Yale *Global Health Justice Partnership*

A PROGRAM OF YALE LAW SCHOOL AND THE YALE SCHOOL OF PUBLIC HEALTH

February 7, 2022

TO: The Independent Expert on protection against violence and discrimination based on sexual orientation and gender identity

RE: The Independent Expert's report to be presented to the 50th Session of the United Nations Human Rights Council

Dear Victor,

Please find below summaries of two relevant research projects from faculty, fellows and students of the Global Health Justice Partnership, for your consideration in your upcoming report.

The first set of materials provides an examination of how the rigid two-sex system, which scholars have termed "cisgenderism" is operationalized, in part, through stigma in legal and health-related domains, with effects on rights and health. This work provides a **transversal frame of analysis** that can, we hope, inform and strengthen your work to review inputs across intersectional research and understanding. This frame, making visible an ideology (cisgenderism) and a mechanism (stigma) highlights barriers to inclusion in decision-making; access to healthcare; inclusion and representation in training and education, and measuring health outcomes and needs. Further, it supports actions in line with an integrated approach to the SDGs, particularly – as you note – the fulfillment of SDG 3 (to ensure health and well-being for all) read alongside SDG 10 (reducing inequality). Finally, in clarifying the complex relationships between stigma and discrimination and adverse health outcomes, it can contribute to the linkages you draw to state obligations and international human rights law protections. The scholarship drawn on in this analysis is global.

The second summary is of GHJP work mapping the status of knowledge (and numerous gaps in knowledge) regarding the mental health of lesbian, gay, trans, bisexual, intersex, and gender non-conforming youth in the U.S. child welfare system. This work has been carried out by an initiative within the GHJP called "Youth Equity Science" or YES.

This work, we hope, is relevant to the question of intersectional **research** and understanding the health care needs of LGTBI and GNC youth. While the materials here are exclusively from the U.S., we believe is an area little attended to, within the U.S. or across the many countries that have such systems. Notably, child welfare systems, which ostensibly serve the safety, permanency, and well-being of children, are often intertwined with other regulatory systems (including education and criminal legal systems) and reflect the axes of social exclusion– including race, religion, and sexuality– in their context. Despite these clear connections to the state and discriminatory practices, child welfare systems they are rarely held accountable, either for their health and rights impacts on families (including both natal and potential) or on young people. In the U.S., federal data reporting requirements for child welfare do not include questions related to LGTBI or GNC youth. Further, wider data and research on trans and gender non-conforming youth in these systems – especially youth of color – are particularly limited, with most studies

excluding them and thereby underestimating the true prevalence of LGTBI and GNC youth in the child welfare system.

In addition to the summary of materials below, we include the current factsheets as an annex. As noted, these materials are drawn from on-going research projects: on stigma and cisgenderism, this research is being conducted by a Yale MPH student, Baqar Husain, who contributed to this submission; materials on the child welfare system drawn from the YES project were synthesized by Daniel Newton, one of our current GHJP Fellows.

Please do not hesitate to reach out with any questions or if we can be of further assistance.

Sincerely,

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I. Frame of Analysis: Cisgenderism Operationalized Through Stigma

[This material included here is excerpted from an unpublished, draft essay, by Baqar Husain, submitted in partial fulfillment of the requirements of a graduate level course at Yale University LAW 20568/SBS585/GLBL529/WGSS 529]

Cisgenderism and Stigma

Cisgenderism is the cultural and systemic ideology, embedded within the framework of legal and healthcare domains, that enforces a hierarchy by which individuals are expected to conform to binary, two -gender norms and punished if they do not.[1] Cisgenderism, when operationalized by stigma, denies, denigrates, and or pathologizes self-identified gender identities that do not align with assigned sex at birth as well as resulting behavior, expression, and community.[2]

Stigma has been explicitly defined as a deeply discrediting attribute that reduces the bearer "from a whole and usual person to a tainted, discounted one."[3]

Stigma, a concept employed and variably defined in many multidisciplinary works, has been synthesized and defined by social epidemiologists Link and Phelan as the co-occurrence of four components: labeling, stereotyping, separation, and status loss and discrimination, all in the context of power exercised by hegemonic groups. Following Link and Phelan's typology, stigma is operationalized by cisgenderism to serve three functions: exploitation and domination, norm enforcement, and disease avoidance.[4]

It is through this structural and interpersonal operation that the power asymmetries, inequality, and violence produced by cisgenderism can be mapped and made the subject of reform.

- Labeling: The first component of Link and Phelan's conceptualization of stigma is that of *labeling,* by which differences are socially selected for salience and a label is affixed.[5] Given that gender is the conducting of one's self in accordance to activities and attitudes deemed normatively acceptable for an individual's sex assigned at birth, it is fundamentally through interactions and institutions that the initial assignment of sex and normative expectations for sexed behavior are created, and that deviance from these expectations is sanctioned in legal institutions.[6]
    - Labeling initiates the lifelong involvement with a legal gender system that directs people into "pre-existing gender channels," appearing in multiple domains from gender-specific naming on birth certificates to the listing of sex on medical reports and educational records.[7] This process creates a "dense mesh of documentation"

[1] Madrigal-Borloz, V. (2021). The law of inclusion [Gender report, Part I]. United Nations. https://undocs.org/A/HRC/47/27.
[2] Lennon, E., Mistler, B.J. (2014). Cisgenderism. *Transgender Studies Quarterly*. 1(1-2): 63–64. doi: https://doi.org/10.1215/23289252-2399623.
[3] Bruce G. Link and Jo C. Phelan. (2001). "Conceptualizing Stigma." *Annual Review of Sociology*. pp.363-385.
[4] Phelan, J. C., Link, B. G., & Dovidio, J. F. (2008). Stigma and prejudice: One animal or two? *Social Science & Medicine*, 67(3), 358-367.
[5] Bruce G. Link and Jo C. Phelan, *supra* note 3.
[6] West C, Zimmerman DH. Doing gender. *Gender & Society*. 1987;1(2):125–151.
[7] Carsten, B., Hutta, S.J. (2012). Transrespect versus Transphobia Worldwide—A Comparative Review of the Human-Rights Situation of Gender-Variant/Trans People. https://transrespect.org/wp-content/uploads/2015/08/TvT_research-report.pdf.

that genders people, constructs social relations based on such gender categorizations, and "corrects" or eradicates that which does not conform to gendered norms and expectations.[8]

- Stereotyping: The historical inclusion of terms pathologizing gender variance within the International Classification of Diseases has been one instance in which nonconformity to gender norms is selected for salience and affixed a label in health contexts.[9] This practice was reflective of both institutional labeling of gender variance, and stereotyping due to associations with illness. It is through deviance from anticipated gender norms that trans expressions of gender are denigrated and pathologized.

- Separation: The third component to consider in conceptualizing anti-transgender stigma is the *separation* of transgender and gender variant people resulting from the labeling of gender variance and associations with illness.[10] This is reflective of stigma's functions of both norm enforcement and disease avoidance.[11]
    - The distinctions between the purported "us" and "them" can be indicated in historical portrayals of transgender people as "freaks and perverts" in various media, and as people with illnesses in need of treatment within scholarly journals.[12] This creation of a transgender 'other' is also seen as a result of the requirement of binary sexing of legal documents that underpin everyday interactions, such as birth certificates, passports, and drivers licenses, which places those outside the binary in conditions of "uncategorization" and as disruptors of gender conventions.[13] The historical medical push to "cure" gender variance through sex-reassignment surgeries and requirements for sex reassignment surgery to permit sex-changes on legal documents jointly reinforce binary gender norms and render both transitioned people and other forms of gender variance invisible.[14]

- Status Loss and discrimination: The fourth component of Link and Phelan's conceptualization of stigma is that of *discrimination and status loss,* wherein discrimination emphasizes the producers of rejection and exclusion.[15] In the context of cisgenderism, the labeling and stereotyping of gender variance constructs the rationale for devaluing, rejecting, and excluding transgender people.[16] For instance, the gendering of common identifying documents such as passports and drivers licenses can increase opportunities for experiences of violence and discrimination when expectations of conformity to gender norms are not met.[17] When denied identity documents accurately reflecting their gender identity, transgender and gender variant people are cut off from work opportunities, denied public services, and are subject to systematic, underreported discrimination in a variety of

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[8] Ibid.
[9] Drescher, J., Cohen-Kettenis, P., Winter, S. (2012). Minding the body: Situating gender identity diagnoses in the ICD-11. *International Review of Psychiatry*. 24(6): 568-577
[10] Bruce G. Link and Jo C. Phelan, *supra* note 3.
[11] Ibid.
[12] Meyerwitz, J. (2004). How Sex Changed: A History of Transsexuality in the United States. Harvard University Press.
[13] Carsten, B., Hutta, S.J., *supra* note 7.
[14] Spade, D. (2003). Resisting Medicine/Remodeling Gender, 18 Berkeley Women's Law Journal. pp. 15; White Hughto, J. M., Reisner, S. L., & Pachankis, J. E. (2015). Transgender stigma and health: A critical review of stigma determinants, mechanisms, and interventions. *Social science & medicine* (1982), 147, 222–231. https://doi.org/10.1016/j.socscimed.2015.11.010.
[15] Bruce G. Link and Jo C. Phelan, *supra* note 3.
[16] Ibid.
[17] Spade, D., *supra* note 14.

domains.[18] Considering the disruptiveness of presentation not in alignment with cis expectations for gender expression and the structuring of everyday institutions around gender, not only can common interactions elicit negative reactions, but they may be perceived as threats to the structuring of the very institutions themselves and elicit violent reactions.[19]

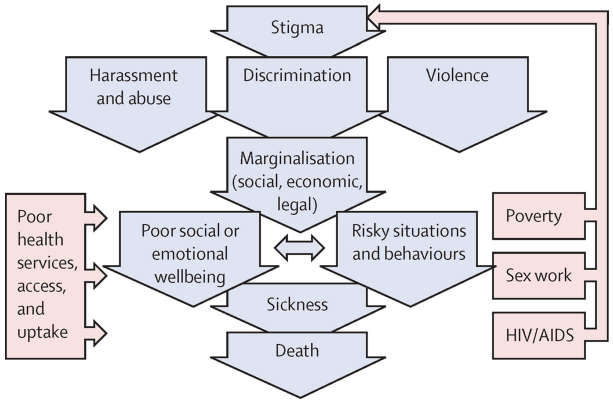
The Stigma-Sickness Slope

The complex relationships and mechanisms linking stigma and discrimination to adverse health outcomes have been usefully depicted in a schematic termed the stigma-sickness slope.[20]

The stigma-sickness slope is conceptualized as an identifiable set of inter-connected power relationships that transgender people are placed in by stigma and prejudice, which in turn produce cascading patterns of discrimination, harassment, and abuse in family, school, work, the provision of services, and in broader society.[21]

This marginalization and discrimination places transgender individuals at risk for poverty and engagement in high risk behaviors, such as risky sex and substance use, that eventually lead to 'sickness' –or more properly, negative health and social outcomes, such as poor mental health and HIV infection, and poverty.[22] The multiple levels and forms of discrimination faced by transgender people and their related impact on health reflect how distributions of health are driven by power, including power constraints, and the ways in which it structures people's engagement the world "and their exposures to material and psychosocial health hazards."[23]

Stigma-Sickness Slope[24]



[18] Carsten, B., Hutta, S.J., *supra* note 7.
[19] Ibid.
[20] Pinkston, M. M., Schierberl, S.A.E. (2020). "Being diagnosed with HIV was the icing on the cake of my life": A case study of fostering resiliency through flexible interventions along the stigma-sickness slope. *Psychotherapy (Chicago, Ill.)*, 57(1), 50–57. https://doi.org/10.1037/pst0000255.
[21] United Nations Development Program. (2012). Lost in Transition: Transgender People, Rights, and HIV Vulnerability in the Asia-Pacific Region. https://www.undp.org/content/dam/undp/library/hivaids/UNDP_HIV_Transgender_report_Lost_in_Transition_May_2012.pdf.
[22] Pinkston, M. M., Schierberl, S.A.E., *supra* note 20.
[23] Krieger N. (2008). Proximal, distal, and the politics of causation: what's level got to do with it?. *American Journal of Public Health*, 98(2), 221–230. https://doi.org/10.2105/AJPH.2007.111278.
[24] United Nations Development Program, *supra* note 21.

The stigma-sickness slope exemplifies embodiment, which refers to how people incorporate, biologically, "the material and social world in which we live."[25] It is through this embodiment of a highly stigmatized social context that vast health inequities arise, such as "significant levels of psychological distress and a disproportionate burden of poor mental and physical health concerns" arising from the instances of discrimination, harassment, maltreatment, and victimization that many transgender people face on a daily basis.[26]

Thus, when conceptualizing stigma, discrimination, and transgender health, causal pathways involving exposure, susceptibility, and resistance should be understood under the auspices of both societal arrangements of power, property, and patterns of production in addition to the constraints and possibilities of biology, which are shaped by evolutionary history, ecologic context, and individual history.[27]

II. LGTBI and GNC Youth Mental Health in the U.S. Child Welfare System

LGTBI and GNC Youth Disparities within the Child Welfare System

Child welfare systems in the U.S. operate at the state and municipal level, with federal policy, including data collection, service quality control and training effected through funding. Identifying accurate numbers of LGTBI and GNC youth within CWS is challenging. Existing data suggests that LGTBI and GNC youth are disproportionately represented within the child welfare system,[28] and these disparities appear to be even more pronounced among LGTBI and GNC youth of color.[29] Scant data exist on trans and non-binary youth in the child welfare system,[30] but existing data suggest that trans and non-binary youth are overrepresented.[31] Further, little data exists on youth enmeshed in both the child welfare and juvenile justice systems, although it is clear that pathways between homelessness, the child welfare and juvenile justice systems, and the criminal legal system are multiple, often depending, variously, on a child's specific reaction to abuse,[32] parents' use of the criminal law to cast their child as a victim in consensual same-sex encounters that they find abhorrent,[33] or circumstances following running away or being kicked out.[34] There is also little research on non-national LGTBI and GNC youth or LGTBI and GNC youth nationals whose parents are non-nationals.

Existing research suggests that disproportionate representation in the child welfare system may be the result of:

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[25] Krieger N., *supra* note 23.
[26] Pinkston, M. M., Schierberl, S.A.E., *supra* note 20.
[27] Krieger N., *supra* note 23.
[28] *See, e.g.*, Baams, L. Wilson, B.D.M. & Russell S.T. (2019). LGBTQ Youth in Unstable Housing and Foster Care. *Pediatrics*, 143(3), e20174211.
[29] *See, e.g.*, Detlaff, A.J. et al. (2018). Lesbian, gay, and bisexual (LGB) youth within in welfare: Prevalence, risk and outcomes. *Child Abuse Negl*, 80, 183–193. doi: 10.1016/j.chiabu.2018.03.009.
[30] Marksamer, J. in (2008). Mischief and Mayhem: A Symposium on Legal Issues Affecting Youth in the Child Welfare and Juvenile Justice Systems. *Cardozo Journal of Law & Gender*, 14, 609–703.
[31] *See, e.g.*, The Trevor Project. (2021). The Trevor Project Research Brief: LGBTQ Youth with a History of Foster Care.
[32] *See, e.g.*, Majd, K., Marksamer, J.and Reyes, C. (2009). Hidden Injustice: Lesbian, Gay, Bisexual and Transgender Youth in Juvenile Courts. National Center for Lesbian Rights.
[33] *See, e.g.*, Wilber, S., Ryan, C. and Marksamer, J. (2006). CWLA Best Practice Guidelines: Serving LBGT Youth in Out-of-Home Care. Child Welfare League of America.
[34] *See, e.g.*, Marksamer, J. (2011). A Place of Respect: A Guide for Group Care Facilities Serving Transgender and Gender Non-Conforming Youth. National Center for Lesbian Rights.

- structural drivers, such child removal at a higher rate for LGTBI and GNC youth than cisgender/heterosexual youth for the stated rationale of abuse and neglect;[35] limited existing community-based services to support families of LGTBI and GNC youth, particularly for families of color and non-English speaking families;[36] and, for lower SES families and families of color, structural forces influencing levels of family instability, which subsequently impacts the likelihood of interaction with the child welfare system;
- community-level drivers, such as LGTBI and GNC youth having a higher risk of experiencing child maltreatment compared to youth who are heterosexual;[37] LGTBI and GNC youth being voluntarily placed in foster care or out-of-home placements by families filing PINS/CHINS petitions;[38] family rejection/conflict with caregivers over sexual orientation and/or gender identity leading to child welfare system entry,[39] and also impacting the ability of LGTBI and GNC youth to reunify or establish permanency within immediate and extended family networks, leaving youth stuck in the child welfare system and/or the juvenile justice system;[40]
- individual-level drivers, such as higher rates of mental health issues/substance use among LGTBI and GNC youth.

Additional research is needed on:

- the root causes of the disproportionate representation LGTBI and GNC youth in child welfare, including which factors influence higher rates of child maltreatment for LGTBI and GNC youth, and neighborhood-level drivers for CWS involvement LGBTQ youth of color;[41]
- the role of sexual orientation and gender identity expression in relation to the risk of child welfare involvement, particularly intersectional research that examines how sexual orientation and gender identity affects risk among youth of color;
- the acceptance/affirmation LGTBI and GNC youth within families of color, including research that challenges covert racialized assumption that family rejection is the primary pathway by which LGTBI and GNC youth of color end up overrepresented in child welfare, looking at structural disadvantage as a root cause;[42]
- the role of education systems on the trajectories to child welfare among LGTBI and GNC youth, who may be invisible within adolescent health surveillance systems;[43]
- how immigration and nationality affect pathways into the child welfare system for LGTBI and GNC youth.

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[35] *See, e.g.*, Majd, K., Marksamer, J.and Reyes, C., *supra* note 32.
[36] Robinson, B. A. (2018). Child welfare systems and LGBTQ youth homelessness: Gender segregation, instability, and intersectionality. *Child Welfare*, 96(2), 29–45.
[37] *See, e.g.*, Friedman, M.S. et al. (2011). A meta-analysis of disparities in childhood sexual abuse, parental physical abuse, and peer victimization among sexual minority and sexual nonminority individuals. *American Journal of Public Health*, 101(8), 1481–94.
[38] Mountz, S. (2018). 'Because We're Fighting to Be Ourselves:' Voices from Former Foster Youth who are Transgender and Gender Expansive. *Child Welfare*, 96(1), 103–125.
[39] Newcomb, M. E. et al. (2019). The influence of families on LGBTQ youth health: A call to action for innovation in research and intervention development. *LGBT health*. 6(4), 139–145.
[40] Mountz, S. and Capous-Desyllas, M. (2020). Exploring the families of origin of LGBTQ former foster youth and their trajectories throughout care. Children and Youth Services Review. 109, 104622–104622.
[41] Majd, K., Marksamer, J.and Reyes, C., *supra* note 32.
[42] Jones, L.V. et al., (2019). A Black feminist approach for caseworkers intervening with Black female caregivers. *Journal of Public Child Welfare*, 14(4), 395–411.
[43] *See, e.g.*, Palmer, N. A., & Greytak, E. A. (2017). LGBTQ Student Victimization and Its Relationship to School Discipline and Justice System Involvement. *Criminal Justice Review*, 42(2), 163-187.

Worse Treatment of LGTBI and GNC Youth than Cisgender/Heterosexual Peers

LGTBI and GNC youth in the child welfare system are more likely to experience discrimination, harassment, and victimization from caseworkers, foster parents, program staff, and/ or peers.[44] LGTBI and GNC youth are also more likely to experience placement instability, with a higher likelihood of experiencing multiple placements[45] and placement in congregate care, such as in group homes or restrictive settings, including isolation.[46] LGTBI and GNC youth have less access to formal and informal supportive relationships with adults,[47] and to affirming services.[48]

Existing research suggests structural drivers for worse treatment include:

- lack of formal anti-discrimination protections for persons in child welfare systems
- lack of affirming/protection policies[49] or mandatory training, or institutional practices, regarding LGTBI and GNC youth within state child welfare systems. For example, most out-of-home care placements and facilities are sex-specific, and many aspects of youths' supervision and care are governed by regulations that reference a youth's sex assigned at birth or perceived gender identity;[50] and there is a lack of screening in foster care for biases against LGTBI and GNC youth.[51]
- drivers related to enhanced risk for multiple placements, such as peer victimization,[52] stigmatization through child welfare system staff viewing LGTBI and GNC youth behavior as 'problematic',[53] lack of foster parents willing or able to accept and provide supportive homes to LGTBI and GNC youth,[54] including due to discrimination against and/or the refusal to certify LGTBI and GNC people as foster parents,[55] and safety concerns in non-affirming placements leading LGTBI and GNC youth to leave or run away;[56]
- structural racism resulting in greater challenges for placement permanency among LGTBI and GNC youth of color, including LGTBI and GNC youth of color being placed at a higher rate in congregate care settings where violence, heterosexism, and trans bias are potentially more frequent;[57]

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[44] *See, e.g.*, Wilson, B.D.M. and Kastanis, A.A. (2015). Sexual and gender minority disproportionality and disparities in child welfare: A population-based study. *Children and Youth Services Review*, 58(C), 11-17.
[45] *See, e.g.*, Wilber, S., Ryan, C. and Marksamer, J. (2006), *supra* note 33.
[46] *See, e.g.*, Sullivan, C., Sommer, S., & Moff, J. (2001). Youth in the margins: A report on the unmet needs of lesbian, gay, bisexual, and transgender adolescents in foster care. Lambda Legal Defense & Education Fund.
[47] Elze, D. (2014). LGBT youth and their families. In G. P. Mallon & P. M. Hess (Eds.), *Child welfare for the twenty-first century: A handbook of practices, policies, and programs* (pp. 158–178).
[48] *See, e.g.*, Mountz, S., *supra* note 38.
[49] *See, e.g.*, Remlin C.W., Cook M.C., and Erney R. (2017). Safe havens: Closing the gap between recommended practice and reality for transgender and gender-expansive youth in out-of-home care. Lambda Legal with Children's Rights and the Center for the Study of Social Policy.
[50] *See, e.g.*, Robinson, B. A., *supra* note 36.
[51] Clements, J.A. and Rosenwald, M., Foster Parents' Perspectives on LGB Youth in the Child Welfare System. *Journal of Gay & Lesbian Social Services*, 19 (1), 57–69.
[52] *See, e.g.*, Elze, D., *supra* note 47.
[53] *See, e.g.*, Laver, M. and Khoury A. (2007). Opening Doors for LGBTQ Youth in Foster Care. American Bar Association.
[54] Mallon, G.P. (2011). Child Welfare For The Twenty-First Century: A Handbook Of Practices, Policies, And Programs.
[55] *See, e.g.*, Fulton v. City of Philadelphia, 593 U.S. __ (2021).
[56] Mallon, G. P., Aledort, N., & Ferrera, M. (2002). There's no place like home: Achieving safety, permanency, and well-being for lesbian and gay adolescents in out-of-home care settings. *Child Welfare*, 81(2), 407–439.
[57] Freundlich, M., & Avery, R. J. (2005). Planning for permanency for youth in congregate care. *Children and Youth Services Review*, 27(2), 115–134

- drivers related to an enhanced risk of being placed in more restrictive settings, such as increased victimization and/or lack of foster/adoptive parents willing to place LGTBI and GNC youth, restrictive placements chosen for safety rather than therapeutic reasons,[58] or a history of placement in restrictive setting leading to a youth being labeled as 'difficult' informing future placement decisions and limiting options for foster care or adoption.

Additional research is needed on:

- the experiences, needs, or preferences of LGTBI and GNC youth of color;
- how to prevent harm and promote positive outcomes for LGBTQ+ once they are involved in the child welfare systems, including how to reduce violence perpetrated against youth by staff and other adults involved in these systems,
- access to employment and safe, affordable housing, and support for decision-making once emancipated from these systems.

Worse Outcomes for LGTBI and GNC Youth than Cisgender/Heterosexual Peers

LGTBI and GNC youth in the child welfare system are more likely than cisgender/heterosexual peers to meet the criteria for adverse mental health outcomes, to be hospitalized for emotional and physical reasons,[59] are more likely to attempt suicide, and reported three times greater odds of reporting a past-year suicide attempt compared to LGTBI and GNC youth who had not been in the child welfare system.[60] They are also more likely to experience homelessness,[61] poorer school functioning,[62] become enmeshed in multiple systems,[63] including the criminal legal system, have greater risk for substance use,[64] greater rates of sexual risk behaviors,[65] are face increased challenges in transitioning from the child welfare system to adult living.[66]

Existing research suggests structural drivers for worse outcomes include:

- poor discharge planning, combined with systemic discrimination and racism, including LGTBI and GNC youth, especially youth of color, being labelled as 'difficult' and consequently receiving less responsive care or even being discharged at age 18 for 'non-compliance' with little planning in place;
- limited effective transitional programs for transition-aged LGTBI and GNC youth;

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[58] *See, e.g.*, Elze, D., *supra* note 47.
[59] *See, e.g.*, Wilson, B.D.M. and Kastanis, A.A., *supra* note 44.
[60] *See, e.g.*,The Trevor Project, *supra* note 31.
[61] *See, e.g.*, Zlotnick, C. (2009). What research tells us about the intersecting streams of homelessness and foster care. *American Journal of Orthopsychiatry*, 79(3), 319–325.
[62] *See, e.g.*, Mountz, S., *supra* note 38.
[63] *See, e.g.*, Irvine, A. (2015). The Overrepresentation of Lesbian, Gay, Bisexual, Questioning, Gender Nonconforming and Transgender Youth Within the Child Welfare to Juvenile Justice Crossover Population. *Journal of Gender, Social Policy & the Law*, 24(2), 243–261.
[64] Salomonsen-Sautel S. et al. (2012). Medical marijuana use among adolescents in substance abuse treatment. *Journal of the American Academy of Child and Adolescent Psychiatry*, 51, 694–702.
[65] VanLeeuwen, J.M. et al. (2006). Lesbian, gay, and bisexual homeless youth: an eight-city public health perspective. *Child Welfare*, 85(2), 151–70.
[66] *See, e.g.*, Mitchell R.C. et al. (2015). Sexual Minority and Heterosexual Former Foster Youth: A Comparison of Abuse Experiences and Trauma-Related Beliefs. *Journal of Gay & Lesbian Social Services*, 27(1), 1–16.

- contributing risk factors related to other intersecting vulnerabilities, including racism, sexism gender identity/sexual orientation, poverty/socioeconomic class, etc.

Finally, greater attention must be paid to supports for, and legal protection against discrimination for all families of LGTBI and GNC, both natal families and prospective, including adoptive families. Failure to address discrimination against non-traditional families is inextricably linked to health justice, as the rights and mental and physical health of members of these families is also of great concern.