experience of sexual and gender minority youth. This literature review discusses the qualitative and quantitative research that identifies barriers faced by BIPOC LGBTQ+ youth in accessing school-based mental health services, including political and school climates, peer support, clinician impact, and family support. The key findings indicate the need for further research focused on the intersections of identity experienced by BIPOC LGBTQ+ youth, and how to address systemic change that creates inclusive school communities. The research also underscores the importance of family support in reducing the risk for suicidality.


*Keywords*: BIPOC, LGBTQ+, mental health, suicidality, school climate, political climate, peers, family

## Introduction and Problem Statement

In the United States, youth who identify as LGBTQ+ experience increased risk of mental health concerns compared to heterosexual or cisgender youth, which includes risks of suicide, depression and barriers to supportive services (Smith-Millman et al., 2019; Pham et al.,2019; Poquiz et al., 2021). According to the National Alliance on Mental Illness (n.d.), suicide is the second leading cause of death for youth ages 15-24 years old and the Trevor Project's 2022 National Survey on LGBTQ+ Youth Mental Health (n.d.) identifies that LGBTQ+ youth of color have attempted suicide at increased rates compared to white LGBTQ+ youth. It is imperative to understand the current state of youth mental health as it pertains to BIPOC LGBTQ+ youth. This author has identified the need to understand how BIPOC students utilize wellness services within the Roseville Joint Union High School District (RJUHSD) to access LGBTQ+ support.

For purposes of this literature review, the term LGBTQ+ is referenced as an umbrella term for those who identify as lesbian, gay, bisexual, transgender and queer/questioning, however this author acknowledges that the term does not fully articulate the differing identities present in the LGBTQ+ community. Additionally, the term BIPOC will be used throughout this work to identify persons who are Black, Indigenous or Persons of Color, while also understanding identities within the BIPOC community cannot be adequately encapsulated with one term.

The Roseville Joint Union High School District is a small, conservative, suburban school district that serves approximately 10,000 students, enrolled in 8 high schools, with 6 comprehensive school sites and 2 alternative education sites. As part of all high schools in the district, wellness centers have been established to address mental health needs for students. Wellness centers provide individual and group therapy, as well as mental health psychoeducation to the entire school campus community. Specific to the LGBTQ+ community, wellness centers provide individual therapy, support groups, as well as work with students who identify as transgender or gender non-conforming to support them engaging in changing their

identification information in the school's information system, as needed. This is a formal procedure known as the interactive planning process.

## Literature Review

The following information reflects the literature available regarding BIPOC LGBTQ+ youth mental health, which includes the theoretical frameworks utilized to understand the experience of BIPOC LGBTQ+ youth, emerging themes related to mental health risks, interventions recommended, as well as future directions for school-based mental health providers and local education agencies. The literature associated with BIPOC LGBTQ+ youth is limited, and therefore some of the information provided will reflect research centered on LGBTQ+ youth overall in addition to BIPOC LGBTQ+ youth. The limitation of research will be addressed throughout this literature review.

### Minority Stress Theory

Prior to discussing the state of LGBTQ+ youth mental health, it's important to acknowledge that much of the research is based in a minority stress theory framework (Myers, 2003). Minority stress theory provides a conceptual framework to understand the stressors and experiences of sexual minority individuals, which includes their identity, stigma, work/other environments that may be hostile, as well as one's internalized phobia regarding their identity (Myer, 2003). This theory was discussed throughout a number of research articles as a way to understand the experiences of LGBTQ+ youth, however it was acknowledged that more research needed to be conducted in order to address its application to gender minorities as well, given the first application was with LGB identified persons (Ching et al.; Myer, 2003). According to Camp et al. (2020), minority stress theory looks at the pervasive nature of the stressors faced by sexual and gender minorities, as well as the increased risk to mental health compared to cisgender and heterosexual individuals. Minority stress theory also acknowledges the intersections of identity for persons who identify as LGBTQ+ and as a person of color, recognizing there are additional stressors that arise (Roig-Palmer & Lutze, 2022; VanBronkhorst et al., 2021).

**BIPOC LGBTQ+ Mental Health**

Mental health risks for LGBTQ+ youth, including BIPOC youth, include higher rates of depression, anxiety, and suicidality, as well as being impacted by the stigma surrounding mental health (AlAzzam et al., 2021; McDanal et al., 2021; Poquiz et al., 2020; Thompson et al., 2021). Due to the stigma associated with mental health, BIPOC youth are less likely to reach out for support (Thompson et al., 2021). Additionally, BIPOC LGBTQ+ community members may experience discrimination from within the LGBTQ+ community, which further stigmatizes and rejects their identity (Darling, 2021). In one study, Darling (2021) conducted data analysis with existing survey data and found that transgender, gender non-conforming, genderqueer persons who are BIPOC, experience health disparities across many different systems. The specific risks associated with BIPOC LGBTQ+ youth discussed below include suicidality and depression.

The Trevor Project's 2022 National Survey on LGBTQ+ Youth Mental Health (n.d.) indicates LGBTQ+ youth of color have attempted suicide at increased rates compared to white LGBTQ+ youth. These findings are consistent with the research described above, and highlight the need for further understanding and intervention into this public health crisis. In one study of youth (13-24 years old) who interacted with online LGBTQ+ content were surveyed to examine if there was an association between suicide attempts and acceptance among peers and family of their sexual orientation and found that many teens who engaged in online support may have been more confident in their sexual orientation (Green et al., 2021). Perez-Brumer et al. (2017), in a quantitative study of over 7,000 transgender youth examined school based victimization and depression in order to understand the psychosocial factors that may be associated to suicidality. This study held the largest sample size of transgender youth in the United States and was the first representative sample. They found that transgender youth considered suicide at rates more than double of cisgender youth and concluded that school-based interventions to reduce depression and increase inclusive school culture could reduce the risk of suicidality among transgender youth (Perez-Brumer et al., 2017). A quantitative study by a medical

examiner found that 59% of 12-17 year olds who died by suicide had records that indicated LGBTQ+ identity. The data researched in this study identified that rejections from peers and family, bullying and romantic relationship difficulty were additional factors associated with many of the deaths (Ream, 2020). It was concluded that the prevalence of suicidality among LGBTQ+ youth may be related to their status as minors and lack of control within their environments (Ream, 2020). This finding exemplifies the point that LGBTQ+ youth may experience powerlessness within their environments. A recent study of LGBTQ+ youth, using cross-sectional survey data found that the youth who had accepting and inclusive peer groups and parents had reduced reports of suicidal ideation and attempts, noting that the parental acceptance held the strongest impact (Green, Price-Feeney & Dorison, 2021). Suicidality among LGBTQ+ youth was studied within a psychiatric facility using quantitative methods based on self-reported data from the youth, and concluded that BIPOC LGBTQ+ youth studied had a higher rate of suicidal attempts compared to white LGBTQ+ youth (VanBronkhorst et al., 2021). They mention that the youth of color have intersecting identities along with LGBTQ+ status, which may contribute to the higher risk of suicide.

While the above information focused on suicidality, it is important to recognize 1 in 6 youth experience depression and depressive symptoms (National Alliance on Mental Illness, n.d.). This statistic is important as it may assist in understanding why addressing the root causes of depression could have impacts on one's risk of suicidality. The Center for Disease Control and Prevention reports that in 2019, 1 in 3 high school students reported experiencing feelings of sadness or hopelessness (CDC, n.d.). Research supports that LGBTQ+ youth are at an increased risk for depression compared to non-LGBTQ+ youth (AlAzzam et al., 2021; McDanal et al., 2021; Poquiz et al., 2020; Thompson et al., 2021). Interestingly, one study found that transgender youth who identify on the binary (transwoman and transman) experience less depression risk than those transgender students who identify as non-binary (Poquiz et al., 2020). AlAzzam et al. (2021) found that the most significant predictor among high school aged

students for suicidality was anxiety and depression. These findings can be understood using the minority stress theory framework, linking marginalization and intersection of identities to increase risk (Meyer, 2003). BIPOC LGBTQ+ are at higher risk for anxiety, depression and suicidality (McDanal et al., 2021; Poquiz et al., 2020; Thompson et al., 2021).

**Barriers to Services**

The following information introduces barriers to service as the research has identified, however it is important to note that the barriers noted here are not an exhaustive list and may not reflect the experience of all LGBTQ+ and BIPOC youth. Thematically, heteronormativity was discussed as a barrier to accessing services and support, recognizing that society has been built upon systemic structures that reinforce heterosexual dominance and the gender binary (Darling 2021; Hobaica et al., 2021; Zullo et al, 2021). Through a mixed methods study of secondary students regarding school climate, heteronormativity in schools can be recognized as the gender binaries that exist in language, within activities, as well as encouraged through socially constructed value systems (Peter, Taylor & Campbell, 2016). In schools, examples of heteronormative practices can be seen daily, including but not limited to using binary languages such as "girls and boys," as well as examining dresscode discrepancies for students.

This author's research of barriers to service for BIPOC LGBTQ+ marginalized youth has been based in both intersectionality and minority stress theory, discussed above (Angoff et al., 2021; Crenshaw, 1989; Darling, 2021; Hobaica et al., 2020; Meyers, 2003; Zullo et al., 2021). Findings from these studies used a combination of methodology to arrive at their conclusions, including dissecting statewide survey data from students in secondary education, to analyzing national survey data responses, and qualitative interviews with focus groups. Collectively they have identified that the multiple identities of LGBTQ+ youth, including that of race/ethnicity create additional stressors to accessing support. The common stressors that were present in the research included but are not limited to: political and school climate, family support, peer support and clinician impact.

### ***Political and School Climates***

Research regarding LGBTQ+ youth mental health has identified the political climate having an impact on youth both directly and indirectly (McDowell, et al. 2020). The oppression of LGBTQ+ persons is not new to this country, however there are many events in recent history that depict the urgency of understanding risk to this community. In the past ten years there have been a multitude of laws that have been enacted across the United States discriminating against youth who identify as transgender, gender non-conforming and other gender minority statuses (McDowell, et al. 2020). Examples of such laws include but are not limited to, the mandated reporting by school personnel of transgender youth to child welfare services, removal or banning of gender affirming healthcare, bathroom bans, as well as discriminatory actions against transgender athletes (Pham et al. 2020). It has also been identified by Pham et al. (2020) that news coverage of the current political climate for LGBTQ+ community members impacts well-being.

The research reflects that school climate is an additional barrier to LGBTQ+ and BIPOC youth receiving support. According to the National School Climate Survey from the Gay Lesbian and Straight Education Network (n.d.), one of the few studies to look at LGBTQ+ experiences as it relates to school climate found that 68% of LGBTQ+ students felt unsafe at school due to their sexual orientation, gender identity or expression. Thompson et al. (2021) suggests a relationship to awareness of social issues and stigma, such that if awareness regarding social issues is low, stigma is high and the inverse is recognized as well. Additionally, authors Payne and Smith (2011), through mixed methods modalities of surveys and interviews, have determined that school climate impacts LGBTQ+ youth, both interpersonally and institutionally. Depression has also been associated to suicidal ideation and both are linked to being impacted by school climate (Peter, Taylor & Campbell, 2017). Despite there being awareness of social issues, the stigma surrounding access to help exists, as well as understanding current interventions need to be appropriately designed to address the needs of LGBTQ+ youth, rather than attempting a

universal fit (Darling, 2021; Zullo et al., 2021). Hobaica et al. (2021) linked the political climate to the school climate data in their study that utilized the Washington Healthy Kids Survey. They found LGBTQ+ students in conservative districts experienced more bullying during the 2016 school year when Donald J. Trump was elected president. A causal relationship was not determined based on the data, however it was recognized as a variable that may have impacted student's experiences. Adults on school campuses that are silent when homophobic or transphobic comments are made communicate a nonverbal message to their LGBTQ+ students regarding who is present to support them (Peter, Taylor & Campbell, 2016; Hobaica et al., 2021). It's important to note that students are likely to assess an adult's level of support through their interactions and observations.

***Family Support***

Studies have shown that LGBTQ+ youth who have experienced a lack of family support, even while still experiencing support from other sources still faced adversity in terms of mental health risk (McConnell, Birkett & Mustanski, 2016; Tankersley et al., 2021). Pariseau et al. (2019) conducted a qualitative study centered upon interpersonal acceptance-rejection theory to examine the relationship between psychosocial factors and family acceptance. They found that transgender students who experience strong family communication have reported less symptoms of depression, however when the caregiver expressed indifference towards the transgender youth's identity this was associated to increased depressive symptoms. The researchers recognize that without a control group to compare, generalizing their findings would not be possible. Youth who experience rejection from families, forced heteronormativity and neglect continue to be at greater risk for their physical and psychological safety (McDermott et al., 2021). The above information highlights the need for family acceptance and support, however the research is also limited. Additionally, a limitation to this study was missing data related to other intersections of identity. This is a recurring limitation in many studies. The two studies suggesting interventions above affirm one another's findings that family support has an

impact on the LGBTQ+ youth's mental health, and future studies could be designed to expand into other intersections of family identity such as race, ethnicity, religion, socioeconomic status, as well as examining the differences between individualist and collective communities.

### ***Peer Support***

Peer support has been designated as a strength for LGBTQ+ youth, and at times support from peers may be the only support the youth have when it comes to their sexual orientation and/or gender identity (McConnell, Birkett & Mustanski, 2016). In one qualitative study focused on peer and adult relationships, it was found that acceptance from peers and adults is also associated with less risk for suicidality (Green, Price-Feeney & Dorison, 2021). The researchers identify that youth may see their peers as their most supportive persons, however this does not replace the experience with the adults in their lives. Another qualitative study, used focus groups to find that one way that peers support their LGBTQ+ friends is to be receptive to using the person's identified pronouns, name and validating their gender expression or sexual orientation (Zullo et al., 2021). The LGBTQ+ youth also reported seeking out online support when in distress (Colvin et al., 2019; Zullo et al., 2021). They suggested that seeking online support may occur when peers are not supportive of one's sexual orientation or gender identity. Tankersley at al. (2021) reported that disclosure of identity could risk psychological and physical safety for the youth. Through their quantitative study, they concluded that poor peer relationships increased risk of victimization, bullying, as well as increased emotional and psychological stress. Asakura (2016) studied resiliency in LGBTQ+ youth through a qualitative study and found that LGBTQ+ youth sought out connection among adults and peers who they felt shared similar values and acceptance. To this end, it was found that the relationships they held with peers and adults helped reduce the marginalization they experienced (Asakura, 2016).

### ***Clinician Impact***

In addition to school climate being correlated with service access and barriers, one particular study utilized direct client voices in the form of interviewing, which was the first of its

kind (Zullo et al., 2021). They noted that BIPOC students and LGBTQ+ youth shared preference towards clinicians of color, recognizing that they also hold marginalized statuses and may be able to understand the student's experience. Zullo et al. (2021) goes on to share that clinicians who maintain a neutrality with acceptance of one's sexual or gender identity may inadvertently appear dismissive to a youth seeeking support. One study found that transgender and gender diverse clients may self-refer more often than cisgender persons based on the health disparities they face, thus be seeking out support where they've received none previously (Colvin et al., 2019). The above illustrates the point that clinicians being available to provide affirming care to their clients is an important aspect of addressing mental health risk for these marginalized groups.

Throughout the research there have been a couple models of intervention introduced to address LGBTQ+ youth mental health. One particular model of interest is the affirmative mindfulness approach where the practice of mindfulness is used when working with sexual and gender minority youth in order to build coping strategies (Iacono, 2019). The approach centers the practice of mindfulness, as well as the identity intersections for BIPOC youth, including recognition that many LGBTQ+ youth of color can experience dual marginalization (Iacono, 2019). Payne and Smith (2011) have proposed a professional development model that aims to create opportunities for educators to learn about the particular needs of LGBTQ+ youth from the youth. This model approaches systemic change within a school-based system and offers an opportunity for educators of all levels to join in creating an inclusive school climate (Payne & Smith, 2011). Their model supports education happening among colleagues as well as offering the opportunity to learn from youth. The two intervention models are only briefly discussed and highlight the importance of future research endeavors to be focused on applied interventions with BIPOC LGBTQ+ youth. Research has yet to identify how to systematically address the risk associated with LGBTQ+ youth mental health, however many elements that impact risk have been discussed.

## Responsibility to Change and Future Directions

Responsibility for change can be a controversial topic, depending on where you are located. The research presented in this literature review has illustrated the systemic problem, resulting in the current state of BIPOC LGBTQ+ mental health. While it is vastly important for clinicians to be prepared to work with this community, it must be recognized that systemic change efforts should focus on reducing stigma and to addressing the needs of BIPOC LGBTQ+ youth through focused therapy, inclusive school climates, support for families, working with educators, and educating the student body. (Colvin et al., 2019; Zullo et al., 2021). Students with increased access to support had less absenteeism, increased school engagement and connectedness (Hobaica et al., 2021). Darling (2021), while using an intersectionality framework goes a bit further and acknowledges that public administrators have responsibility for creating the marginalized system present today, as well citing this country's history of slavery, dominance and oppression (Crenshaw, 1989). While this statement is broader than school based mental health, it does identify the foundation of many white supremacist based systems, including schools.

## Conclusion

The research has shown that BIPOC LGBTQ+ youth mental health is of great concern due to the risk factors for suicide, depression, bullying and victimization (AlAzzam et al., 2021; McDanal et al., 2021; Perez-Brumer et al., 2017; Poquiz et al., 2020; Thompson et al., 2021). While suicide risk factors remain high for these youth, researchers have identified variables that area associated with reduced risk: creating inclusive school climates, educating educators regarding the needs of BIPOC LGBTQ+ youth, creating safe spaces on campus for peer support, addressing family needs, as well as working with government, to ensure protections for these youth. Limitations to the research above include understanding how BIPOC LGBTQ+ youth experience stressors related to family and peer support, understanding how their marginalization and oppression may be different within a school setting, as well as

understanding how each identity within the BIPOC and LGBTQ+ communities experience life while in schools. The research thus far has focused on the LGBTQ+ community as a whole, with some information related to transgender youth, but there is a general lack of understanding regarding the specific community impact.

## Gap Analysis

The Roseville Joint Union High School District is a small, conservative, suburban school district that serves approximately 10,000 students, enrolled in 8 high schools, with 6 comprehensive sites and 2 alternative education sites. The distribution of racial and ethnic identities in the district are: 53% white, 20% Latino/Hispanic, 4% Black/African American, 5% multi-racial, and 16% Asian, Pacific Islander, Native, and Indigenous. Each high school campus has a wellness center that was implemented to address the mental health needs of students and their families, as an aim from the school district to support addressing barriers to academic success. The five focus areas for wellness centers are: mental health, attendance and truancy support, assessment and referrals, substance use intervention, and community partnerships and referrals. Wellness centers are operating in their fifth year and are staffed with licensed mental health professionals, community liaisons, as well as trainees who are enrolled in field practicum through local universities.

Students on campus can utilize wellness services in a variety of ways including taking 5-10 minute breaks from class, walking-in and requesting someone to talk to, as well as engaging in formal therapy services. Wellness centers provide individual and group therapy, as well as mental health psychoeducation to the entire school campus community. Specific to the LGBTQ+ community, wellness centers provide individual therapy, group support, as well as work with students who identify as transgender or gender non-conforming to support them engaging in the interaction process, which supports students changing their identifying information in the school's information system, such as name, pronouns, gender, etc.

The major stakeholders associated with the wellness centers are the students, families and school communities. The focus of this research question centered upon Black, Indigenous, Persons of Color (BIPOC) LGBTQ+ (lesbian, gay, transgender, queer and other identities) youth in the school district. When examining the services available to this population, there are gaps in understanding how they are utilizing wellness services and to what extent. There are a variety of services that are available to these students, however it is unclear if BIPOC LGBTQ+ youth are engaging in formal relationships with wellness centers through individual or group therapy or utilizing informal services through walk-ins or breaks.

Wellness centers gather data from each student who accesses services daily. This data is reviewed multiple times per year to assess information regarding the students we are serving, as well as what needs students, staff, and parents are reporting. According to the data from the 2021-22 school year, across all wellness centers, we served over 1,300 students, had over 11,000 students walk-in to wellness for support. 78% of students who self-referred for individual or group therapy asked for help with anxiety and/or depression. In addition to those focus areas students sought support with family conflict, LGBTQ+ identity, suicidality, and peer support. Students who self-referred disclosed their gender identity as 60% female, 22% male, and 18% prefer not to say or other gender.

The mission from the Roseville Joint Union High School District is to ignite innovative and meaningful learning, inspire powerful impact in our communities and to prepare all students for multiple paths to success (RJUHSD, n.d.). While this mission statement implies inclusivity for all students, in practice this is not occurring. As mentioned above this particular school district is very conservative and rarely makes district-wide statements to denounce forms of racism, discrimination, or harrassment to marginalized communities, however the board policies are advertised on the district's webpage. In this vein, addressing the needs of BIPOC LGBTQ+ members has been challenging and is unclear. In order to better understand the problem it would be imperative to understand the students' current experiences with school

climate, school staff support, peer support and mental health services. The aim in this pursuit would be to highlight and explore what is currently happening and how to support research informed practices within the school community.

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**APPENDIX A**

| | **Authors** | **Research** |
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| 2 | Ching, T. H. W., Finkelstein-Fox, L., Lee, S. Y., & Watson, R. J. (2022). Effects of sexual and gender minority stress on depressive symptoms among adolescents of color in the United States. *Cultural Diversity and Ethnic Minority Psychology*. Advance online publication. https://doi.org/10.1037/cdp0000562 https://doi.org/10.1037/cdp0000562 | Quantitative |
| 3 | Colvin, E. G. H., Tobon, J. I., Jeffs, L., & Veltman, A. (2019). Transgender clients at a youth mental health care clinic: Transcending barriers to access. *Canadian Journal of Human Sexuality*, *28*(3), 272–276. https://doi-org.ezproxy.simmons.edu/10.3138/cjhs.2019-0004 | Quantitative |
| 4 | Darling, M. J. T. (2021). Living on the margins beyond gender binaries: What are the challenges to securing rights. *Public Integrity*, *23*(6), 573–594. https://doi-org.ezproxy.simmons.edu/10.1080/10999922.2020.1825180 | Quantitative |
| 5 | Green, A. E., Price-Feeney, M., & Dorison, S. H. (2021). Association of sexual orientation acceptance with reduced suicide attempts among lesbian, gay, bisexual, transgender, queer, and questioning youth. *LGBT Health*, *8*(1), 26–31. https://doi-org.ezproxy.simmons.edu/10.1089/lgbt.2020.0248 | Quantitative |
| 6 | Hobaica, S., Kwon, P., Reiter, S. R., Aguilar, B. A., Scott, W. D., Wessel, A., & Strand, P. S. (2021). Bullying in schools and LGBTQ+ youth mental health: Relations with voting for Trump. *Analyses of Social Issues & Public Policy*, *21*(1), 960–979. https://doi-org.ezproxy.simmons.edu/10.1111/asap.12258 | Quantitative |
| 7 | McConnell, E. A., Birkett, M., & Mustanski, B. (2016). Families matter: Social support and mental health trajectories among lesbian, gay, bisexual, and transgender youth. *Journal of Adolescent Health*, *59*(6), 674–680. | Quantitative |

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| 8 | Perez-Brumer, A., Day, J. K., Russell, S. T., & Hatzenbuehler, M. L. (2017). Prevalence and correlates of suicidal ideation among transgender youth in California: Findings from a representative, population-based sample of high school students. *Journal of the American Academy of Child & Adolescent Psychiatry*, *56*(9), 739–746. https://doi-org.ezproxy.simmons.edu/10.1016/j.jaac.2017.06.010 | Quantitative |
| 9 | Poquiz, J. L., Coyne, C. A., Garofalo, R., & Chen, D. (2021). Comparison of gender minority stress and resilience among transmasculine, transfeminine, and nonbinary adolescents and young adults. *Journal of Adolescent Health*, *68*(3), 615–618. https://doi-org.ezproxy.simmons.edu/10.1016/j.jadohealth.2020.06.014 | Quantitative |
| 10 | Tankersley, A. P., Grafsky, E. L., Dike, J., & Jones, R. T. (2021). Risk and resilience factors for mental health among transgender and gender nonconforming (TGNC) youth: A systematic review. *Clinical Child and Family Psychology Review*, *24*(2), 183–206. https://doi-org.ezproxy.simmons.edu/10.1007/s10567-021-00344-6 | Quantitative |
| 11 | Thompson, A., Hollis, S., Herman, K. C., Reinke, W. M., Hawley, K., & Magee, S. (2020). Evaluation of a social media campaign on youth mental health stigma and help-seeking. *School Psychology Review*, *50*(1), 36–41. | Quantitative |
| 12 | VanBronkhorst, S. B., Edwards, E. M., Roberts, D. E., Kist, K., Evans, D. L., Mohatt, J., & Blankenship, K. (2021). Suicidality among psychiatrically hospitalized lesbian, gay, bisexual, transgender, queer, and/or questioning youth: Risk and protective factors. *LGBT Health*, *8*(6), 395–403. https://doi-org.ezproxy.simmons.edu/10.1089/lgbt.2020.0278 | Quantitative |
| | **Authors** | **Research** |
| 1 | AlAzzam, M., Abuhammad, S., Tawalbeh, L., & Dalky, H. (2021). Prevalence and correlates of depression, anxiety, and suicidality among high school students: A national study. *Journal of Psychosocial Nursing & Mental Health Services*, *59*(8), 43–51. https://doi-org.ezproxy.simmons.edu/10.3928/02793695-20210426-02 | Qualitative |
| 2 | Asakura, K. (2017). Paving pathways through the Pain: A grounded theory of resilience among lesbian, gay, bisexual, trans, and queer youth. *Journal of Research on Adolescence (Wiley-Blackwell)*, *27*(3), 521–536. https://doi-org.ezproxy.simmons.edu/10.1111/jora.12291 | Qualitative |

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|---|---|---|
| 3 | McDermott, E., Gabb, J., Eastham, R., & Hanbury, A. (2021). Family trouble: Heteronormativity, emotion work and queer youth mental health. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine*, *25*(2), 177–195. https://doi-org.ezproxy.simmons.edu/10.1177/1363459319860572 | Qualitative |
| 4 | Payne, E., & Smith, M. (2011). The reduction of stigma in schools: A new professional development model for empowering educators to support LGBTQ students. *Journal of LGBT Youth*, *8*(2), 174–200. https://doi-org.ezproxy.simmons.edu/10.1080/19361653.2011.563183 | Qualitative |
| 5 | Pham, A., Morgan, A. R., Kerman, H., Albertson, K., Crouch, J. M., Inwards-Breland, D. J., Ahrens, K. R., & Salehi, P. (2020). How Are transgender and gender nonconforming youth affected by the news? A qualitative study. *Journal of Adolescent Health*, *66*(4), 478–483. https://doi-org.ezproxy.simmons.edu/10.1016/j.jadohealth.2019.11.304 | Qualitative |
| 6 | Ream, G. L. (2020). An investigation of the LGBTQ+ youth suicide disparity using national violent death reporting system narrative data. *Journal of Adolescent Health*, *66*(4), 470–477. https://doi-org.ezproxy.simmons.edu/10.1016/j.jadohealth.2019.10.027 | Qualitative |
| 7 | Roig-Palmer, K., & Lutze, F. E. (2022). Confronting oppression: Reframing need and advancing responsivity for LGBTQ+ youth and young adults. *Women and Criminal Justice*, *32*(1–2), 2–28. | Qualitative |
| 8 | Smith-Millman, M., Harrison, S. E., Pierce, L., & Flaspohler, P. D. (2019). "Ready, willing, and able": Predictors of school mental health providers' competency in working with LGBTQ youth. *Journal of LGBT Youth*, *16*(4), 380–402. https://doi-org.ezproxy.simmons.edu/10.1080/19361653.2019.1580659 | Qualitative |
| 9 | Zullo, L., Seager van Dyk, I., Ollen, E., Ramos, N., Asarnow, J., & Miranda, J. (2021). Treatment recommendations and barriers to care for suicidal LGBTQ youth: A quality improvement study. *Evidence-Based Practice in Child & Adolescent Mental Health*, *6*(3), 393–409. https://doi-org.ezproxy.simmons.edu/10.1080/23794925.2021.1950079 | Qualitative |
| | **Authors** | **Research** |
| 1 | McDanal, R., Rubin, F. A. K. R., & Schleider, J. L. (2022). Associations of LGBTQ+ identities with acceptability and efficacy of online single-session youth mental health interventions. *Behavior Therapy*, *53*(2), 376–391. https://doi-org.ezproxy.simmons.edu/10.1016/j.beth.2021.10.004 | Mixed Methods |

| 2 | Peter, T., Taylor, C., & Campbell, C. (2016). 'You can't break…when you're already broken': The importance of school climate to suicidality among LGBTQ+ youth. *Journal of Gay & Lesbian Mental Health*, *20*(3), 195–213. https://doi-org.ezproxy.simmons.edu/10.1080/19359705.2016.1171188 | Mixed Methods |
|---|---|---|

## APPENDIX B

## END OF THE YEAR NUMBERS

### REFERRALS - Mental Health - Tier 2 & 3 services

| | **2021/22** WELLNESS, STUDENT, & GUARDIAN | **2020/21** WELLNESS, STUDENT, & GUARDIAN | **2019/20** | **2018/19** | **2017/18** |
|---|---|---|---|---|---|
| **RJUHSD** | 1,150 | 1,040 | **931** | **625** | **292** |

### 2021/22 REFERRALS BROKEN DOWN BY SOURCE

| | **WELLNESS** | **STUDENT** | **GUARDIAN** |
|---|---|---|---|
| **RJUHSD** | **732** | **344** | **71** |

### All REFERRALS - GRADE

| | **9** | **10** | **11** | **12** |
|---|---|---|---|---|
| **2021/22 RJUHSD** | 24.9% | 28.3% | 25.5% | 21.3% |
| 2020/21 RJUHSD | 26.4% | 25% | 24.8% | 23.8% |
| **2019/20 RJUHSD** | **25%** | **31%** | **25%** | **19%** |
| **2018/19 end of year** | 23% | 31% | 29% | 17% |

| | **IEP** | **504** | **EL** | **FOSTER OR HOMELESS OR PROB** | **TITLE I** |
|---|---|---|---|---|---|
| **2021/22 RJUHSD** | 12.7% | 11.8% | 7.2% | 7% | 26% |
| 2020/21 RJUHSD | 11% | 14% | 4.4% | 5% | 23.3% |

| | | | | | |
|---|---|---|---|---|---|
| **2019/20 RJUHSD** | 9% | 14% | 7% | 7% | 27% |
| **2018/29 RJUHSD** | 11.1% | 17.3% | 5% | 9.3% | 55% |

## Reason for referral broken down by source

****doesn't include tobacco/substance discipline referrals or attendance specific referrals*****

| | **Student Referrals** 344 | **Guardian Referrals** 71 | **Staff Wellness Referrals** 732 |
|---|---|---|---|
| **2021/22 RJUHSD**<br><br>1150 total referrals | Anxiety: 79%<br>Depression: 58%<br>Eating: 22%<br>Family Dynamics: 36%<br>Group Interest: 27%<br>Substance: 4%<br>Tobacco: 2%<br>Grief & Loss: 8%<br>Self Esteem: 38%<br>Peer relationships:27%<br>Trauma:24%<br>LGBT support:19% | Anxiety: 75%<br>Depression: 45%<br>Eating: 11%<br>Family Dynamics: 38%<br>Substance: 6%<br>Tobacco: 9%<br>Grief & Loss: 3%<br>Self Esteem: 32%<br>Peer relationships: 25% | Anxiety: 49 %<br>Depression: 44 %<br>Emotional Regulation: 19%<br>Family Dynamics: 30 %<br>Substance: 5%<br>Tobacco:3%<br>Grief & Loss:12%<br>Suicidal Ideation: 6%<br>Self Injurious: 5%<br>Self Esteem: 11%<br>Peer relationships: 20%<br>Trauma: 14%<br>Hyperactive/Inattentive: 4%<br>Eating concerns 5%<br>LGBT support: 5%<br>Group Specific: 10% |
| **Gender** | 22.3 % Male<br>59.8 % Female<br>17.9 % Other or prefer not to say | 43.7 % Male<br>49.3 % Female<br>7 % Other or prefer not to say | 42.2 % Male<br>52% Female<br>5.8 % Other or prefer not to say. |
| **Grade** | 25.9 % Freshman<br>28.5 % Sophomore<br>23.8 % Junior<br>21.8 % Senior | 38 % Freshman<br>33.8 % Sophomore<br>19.7 % Junior<br>8.5 % Senior | 23.2 % Freshman<br>27.7 % Sophomore<br>26.8 % Junior<br>22.3 % Senior |

## WELLNESS STAFF REFERRALS & SERVICES RECEIVED

| | **SERVICES RECEIVED** | **Reason for referral - 1150 total** |
|---|---|---|
| **2021/22 RJUHSD**<br><br>1150 Referrals<br><br>2,579 Total services provided | Triage: 692 ( 60%)<br>Individual: 316 ( 28%)<br>Group: 254 ( 22%)<br>Attendance: 265 ( 23%)<br>Case Management: 363 ( 32%)<br>Substance or Tobacco: 130 ( 11%)<br>Outside services: 29 ( 2.5%)<br>Referred Out: 23 ( 2%)<br>Declined: 176 ( 15%) | Anxiety: 56%<br>Depression: 46%<br>Emotional Regulation: 24%<br>Family Dynamics: 30%<br>Substance: 4%<br>Tobacco:3%<br>Grief & Loss:9%<br>Suicidal Ideation:4%<br>Self Injurious: 5% |

| | | |
|---|---|---|
| Serving 11% of the district population | | Self Esteem: 20%<br>Peer relationships:22%<br>Trauma: 16%<br>Hyperactive/Inattentive: 3%<br>Eating concerns 10%<br>LGBT support: 8% |
| 2020/21<br>RJUHSD<br><br>935 Students<br>**unduplicated referrals**<br><br>Total services provided<br>1,456 | Triage: 558 (60%)<br>Individual: 324 (35%)<br>Group: 177 (19%)<br>Attendance: 210 (29%)<br>Case Management: 213 (23%)<br>Substance or Tobacco: 41 (4.3%)<br>Outside services: 40 (4%)<br>Declined: 179 (19%) | Anxiety: 41%<br>Depression: 42 %<br>Emotional Regulation:12 %<br>Family Dynamics: 24 %<br>Substance:26 %<br>Tobacco: 3%<br>Grief & Loss:29%<br>Suicidal Ideation: 3%<br>Self Injurious: 3%<br>Self Esteem: 9%<br>Peer relationships: 10%<br>Trauma: 9%<br>Attendance:2%<br>Covitality: 3.5%<br>Hyperactive/Inattentive: 3%<br>Eating concerns 4.5%<br>LGBT support: 3% |
| **2019/20 - RJUHSD**<br>Total referrals: **931**<br><br>Total services provided<br>**913** | Individual **343**<br>Group **232**<br>Teen Intervene **108**<br>Case Management **47**<br>Attendance **79**<br>Declined **116**<br>Support Plans **104** | Anxiety 27%<br>Depression 25%<br>Emotional Regulation 13.5%<br>Family Dynamics 22%<br>Grief & Loss 8.8%<br>Suicidal Ideation 4%<br>Self Injurious 2.5%<br>Self Esteem 6%<br>Peer relationships 8%<br>Trauma 3% |
| **2020/21 - ANHS**<br><br>198 total referrals<br><br>Total services provided<br>**281** | **# of students receiving service:**<br>Triage: 108<br>Individual: 59<br>Group: 53<br>Attendance: 17<br>Case Management/Check-ins: 40<br>Substance or Tobacco: 4<br><br>Referred out or Outside services: 10<br>Declined: 23 (13%) | Anxiety: 39%<br>Depression: 31 %<br>Family Dynamics:29%<br>Substance: 4%<br>Tobacco: 4%<br>Grief & Loss: 9%<br>Self Esteem: 19%<br>Peer relationships:26%<br>Trauma: 12%<br>Eating concerns 6%<br>LGBT support: 9% |

## Other Services: TIER 1 & TIER 2

| | Assessment or Support Plans Created For Suicidal Ideations or Self Harm<br>Crisis Services | Groups<br>Tier 2 Interventions | Classroom Presentations<br>Tier 1 interventions |
|---|---|---|---|
| **RJUHSD 2021/22** | 208 | 43 Groups<br>354 Students | 479 Presentations/Classes<br>10,974 Students (double counted)<br>25,661 Minutes (427.68 hrs) |

| | | | |
|---|---|---|---|
| **RJUHSD 2020/21** | 70 | 40 Groups<br>209 Students | 530 Presentations/Classes<br>11,732 Students (double counted)<br>25,563 Minutes |
| **RJUHSD 2019/20** | 104 | | |

# EQUITY DATA COMPARISON

| | IEP | 504 | EL | FOSTER OR HOMELES S OR PROB | TITLE I |
|---|---|---|---|---|---|
| **2021/22 RJUHSD** | 12.7% | 11.8% | 7.2% | 7% | 26% |
| 2020/21 RJUHSD | 11% | 14% | 4.4% | 5% | 23.3% |
| **2019/20 RJUHSD** | 9% | 14% | 7% | 7% | 27% |
| **2018/29 RJUHSD** | 11.1% | 17.3% | 5% | 9.3% | 55% |

| | District/School Totals | Wellness Caseloads & Referrals - Student self identity |
|---|---|---|
| **2021/22 RJUHSD** | White: 53.4%<br>Hispanic/Latino: 20.5%<br>AA/Black: 3.7%<br>Multiracial: 4.5%<br>Asian/PI/Filipino/Native/ME/Indian 16%<br><br>EL/Foster/Homeless: 5.2%<br>Title I: 29.5%<br>Disabilities: 8.1%<br>n=10,627 | White: 48%<br>Hispanic/Latino:19.4%<br>AA/Black: 7.4%<br>Multiracial: 9%<br>Asian/PI/Filipino/Native/ME/Indian 16.2%<br>N= 1,306<br><br>EL/Foster/Homeless: 10%<br>Title I: 18%<br>IEP Disabilities: 9%<br>504 Disabilities: 9%<br>N= 1150 |
| **2020/21 RJUHSD** | White: 55.8%<br>Hispanic/Latino: 19.4%<br>AA/Black: 3.9%<br>Multiracial: 3.5%<br>Asian/PI/Filipino/Native/ME/Indian 15.6%<br><br>EL/Foster/Homeless: 5.5%<br>Title I: 28.4% | White: 53.2%<br>Hispanic/Latino:19.2%<br>AA/Black: 5.6%<br>Multiracial:9.3%<br>Asian/PI/Filipino/Native/ME 12.7%<br><br>N=635 |

| | | |
|---|---|---|
| | Disabilities: 7.2%<br><br>N= 10,468 | |
| **2019/20 RJUHSD totals** | White - 57.5%<br>Hispanic/Latino- 18.3%<br>AA/Black - 3.8%<br>Multi - 3.5%<br>Asian, PI, Filipino, Native, Latino, ME - 15% | White - 54.8%<br>Hispanic/Latino- 21.6%<br>AA/Black - 6.8%<br>Multi - 5.3%<br>Asian, PI, Filipino, Native, Latino, ME - 11.5% |
| **2018/19 RJUHSD TOTALS** | White - 58.5%<br>Hispanic/Latino- 18.3%<br>AA/Black - 3.9%<br>Multi - 3.8%<br>Asian, PI, Filipino, Native, Latino, ME - 13.9% | White - 63%<br>Hispanich/Latino - 26%<br>Black/AA - 8%<br>Asian, PI, Filipino, Native, ME- 13% |