



# **LGBTQ Population Evaluation Guidelines**

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## Introduction

### ***Community-Based Programs, Community-Defined Evidence, and LGBTQ Mental Health***

Communities in need have traditionally pooled resources and worked together to address shared problems using strategies they perceive to be effective in addressing those needs. **Lesbian, Gay, Bisexual, Transgender, Queer and Questioning (LGBTQ)** communities have been no different. Living in hostile and discriminatory environments associated with poor mental health and wellness, LGBTQ individuals who turn to mainstream mental health services providers too often receive assistance that fails to fully value, understand, and support their needs. LGBTQ populations have historically been either unserved, underserved, or inappropriately served by mental health services providers, and the lack of effective care has produced well-documented mental health disparities: higher rates of suicide attempts among LGBTQ youth, higher levels of anxiety and depression among LGBTQ adults and elders, higher rates of substance use disorders, etc.

To reduce mental health disparities, LGBTQ community members have established innovative, community-based programs and practices to address community needs. Designing innovative programs presents challenges. In the absence of evaluation research into whether existing models of service are effective with LGBTQ populations, LGBTQ community-based programs have implemented models of service that held validity as the community defined it. A **Community Defined Evidence Program or Practice (CDEP)** refers to a grassroots response to community problems that are otherwise not effectively addressed by existing programs and practices grounded in evaluation science.

What has emerged and evolved over time are a myriad of community-based organizations and services validated by community-defined evidence: LGBTQ community centers and clinics, social and emotional support groups designed for LGBTQ people on issues relevant to their lives, LGBTQ-inclusive spiritual and religious organizations, school-based anti-bullying and anti-suicide campaigns, and gay/straight alliance clubs at high schools, colleges and universities. LGBTQ community-based programs provide an array of services across multiple sectors such as public health, social services, mental health, education, and housing.

New CDEPs continue to emerge and evolve. As seen in other communities, services have historically focused on the needs of the wealthiest – gay white cisgender men – and have marginalized those less privileged. As more community members are being awakened to the injustice of this historical bias, LGBTQ community-based programs are increasingly being designed by and for LGBTQ+ communities in all their diversity, inclusive of people of color and people across the full spectrum of gender and sexuality.

LGBTQ CDEPs share a commitment to improving the quality of community life by addressing priority needs related to wellness so LGBTQ individuals, families, and communities can thrive. Creating an environment where LGBTQ health and wellness problems are prevented or addressed through early intervention reduces negative mental health outcomes. In public health terms, LGBTQ CDEPs are considered mental health **Prevention and Early Intervention (PEI)** programs: they reduce disparities in mental health by increasing access to supports that effectively improve LGBTQ mental health by addressing potential mental health problems before they develop or as they begin to emerge.

## ***Benefits of Evaluating a CDEP***

LGBTQ-serving programs are deeply dedicated to being effective and responsive in what they are doing, but few have consistently had the resources to support rigorous program evaluation. For those who do, program managers can use evaluation data to continuously improve program services as well as to showcase program achievements to the LGBTQ community at large. Positive outcomes and community support can be used to demonstrate to potential funders that the program is effective, valued and should be sustained. Evaluating a CDEP is a way to support long-term sustainability.

In general, evaluation questions fall into five main groups:

- **Implementation:** Were your program's activities put into place as originally intended?
- **Effectiveness:** Did your program achieve the goals and objectives it was intended to meet?
- **Efficiency:** Are your program's activities being implemented with appropriate use of resources (e.g., budget, staff time)?
- **Cost-effectiveness:** Do the program gains exceed the cost of producing the programs?
- **Attribution:** Can the outcomes achieved be linked to the program, as opposed to other factors?

## ***Organization of the LGBTQ Population Evaluation Guidelines***

The LGBTQ Population Evaluation Guidelines (the Guidelines) were developed during Phase II of the **California Reducing Disparities Project (CRDP)**, an initiative funded by the Office of Health Equity at the California Department of Public Health. CRDP was developed in response to well-documented mental health disparities that impact communities that have been historically unserved, underserved, and inappropriately served. The initiative seeks to identify solutions that reduce or eliminate disparities and improve mental health for five populations: African Americans; Asians and Pacific Islanders; Latinos; Native Americans; and LGBTQ. Building upon promising community practices and strategies for systems change identified in Phase I, CRDP Phase II focuses on supporting seven community-based organizations within each population group over six years so they can effectively implement innovative programs and demonstrate community-defined evidence to reduce mental health disparities.

The Guidelines provide guidance to CRDP Phase II Grantees as well as other mental health PEI service providers and evaluators addressing the effectiveness and impact of program services for LGBTQ individuals, families, and communities. They are organized into the following seven sections:

- 1) Prioritizing Community Representation. The first section introduces the **community-based participatory research** framework that grounds evaluation plans in a process that engages community stakeholders and ensures they are involved throughout all evaluation processes from needs assessments, through exploration of how the CDEP addresses a community need, to the interpretation of evaluation findings.
- 2) Describing the Program. The second section introduces the concepts of **theories of change** and **logic models**, two foundations of evaluation planning that tie program services to how the community understands the problem, identifies its potential causes, proposes solutions, and specifies what evidence would signal success. It begins by describing how to conduct a community needs assessment, select a population of focus, and identify desired outcomes. It concludes by describing how to tie it all together visually in a manner that supports rigorous evaluation of program effectiveness.
- 3) Selecting an Evaluation Design. The third section of the Guidelines compares various types of **evaluation approaches** to weigh their relative merits within real world constraints at the

program level. Options include experimental designs, quasi-experimental designs, and non-experimental designs.

- 4) Assessing CDEP Implementation through Process Measurement. The fourth section describes how the collection of **process measures** can be used to document program outputs, monitor community engagement, and contextualize outcome findings.
- 5) Accounting for Demographic Differences. The fifth section details options for collecting data on **sexual orientation and gender identity (SOGI)** and other demographic factors impacting program engagement outcomes. It begins with a discussion of terms used in recent surveys and how community members responded to those options, and concludes with community-based recommendations for collecting SOGI data.
- 6) Collecting Data with LGBTQ Cultural Competence. The sixth section presents a discussion of **cultural and linguistic considerations** when collecting data from LGBTQ populations.
- 7) Analyzing and Reporting Findings to LGBTQ Community Stakeholders. The final section discusses how CDEP evaluation findings can be analyzed and utilized to improve program services, expand program reach, and achieve program sustainability.

The Guidelines will be a living document grounded in prevention research science, the community-based participatory findings of the CRDP Phase I LGBTQ population report “First, Do No Harm,” and the evolving opinions and perceptions of the LGBTQ communities we aim to serve. Annual updates will be posted at the CRDP LGBTQ TA Center website each April through the end of the CRDP initiative in 2022.

## Prioritizing Community Representation

The seven LGBTQ-serving organizations funded through CRDP adopt a CBPR approach that engages LGBTQ community stakeholders as partners in the evaluation of their CDEPs. When evaluating CDEPs it is crucial to engage the community that created the program or practice to help evaluators. Community members can help articulate the CDEP’s theory of change, develop a logic model, and identify measures of success. This input should be reflected in the evaluation plan using community-based participatory research. **Community-Based Participatory Research (CBPR)** involves community members and key stakeholders as partners in all phases of program development, evaluation planning, and reporting. Stakeholders can include anyone who has an interest or stake in your evaluation findings, including:

- Funders or donors
- Program staff
- LGBTQ community members and program participants
- Family members or allies of LGBTQ individuals
- Partner agencies or organizations such as education, housing, and mental health provider associations
- Members of the community at large

Advantages of participatory evaluation include:

- Increased responsiveness to community needs
- Increased relevance for user audiences
- Improved cultural appropriateness of methods
- Increased validity of findings
- Increased trust and community ownership of the evaluation process



- Potential for broader dissemination of findings
- More effective use of findings to guide program improvements

## ***Community Advisory Boards***

**Community Advisory Boards (CABs)** can offer a formal structure for bringing together members of the LGBTQ community as part of a CBPR approach and for ensuring that program planning, implementation, and evaluation processes are grounded in and relevant to the communities being served. The ideal is to engage representatives from the community from the initial phase of the planning process through implementation and evaluation, with the aim of establishing basic agreements on how the program and its evaluation will address a priority need in the community. Priority needs addressed by CRDP LGBTQ CDEPs include, but are not limited to:

- Promoting mental health and wellness
- Improving personal, family and community well-being
- Increasing access to transition-related primary health care
- Decreasing disparities in access to mental health supports and services
- Preventing mental illness
- Preventing early signs of mental illness from getting worse

When forming an advisory board, it is important to clearly outline expectations for membership and continuing participation, including roles and responsibilities and intensity and duration of participant involvement. Programs should also determine how the CAB will engage with the Board of Directors. If the CAB is initially an informal group, it can be formalized with clear advisory role to the organization, either directly through the staff, or potentially as a sub-committee of the Board of Directors. The CAB can serve multiple key functions: liaisons to segments of a community, advocates for the importance of an initiative, and champions in various arenas such as the policy/legislative process, various health and human service administrations, the school district, and elected officials. CABs can be used to review plans and weigh in on each stage of program development and evaluation planning.

When working within LGBTQ communities, ensuring inclusivity and broad community representation may involve taking steps to address transportation barriers and communication needs as well as privacy and confidentiality concerns of community members who have chosen not to publicly disclose their sexual orientation or gender identity, or who wish to avoid anti-LGBTQ stigma. Strategies may include holding meetings off-site or remotely via conference call and providing translation or transportation services when needed.

## **Describing the Program**

Prior to CDEP planning, implementation, or evaluation is the need to describe the program. What community needs will it address? Which community members will the program aim to serve? What outcomes would signal success, and how will they be measured?

The next step is to consider the overall environmental context in which the CDEP will seek change. What factors will impact the success of the CDEP? What assumptions and hypotheses are built into the CDEP model? What intermediate outcomes or preconditions must be met before long term change can occur? What indicators can be used to assess intermediate outcomes or preconditions?

After these questions are answered, a visual representation of the CDEP can be prepared that details all program inputs, activities, outputs, and outcomes with the specificity required to evaluate the CDEP with scientific rigor.

## ***Gathering Information on Community Needs***

Needs assessment is a critical planning step that is used to identify priority needs or issues within the community that may be addressed through programming or policy change. Conducting one helps program planners understand the context, strengths, opportunities, and challenges that a community faces. The needs assessment process can also involve mapping of existing resources in the service environment and identifying gaps in service systems. During the community needs assessment phase of program planning, multiple information or data sources can be analyzed that will inform or support the needs to be addressed. Accessing multiple data sources will increase the comprehensiveness of knowledge about the problem and improve program and evaluation planning. Local, city or county health epidemiological or service utilization data can be a good starting point. When characterizing the problem, look for:

- Prevalence
- Trends
- Disparities between groups
- Severity of harm
- Amenability to change or mitigation

A significant challenge for LGBTQ-serving programs or providers is that many secondary data sources traditionally used in needs assessment efforts cannot be disaggregated by sexual orientation or gender identity and so fail to reflect the unique experiences of LGBTQ communities. One solution is to use data extrapolation to assess the size of a service population or needs within a community. For example, if information on the size of the LGBTQ community is not available for a geographic area, use national or state percentages and apply percentages to the geographic area of interest. For programs serving school populations, use data from GLSEN's national sample and apply percentages to local school populations to estimate the number of LGBTQ youth who are impacted by bullying and harassment.

Another challenge can be ensuring data on community needs represents the needs of everyone in the community. A CAB that is inclusive and representative of the broad community can help confirm that information gathered through the needs assessment process is broadly representative of the entire LGBTQ community, including community members who belong to other groups (e.g., racial, religious, economic, or disability) who may have reason to be more reluctant to identify to others their sexual orientation or gender identity. Demographic data on regional diversity can also be used to determine whether the available needs assessment data is representative of everyone in the community or will require augmentation by other sources or methods.

When population-level data on community needs is not available and cannot be extrapolated from other sources, programs may choose to rely more heavily on grassroots, primary data collection strategies that can be customized to the specific areas of need and service populations of interest. Examples of primary data collection strategies that can complement epidemiological data include focus group discussions, community dialogue (e.g., community town hall meetings), key informant interviews, and community surveys that can help gauge the needs of the community as its members experience them.

For existing programs, records reporting the number and characteristics of community members served provide a measure of whom programs have successfully reached and who might be underrepresented in the service population. Examples include:

- Information on place of residence can tell you which geographic areas present transportation barriers that may make program services less accessible to potential participants.
- Data on the race, culture, and language of participants will tell you if you have adequately appealed to different cultural communities or have offered linguistically accessible services.
- Waiting lists give you a sense of service demand that is not currently being met with existing resources.
- Attrition and retention data may point to issues related to service relevance or overall quality and cultural responsiveness.

Once obtained, service population data can establish benchmarks of effective service. For example, how many LGBTQ community members could benefit from your program within your service region? How are they distributed between categories like lesbian, gay, bisexual, transgender, queer, questioning, and other terms used locally to describe sexuality and gender? How is the LGBTQ community you serve diverse by race, ethnicity, language, and other intersectional service needs?

## Focus Groups

Focus groups are one way to collect information on the knowledge, attitudes, and beliefs of a select group of people. Group members can be selected based on commonalities related to a topic, such as people who will benefit from a new program or policy, or people who have the power to change policies related to the topic. Focus groups help program stakeholders gain insight into what motivates a change in knowledge, attitudes, and beliefs towards the priority health need the program will address. They are usually held with a group of no more than 15 participants and include both a discussion facilitator as well as a scribe. A focus group guide is usually developed containing discussion prompts that are open-ended with suggested wording and probes to address the underlying topic. Questions used to gather information during CRDP Phase I included:

- What in your [city, county, or region] makes it easier to be LGBTQ?
- What supports or services are needed to improve the lives of LGBTQ people in your [city, county, or region]?
  - What gaps in services currently exist?

Other questions could include:

- What challenges have you experienced in accessing existing services that would potentially make it easier to be LGBTQ in your [city, county, or region]?
- What solutions have you found to overcome those challenges to service access in your “[city, county, or region]”?

As with other techniques to obtain information on sensitive topics related to sexuality and gender, it is essential to first establish a safe space where privacy and confidentiality are assured. Facilitators should adapt discussion prompts to match the vernacular of participants, to respond appropriately to group dynamics, and to add depth to the information gathered. Facilitators should also ensure that all participants have an equal opportunity to contribute.

## Key Informant Interviews

Key informant interviews are like focus groups except they are held with a single individual at a time. Key informants are selected due to their unique and/or extensive knowledge of a topic related to assessing the need for, planning, implementing, or evaluating a program or service. The technique is otherwise similar to focus groups in establishing an atmosphere of confidentiality and trust, asking open-ended questions, and following up responses with additional probes to gain in-depth knowledge on the topics of interest.

## Public Opinion Polls

Quantitative measures like public opinion polls can be paired with qualitative focus group and key informant findings to gauge the representativeness of qualitative findings within the population of focus. When working with LGBTQ populations, conducting a public opinion poll often involves convenience sampling from bars, community centers, LGBTQ neighborhoods, inclusive religious and spiritual organizations, and other areas where LGBTQ people congregate. Another strategy is using social media surveys with a “snowball sampling” design where respondents fill out an online survey and forward the link to other community members who then fill out the survey and forward the link to their friends and acquaintances until the process snowballs into a large sample size. The snowball effect can be enhanced by offering incentives such as entering the first 100 respondents in a raffle. Participants interested in the raffle can add their contact information and programs can mail a gift card that does not identify the source. This option can help reach individuals who are not ready to publicly disclose. Social media such as Facebook and Instagram can be particularly effective when sampling teens, young adults, and regions where no areas exist where openly LGBTQ people congregate in sufficient numbers to support a convenience sample.

## ***Selecting a Population of Focus***

Identifying specific community groups and individuals that a program will serve begins with an assessment of the community needs data you have gathered. As when characterizing the problem, when selecting a population of focus look for:

- **Prevalence**: Which community groups and individuals experience the highest rates of the priority need? Which experience lower prevalence of need?
- **Trends**: Which groups and individuals are experiencing an increase in the priority need over time? Which ones are experiencing a decrease in need over time?
- **Disparities in access to existing providers**: What differences exist between groups in the necessity for your CDEP to address the priority need?
  - Do some individuals have health coverage and transportation that provides them access to culturally responsive mental health services that address the priority need?
  - Do some individuals or groups have no access to services at all, or only to services that are ineffective and culturally or linguistically incompetent?
- **Severity of harm**: Which groups and individuals are most likely to experience mental distress or harm if the priority need is left unaddressed? Who are the most vulnerable members of your community in regard to the priority need?

- **Amenability to change or mitigation:** Which individuals or groups are most likely to benefit from your CDEP? Whose needs are beyond the capacity of your CDEP to impact in a meaningful way?
- **Resource availability.** Which individuals or groups are most likely to benefit from your program given the resources you have to conduct outreach and implement your CDEP?
  - Can your CDEP rollout with a population of focus limited by resource availability, then increase its scope and breadth over time to include more community members and groups?

**Community awareness of need.** Another way to select a population of focus for your CDEP is in response to a specific incident that occurred in the local LGBTQ community that highlighted deficiencies in existing health care delivery systems, or problems in how law enforcement or social service responders reacted to a community need. If the incident engendered broad outrage and a call to arms within a community motivated and able to support and sustain a CDEP that can prevent the incident from recurring within that population, focusing on community members and groups most susceptible to that specific harm is a way to create a CDEP with broad community support and sustainability.

Each community determines who will be the priority population of focus for the proposed CDEP being evaluated. The justification or rationale provided for identifying the population of focus will serve as a foundation for building relationships, attracting community support, and obtaining financial sustainability. If the population of focus does not include community members or groups directly affected by the priority need who did not have a voice in the decision-making process, or who were not included in the needs assessment data collection effort, conflict may ensue. Such conflict provides an opportunity for leadership to build organizational capacity to ensure that inclusive, representative practices are used moving forward that can ameliorate and prevent missteps and errors that occurred in the past.

## ***Identifying Outcomes***

Outcome evaluation measures translate the goals that the CDEP aims to achieve into concrete indicators of change in policy, practice or climate or culture, or attitudes, feelings, or levels of functioning.

CDEP outcomes should be SMART:

- **Specific:** Define what you want to achieve in clear, concrete terms.
- **Measurable:** Include quantitative targets for measuring achievement.
- **Achievable:** Ensure that outcomes fall within the scope of the program's control or sphere of influence.
- **Realistic:** Ensure that outcomes can be reasonably achieved with available resources and within specified timelines.
- **Time-Bound:** Include target dates for when outcomes will be accomplished.

For example:

*By the end of Year 1, 80% of LGBTQ seniors attending program-sponsored events will report increases in sense of social support, community connectedness, and wellness as measured by increases on pre-post surveys.*

Outcomes used in previous evaluations of similar programs can be a starting point for selecting outcome measures. Community participatory methods will also help identify:

- What results do you want to see?
- How will you know that the program is successful?

When selecting the language for your outcome measures, engaging community stakeholders in defining desired outcomes will help ensure buy-in. LGBTQ individuals and communities have historically experienced a medical model of psychological and psychiatric treatment that pathologizes their identities. Transgender individuals seeking transition-related health services continue to be required to first see mental health providers before gaining access to treatments and surgeries available to cisgender individuals without mental health examination. It is therefore important to differentiate in your outcome measures why an individual is accessing mental health care: in response to systemic gatekeeping required to access transition-related care essential to living authentically and maintaining mental wellness, or in response to actual mental health concerns and conditions that need addressing to achieve mental wellness? For many transgender individuals experiencing psychological distress, simply gaining access to culturally competent health services is all that is needed to achieve mental wellness.

Emerging, community-defined practices avoid the use of stigmatizing labels associated with the medical model of “mental illness” which has been used historically to inappropriately serve LGBTQ community members. A more strengths-based model of mental wellness and resiliency that acknowledges the role of societal prejudice and discrimination on mental wellness would generate evaluation objectives and measures more culturally acceptable within LGBTQ communities. These objectives and measures often relate to systems change, including the role of stigmatizing climates such as schools and traditionally oppressive systems of health care.

Examples of strength-based measures include:

- What are some of the biggest barriers/obstacles you have faced as an LGBTQ person?
- What did you do to cope with the challenges you encountered?
- How did you learn to cope with the challenges you experienced?
- Do you recall if you had positive and/or supportive role models?

LGBTQ-serving programs have advocated for a paradigm shift in how mental illness is conceptualized within the LGBTQ community. Specifically, LGBTQ stakeholders note that symptoms of mental illness are often manifestations of the psychological harm LGBTQ people experience as the result of pervasive discrimination, persecution, and denial of personhood. There is a need to acknowledge that the symptoms labeled “mental illness” may be understandable – even contextually functional – ways to react psychologically to social harms, in the absence of appropriate mental health services and community support. There is also the need to clarify that the “mental illness” risks discussed relate to what may happen if the individual’s essential survival needs are not met due to discrimination, if they are otherwise harmed psychologically due to discrimination, and if culturally responsive primary and mental health care is not available to them.

This change in focus from individual pathology to personal wellness and systems-level change will help reduce the stigma perceived by LGBTQ populations interacting within a medical model of receiving services from mental health prevention and early intervention providers.

## Quantitative Data Sources

Quantitative data is numerical in nature and generally collected via surveys and polls. Questions and responses are attached to a code, and scales are developed to measure the effect or impact of an intervention. Quantitative data can provide information about whether a finding is random or statistically significant.

## Qualitative Data Sources

Qualitative data sources capture information that is not directly translatable into numbers, such as conversations recorded during key informant interviews, focus groups and town hall meetings, and information provided through personal testimonial and “fill in the blank” or “Other: Specify” fields embedded in quantitative surveys. Observational data can also be qualitative in nature. Qualitative data is exploratory in nature, used to gain in-depth understandings of complex knowledge, attitudes, and beliefs underlying how a population of focus thinks about a topic of interest. It can be used to refine service provision and to generate hypotheses that drive further research. It can also be used to develop quantitative measures that through population sampling can explore how widespread findings from qualitative sources apply to a population of focus.

Data obtained from qualitative sources serves to identify concerns and needs, priorities, action steps or plans, and how to know if something is working or is effective. Qualitative data provides context and can be used to help interpret quantitative findings. Qualitative data collection methods also can be used to explore matters of cultural competency that would be impossible to understand through quantitative methods alone.

## Mixed Methods Data Sources

A mixed-methods approach to outcome data utilizes both qualitative and quantitative data collection and analysis. While the collection of quantitative outcome measures is critical to evaluating program services, qualitative data can help provide depth and meaning to participant’s experiences with perceived barriers and successes.

## ***Creating a Theory of Change and Logic Model***

### Theories of Change

All programs embody an informal theory of change, explicitly or implicitly. A formal Theory of Change is a tool that captures the big picture of everything that impacts the change desired by the stakeholder community, including influences related to the environment or context that are outside control. The tool shows all of the pathways to change that are known to be true as well as assumptions and hypotheses. The tool helps complete the sentence “if we do X then Y will change because...”. It defines long-term goals and then maps backwards to identify necessary preconditions in order for change to occur. Necessary preconditions then become the intermediate goals that intervention strategies aim to influence. Creating one is a good way to clarify:

- How does the community perceive/conceptualize/think about the priority need?
- What change outcome is desired by the community?
  - Who or what will change?
  - What changes will occur in the short, intermediate, and long terms?
- What factors does the community perceive as contributing in some way for the desired change to occur? How are they related to the long-term goal?
  - What does the community perceive as protective factors? In other words, what things are considered helpful for the desired change to occur?
  - What does the community perceive as risk factors? In other words, what things are considered unhelpful for the desired change to occur?



- According to the community, what should be done?
  - What assumptions are imbedded for the strategy to create change?
  - What can be influenced?

Long-term mental health PEI outcomes can include:

- LGBTQ youth feel safe and socially included at school.
- LGBTQ community members do not experience disparities in mental health.
- LGBTQ community members have survival needs met.
- LGBTQ community members can live an open and authentic life.
- LGBTQ seniors feel socially included.

Intermediate-term mental health PEI outcomes can include:

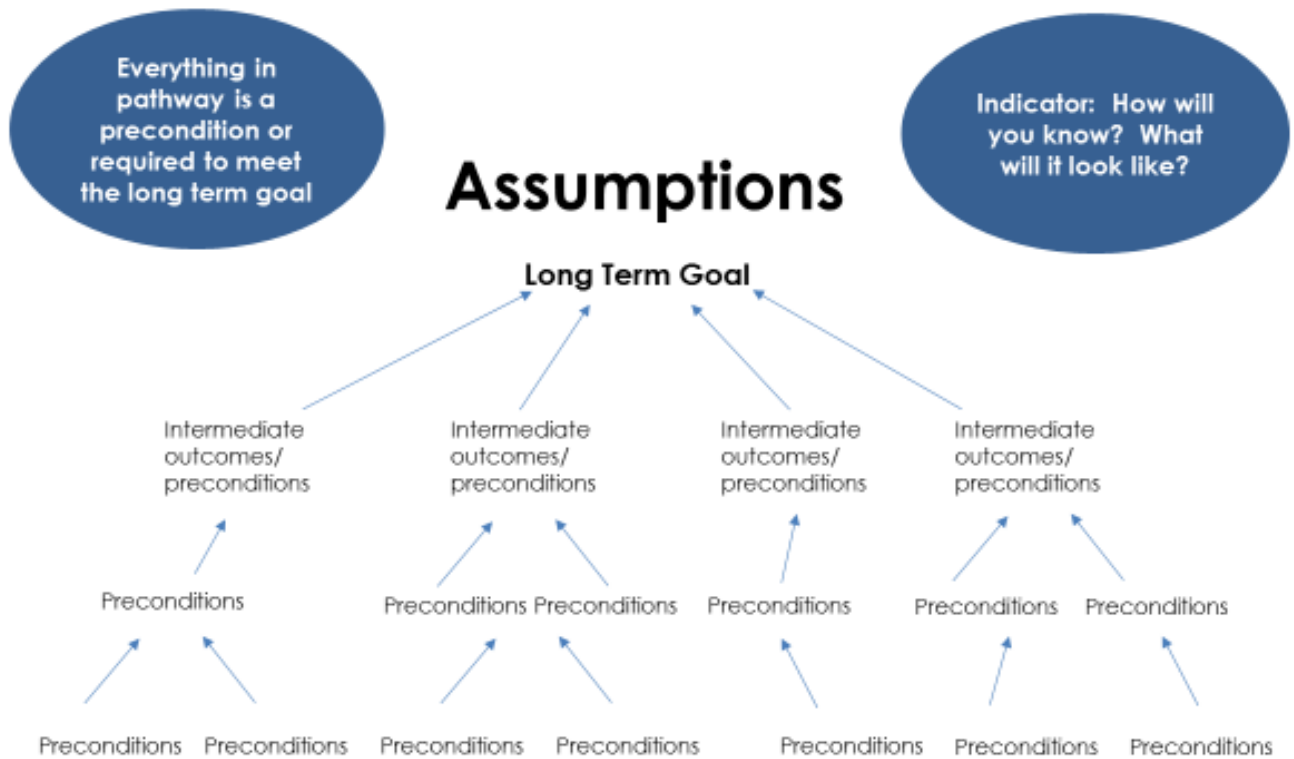
- Increase mental health awareness and reduce mental health stigma.
- Reduce access barriers that contribute to mental health disparities.
- Increase cultural competency of the education and health care workforce.
- Improve the climate and culture of school and workplace environments to reduce bias and promote inclusivity.
- Promote access to gender affirming health and legal services.
- LGBTQ individuals, couples, and families have access to culturally appropriate mental health care.
- Transgender community members have access to high quality, gender affirming health and legal services.
- LGBTQ youth have access to Gay-Straight Alliances or Rainbow Clubs at their school, and anti-bullying programs are implemented throughout their school district.
- Community members access and remain engaged in the above services and supports.

Strategies can include:

- Provide culturally competent mental health counseling.
- Provide hormone gender affirmation services.
- Provide Safe Space for support groups and social events.
- Provide legal advocacy for engaging health care providers and schools.
- Train school districts to address bullying.
- Build regional capacity to provide gender affirmation services.

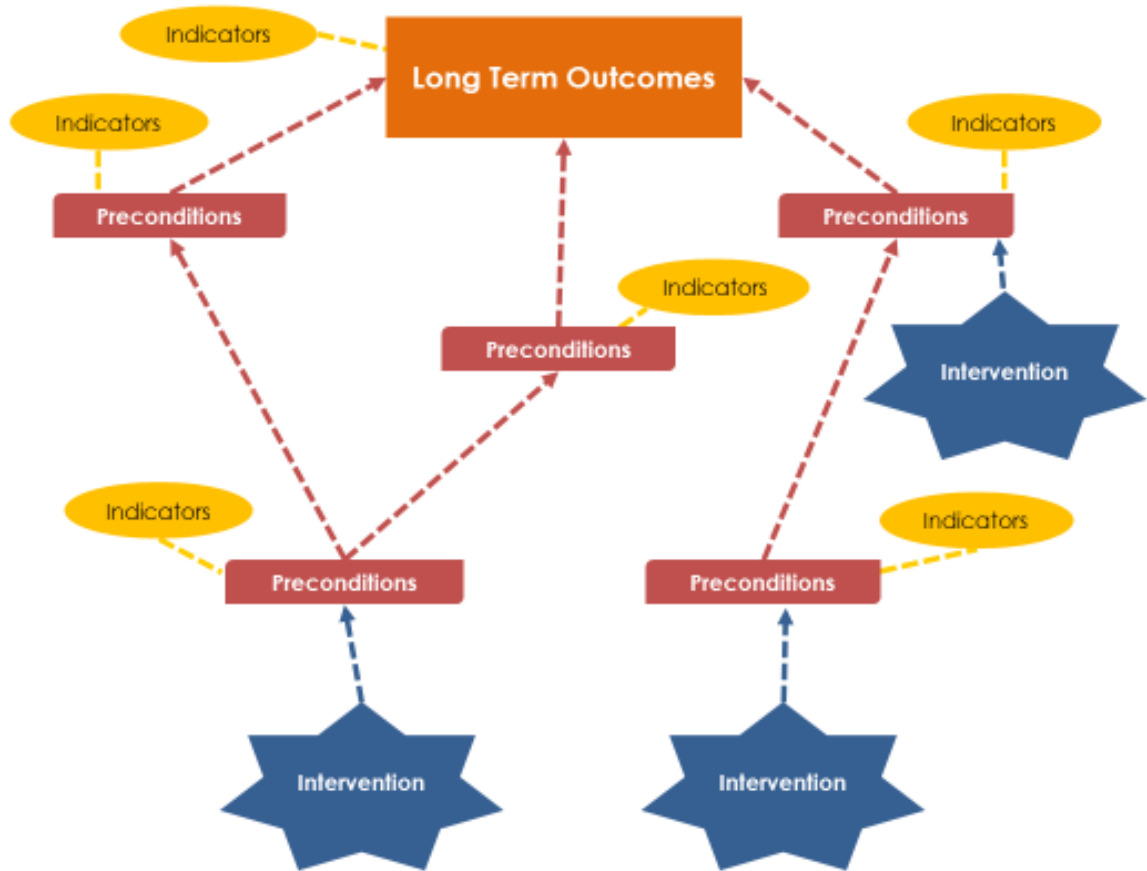
Theories of change can be expressed using multiple formats. One way to structure a theory of change is by creating a complex map of the layers in the pathway of change. Some factors can be assumed or anticipated, and some cannot. All must be linked to the layer above and all must have indicators of success associated with them.





**What are the assumptions that tie the preconditions to the long term goal?**

Another way to look at Theory of Change is in a format that includes where the intervention strategies have their effect.



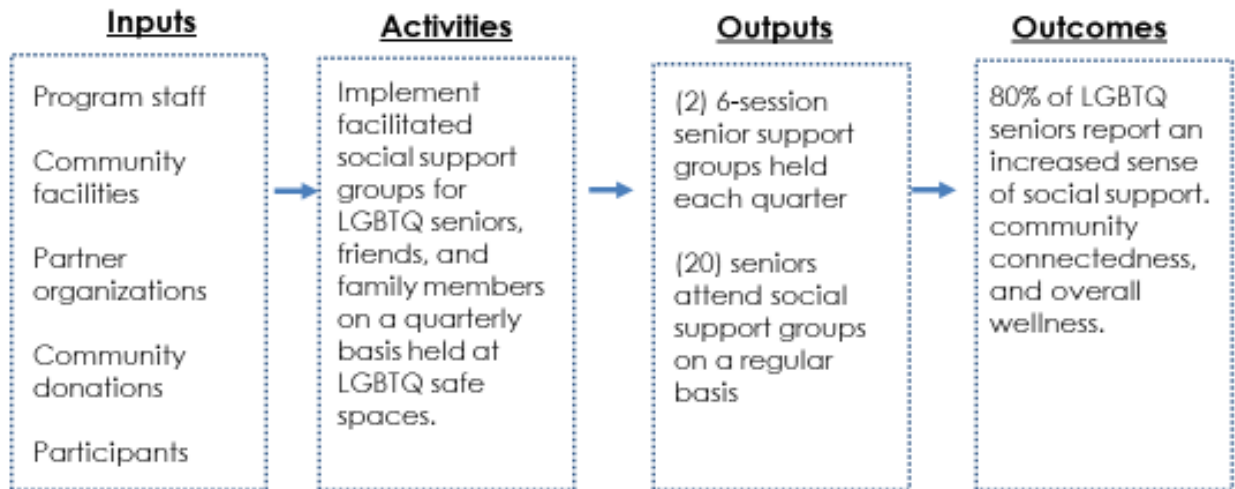
## Logic Models

Logic models are tools used in program evaluation to translate theories of change into visual linkages among program strategies, outputs, and outcomes with sufficient specificity to enable services to be evaluated. They are usually program-specific and articulate the logic underlying a program design by demonstrating the relationships among priority needs, program goals and objectives, inputs, strategies, and resulting outputs/outcomes. They are also effective tools for program planning, management, evaluation, and communication.

A simple logic model would include the following elements:

**Purpose/Statement of Need**

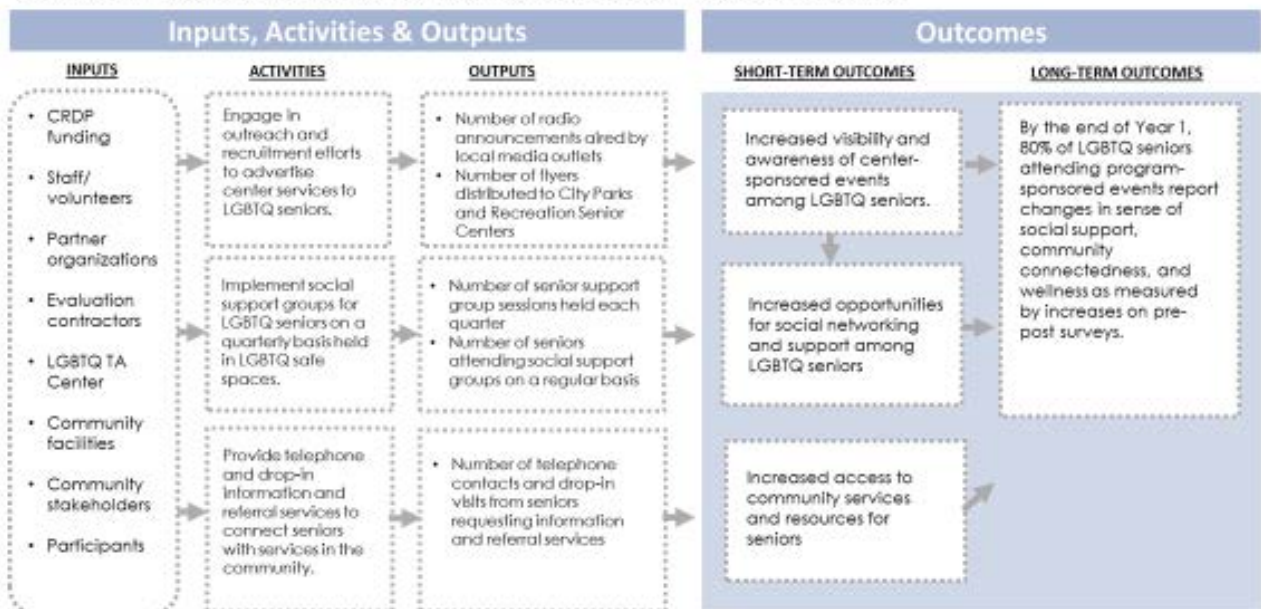
LGBTQ seniors are often isolated without adequate support networks or opportunities for meaningful community engagement, particularly in more conservative, rural communities.



A more advanced logic model would provide more detail relevant to the evaluation plan:

**PURPOSE/STATEMENT OF NEED**

LGBTQ seniors are often isolated without adequate support networks or opportunities for meaningful community engagement, particularly in more conservative, rural communities. Social isolation impacts overall wellness.



## Differences between Theories of Change and Logic Models

Theory of Change	Logic Model
<ul style="list-style-type: none"><li>• Focuses on the big picture</li><li>• Graphically depicts causal relationships among components; details assumptions and pre-conditions for achieving change; includes narrative summarizing interrelationships</li><li>• Explains <b>why</b> programs and strategies are expected to produce outcomes</li><li>• May include organizational values and guiding principles</li></ul>	<ul style="list-style-type: none"><li>• Focuses specifically on CDEP to be implemented and measured</li><li>• Graphically depicts relationship between program inputs, activities, and outcomes</li><li>• Explains <b>what</b> programs are doing (your CDEP) and <b>how</b> they are doing them, not why strategies are expected to produce outcomes</li><li>• Identifies SMART outcomes for each activity or component</li></ul>

## Selecting an Evaluation Design

An evaluation design is simply a plan for conducting evaluation. It provides the structure for answering evaluation questions. An evaluation design should be based on and aligned with the program Theory of Change and Logic Model, the resources available for the evaluation, and the funder's evaluation expectations. There are three major types of designs: experimental, quasi-experimental, and non-experimental. Selecting the appropriate design with a well thought out plan provides a strong foundation for achieving a successful and informative program evaluation.

### ***Experimental Design***

Experimental designs require that all potential program participants have an equal chance of assignment to a group that will receive the intervention, or assignment to a group that will not (i.e., the control group). Random assignment should result in the absence of any differences between the experimental and control groups that would impact the outcome the evaluation. Demographic and other participant characteristic data can then be used to explore between-group differences in the size of outcome effects measured before and after the intervention is over.

True experimental designs that incorporate random assignment to an intervention or control group are the most powerful, least biased way to evaluate program services to ensure they effectively achieve desired outcomes. These designs work best with interventions that are short in duration and do not include longitudinal data collection much beyond the intervention period. They also work in situations

where program resources severely limit access to program services, and participants will need to be on a waitlist anyway before a cohort with room for them to participate is available.

### How to Create a Control Group from a Waitlist

Randomly assigning a community member who seeks access to and has great need for available program services to a control group that does not provide services would be unethical. When providers cannot immediately enroll all interested community members in program services due to limitations in organizational capacity and cannot base program participation on an individual-level needs assessment, a waitlist can be used to create a control group that supports rigorous experimental design.

To do this, prior to the beginning of services, everyone interested and eligible for program services would be added to a waitlist, and immediately before a new cohort of intervention participants starts to receive services, the first “X” number of waitlist members (where “X” = 2 times the intervention cohort size) would be randomly assigned to either the intervention group or a non-intervention control group of equal size. When the next intervention cohort begins, previous control group members would then automatically become intervention group members and nobody would be randomly assigned to a control group. Then the cycle would repeat: odd number cohorts (1, 3, 5) would include a randomized control group, while even number cohorts (2, 4, 6) would include only intervention participants and no control group. In a true experimental design, the analysis of data would compare and contrast data only between individuals randomly assigned to an intervention or control group during odd number cohorts. Data collected during even number cohorts could be included in a non-experimental design discussed below.

Waitlist members not assigned to either group during odd number cohorts would remain on the waitlist until the next odd number cohort begins. At that point they would become eligible for randomization based on their position on the waitlist as described above. Except for cases where outcome measures are collected from intervention group members beyond the beginning of the next intervention cohort, control group members would provide outcome measures using the same timing and instrumentation used with intervention group members.

### ***Quasi-Experimental Design***

Program evaluations often employ a quasi-experimental design that measures desired outcomes among participants before and after services are received but does not include a randomized control group. This design is best for programs that can begin providing services to community members as they express interest in the program. It is also preferred by programs with waitlists too short to allow randomization into a temporary control group. Additionally, programs providing mental health PEI services to LGBTQ individuals identified at high-risk during an individual-level needs assessment process cannot randomly assign some program applicants to a group that will not receive services for any duration of time. For example, LGBTQ individuals on the verge of homelessness or feeling suicidal could experience severe negative outcomes if their needs are left unaddressed while serving as a control group subject, or while waiting on a list where program access is not based on assessed need.

Quasi-experiments involve the creation of a comparison group matched to the intervention group by as many relevant factors as possible who have not and cannot receive services similar to your program’s services. Comparison groups allow an evaluator to determine whether changes over time can be attributed to program engagement or would have occurred anyway without program engagement. Relevant comparison factors include demographics (age, gender, sexual orientation, race/ethnicity,

etc.), education, employment, and baseline measures of desired outcomes. Comparison group members would qualify for but do not have reasonable access to program services for any number of reasons, including geographical distance to the intervention site, travel times and conditions, and lack of private or public transportation that is affordable and accessible to the individual. For most programs, a comparison community would be identified that is similar to the community you serve in all ways except for the availability of services similar to what your program provides, usually separated by geographic distance.

### How to Create a Comparison Group in School Settings

For providers serving youth in school settings, one strategy to find out whether LGBTQ youth who have access to your program do better mentally and academically is to select a comparison school without a similar program that is matched to your intervention school by as many demographic and cultural factors as you can measure and/or access and collect and contrast outcomes from both schools. Collecting data from a random sample of classrooms from each school is usually much more feasible than sampling individual students. In middle and high school settings, programs need to sample among elective classes that anyone would take (e.g., chorus, band, drama club, or physical education) to avoid selection bias associated with the academic level of students enrolled. If you choose to sample, be sure your sample size is adequate to represent the youth expected to identify within the LGBTQ+ spectrum and incorporate oversampling and data weighting methods to ensure culturally diverse LGBTQ+ youth are represented in an analyzable way in your dataset.

### How to Create a Comparison Group from a Waitlist

Program participants can serve as their own comparison group during the time they are waiting to receive services as long as they are on the waitlist for the duration of a single program cycle. The technique involves collecting pre-intervention data at first program interface, waiting the length of time that the intervention they will later receive lasts, and then collecting data using the post-intervention survey when that time ends. When a spot opens for them to participate in the intervention, they would retake the pre-intervention survey, and complete another post-survey after the intervention is completed. If the waitlisted comparison group member engages in program services other than the primary intervention being evaluated that may impact outcomes during the wait, dosage data should be collected to help understand the role of program services on differential outcomes between pre- and post-tests.

## ***Non-Experimental Designs***

Non-experimental evaluations collect data solely from program participants and do not require the creation of a randomly-assigned control group or a matched comparison group. Non-experimental evaluations can be as simple as collecting data before and after program participation or can add complexity by collecting ongoing individual-level data on program exposure and satisfaction/outcomes after every service engagement or program session.

### Pre/Post Design

This type of evaluation is one of the most popular and easiest designs to implement and analyze. It requires program participants to fill out an evaluation instrument before receiving program services and



immediately afterward. Because it does not include measures from either control or comparison subjects, it cannot differentiate whether program participants would have experienced improvements in mental health and wellness over time with or without the program. It also doesn't measure whether changes associated with program participation are transient or lasting.

### Pre/Post Design with Long Term Follow Up

This type of evaluation also does not include measures from either control or comparison subjects. Program participants fill out an evaluation instrument before receiving program services and immediately afterward, and then again at least one time in the future to measure lasting impacts of the program on the mental health and wellness of program participants. Incentives must be carefully planned in advance to motivate program participants to provide follow up data either online or in person; if a significant proportion of participants don't provide long-term follow up data, its usefulness can be questioned. Determining the most effective level of incentive can be done through formative research prior to evaluation implementation. Brief surveys of potential program participants are most effective in setting an incentive level.

### Post-Session Design with Continuous Quality Improvement

The evaluation design best suited for continuous quality improvement involves collecting brief data on client satisfaction and outcomes following each engagement with program services. The data can be assessed on a continuous or periodic basis to inform providers about the effectiveness of program services on a quicker turnaround than other forms of program evaluation, which enables providers to adjust services quickly and increase the likelihood that other types of data collected (such as pre/post tests) will document successful outcomes.

### Program Fidelity and Continuous Quality Improvement

Having program staff not involved in providing services silently observe the implementation of services is another strategy to obtain information relevant to continuous quality improvement, including whether the program strategy is being implemented as planned. The technique requires program participants to feel comfortable and trust the observer, usually a program staff member they know, and may not be appropriate for all service populations.

## ***Sampling Techniques***

For programs serving cohorts of 75 or fewer participants, collecting demographic and outcome data from everybody is the best practice. If you are serving an entire school district or working in other situations where a census of all program participants is unfeasible, representative sampling techniques should be utilized. The larger the sample size, the more likely you will be able to identify small program effects. Whatever sampling tool is used – random number generation or picking IDs out of a hat – all program participants should have an equal chance of being included in the evaluation. If a matched pre-/post-test design is used, it is important to also collect individual-level contact data needed to have data from both the pre- and post-phase of program implementation. That includes trying to collect data from anybody who dropped out of the program before its end and the post-test was administered so you can understand their experience as well. Since you will have program exposure data matched to

individual participants, the fact that you're including dropouts at the post-test will not weaken your analysis. In fact, it will extend the relevance of program services to a broader audience.

In qualitative study design, potential participants can be identified by going into the community of focus and accessing individuals with key information or influence such as community leaders, respected elders, a popular school teacher, or community members who would benefit from your program's services. These individuals can then help identify other individuals who could provide useful qualitative data. Focus group or town hall participants can be made up of individuals who are stakeholders in a given community, such as leaders of organizations who serve a population you wish to serve, and others who share similar demographic profiles such as age, ethnicity, gender identity, sexual orientation, and other characteristics possessed by the group who will be the focus of a program or service.

## **Assessing CDEP Implementation through Process Measurement**

Process information should ideally be collected individually from all program participants for needs assessment purposes as well as at the earliest possible interface between the individual and your program. The data can be used to calculate rates of program engagement and retention and when possible disaggregated by sexual orientation, gender identity, and other demographic variables such as race and ethnicity. How this information is obtained begins with the language used to obtain it; we will later discuss recommendations on how this data should be collected, analyzed, utilized, and reported.

### ***Intake Forms***

Intake forms used in LGBTQ CDEPs usually include basic data such as age, race, ethnicity, sexual orientation, gender identity, sex at birth, legal name, name, gender pronouns, and day the CDEP was first engaged. Depending on the type of CDEP, intake forms may also provide additional data on grade level and school, disability, history of trauma, history of mental illness, substance use, and medications taken. If intake form data is collected consistently it can augment data collected for pure evaluation purposes and reduce the burden on participants of lengthy data collection instruments asking for information already available at the individual level.

### ***Program Exposure***

It is recommended that data on program involvement (aka "dosage data") be included at the individual participant level. This includes the number of program meetings or sessions the participant attended, and the quality of program involvement when participating.

Dosage data can be used to calculate program- and individual-level rates of engagement and contrast the characteristics of individuals who remain in the program at varying rates of engagement, and those who drop out. Dosage data can answer whether participants at higher risk for low engagement or dropout can be identified from intake or pre-test data and provide guidance for tailoring program services to better meet their needs. Dosage data can also help the evaluator understand more specific differential outcomes among participants, such as differential program effect sizes.

Lastly, program exposure data can also be used as a measure of program fidelity. Usually participants will need to meet some minimum threshold for participation to be counted as receiving the full intervention. For example, if only half of your participants receive the full course of services



recommended by your program, can you say that you implemented it with fidelity? If someone wanted to replicate your model, how much is enough to achieve the desired outcome? What is the minimum amount of participation required for your services to achieve the desired outcomes?

## ***Program Outreach***

Data on program outreach measures successes in program implementation at the community level. While process data collected at intake and during program engagement assesses program achievements at the individual and group level for community members choosing to participate in your program, process data on outreach strategies assesses program achievements in engaging the community of focus and drawing in those who would find value in and benefit from program services.

As when involving LGBTQ communities in identifying desired outcomes and promising interventions, engaging the grassroots when designing and implementing outreach strategies helps ground them in your local social context and improves the likelihood strategies will succeed. Community involvement in outreach planning also helps set benchmarks for measuring success by helping to identify the number, characteristics, and location of individuals within your population of focus in your service region.

Questions an analysis of program outreach process data can answer include:

- Which individuals and groups were drawn into your program by which outreach efforts, and how well did they represent your population of focus?
- Which outreach modalities were successful with different segments of your population of focus?
  - Was outreach through social media successful for some but not others?
  - Were you able to connect to LGBTQ elders through mainstream senior service centers?
  - Were the elders you reached at the centers representative of all LGBTQ elders in your service region?
- What influence did the characteristics of outreach workers have on who engaged?
  - How did the gender identity, gender expression, sexual orientation, age, and/or linguistic characteristics of outreach workers impact success recruiting different individuals into your program?
  - What type of training and supervision of outreach workers was associated with successful community engagement?

All these factors may influence program recruitment success, and they will be difficult to recall during the analysis phase unless you build-in collecting this information throughout program implementation into your evaluation planning.

## ***Retention Strategies***

Another element of process data collection is the documentation of strategies used to retain participants in your program and its evaluation beyond implementing program services and an evaluation that they experience immediate benefit from participating in. Strategies include providing an award or prize when a participant completes evaluation surveys like pre-/post-/follow-up tests, attends meetings, or completes a full course of services. Incentives can involve raffles during meetings or

gatherings, gift cards, social activities and events for program participants and graduates, and/or space on a social media platform open only to program participants and graduates.

## **Accounting for Demographic Differences**

An essential step in evaluating whether mental health prevention and early intervention services are effective for LGBTQ populations includes capturing information on where individuals identify on the LGBTQ spectrum. This requires collecting and utilizing data on sexual orientation and gender identity (SOGI) at all phases of program evaluation.

As with any historically misunderstood and marginalized population, the words chosen when evaluating programs serving LGBTQ communities will heavily influence the responses provided. The best way to ensure your data collection questions and response sets match the preferred identities of the community that you aim to serve is to engage the community when designing and executing your evaluation plans.

When working with the community during community participatory evaluation activities, it is helpful to remember that LGBTQ communities continue to grow and evolve along with our understanding of gender and sexuality, and that terms used will evolve as well. Distinctions between labels imposed on LGBTQ community members and labels they choose for themselves are significant, and labels continue to evolve over time.

To learn the range of terms currently used by communities of focus to label their sexual orientation and gender identity in your service region, use key informant interviews, focus groups, or polling in venues where your community of focus congregates. Be sure to reach out to all segments of your community of focus, not merely to those members most visibly engaged with the majority LGBTQ community. Oversample people with intersectional identities so you can draw conclusions about everybody you desire to serve effectively. Do not use the term “other” to describe anybody individually or as a group during data collection or when reporting back to the community.

Once you have identified the range of SOGI terms used locally by your communities of focus, use them to allow sexual and gender minority community members to self-identify in a way that makes sense to them in their cultural context. Do not impose your opinion of what term somebody else should use for themselves; use the terms they prefer. Not all sexual and gender minorities embrace the terms “lesbian,” “gay,” “bisexual,” “transgender,” “queer” or “questioning.”

Before we provide our recommendations for evaluating mental health prevention and early intervention services for LGBTQ communities, it is useful to examine previous efforts to obtain data related to sexual orientation and gender identity. Below is a discussion of how state and national data collection efforts and other researchers have handled questions of gender identity and expression, sexual orientation, and the LGBTQ spectrum beyond the labels of LGBTQ.

### ***Gender Identity and Expression***

#### **Terms Identified During CRDP Phase I**

Phase I of the CRDP sampled LGBTQ community members across California using community participatory strategies to find out how they label their own sexual orientation and gender identity. The questions and response sets were created with input from over 400 people from LGBTQ communities

during 12 community dialogue sessions held across the state in 2010-2011. English and Spanish versions of the survey were used. Fourteen advisory groups representing diverse topics, populations, and geographic regions were involved in the process. Data was collected using online methods in a snowball sampling design to recruit anyone in California who identified as LGBTQ, ever wondered if they might be LGBTQ, or were parents of LGBTQ children. All ages were included and participation was anonymous. The snowball sampling involved disseminating surveys to the personal and professional networks of CRDP project staff and community members involved in the 14 advisory groups, posting the survey link on social media sites such as Facebook and Twitter, hosting the survey link on LGBTQ organizational websites, and mailing out online survey links to the Equality California<sup>1</sup> email database.

The final sample included 3,023 respondents: 66% were adults age 26-59, 19% were transition age youth age 16-25, 15% were older adults age 60-89, and 0.6% were youth ages 14-15. When asked about assigned sex at birth, 49% of LGBTQ respondents were assigned “male,” and 51% of respondents were assigned “female.”

### *Gender Identity Terms in California’s LGBTQ Community as a Whole*

When asked what term best describes their current gender identity, the following results were obtained:

Gender Identity in LGBTQ Survey, CRDP Phase I, N=3,023	Percent
Man/Boy	46%
Woman/Girl	42%
Genderqueer	5%
Androgynous	4%
Transgender	2%
Transman	2%
Transwoman	1%

### *Gender Identity Terms Among California’s Trans Spectrum Individuals*

In the same survey described above, LGBTQ community members whose birth sex did not match their gender identity were grouped as “Trans Spectrum.” Their representation within the overall sample follows:

Gender Identity in LGBTQ Survey, CRDP Phase I, N=3,023	Percent
Men Assigned Male at Birth	44%
Women Assigned Female at Birth	41%
Trans Spectrum Individuals	15%

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<sup>1</sup> Equality California is a statewide LGBTQ civil rights organization with a mission that includes advancing the health and well-being of LGBTQ Californians through direct health care service advocacy and education.

Trans Spectrum respondents as a group reported their gender identity as follows:

Gender Identity Among Trans Spectrum Individuals in LGBTQ Survey, CRDP Phase I, N = 453		Percent
Genderqueer		32%
Androgynous		24%
Transgender		11%
Transman		11%
Man/Boy		9%
Woman/Girl		7%
Transwoman		6%

### Intersex

“Intersex” is a term that has historically been used by the medical establishment to refer to someone with differences in chromosomes, gonads (i.e., ovaries or testes), hormonal profiles, and/or anatomy that challenge conventional concepts about what “male” or “female” bodies should look like. Some intersex conditions are apparent at birth, while others become apparent at puberty or later. Some intersex conditions are never identified. Many transgender and gender nonconforming people who identify as “intersex” do not meet the criteria used by the medical establishment for the term. In fact, there is no standard definition of the term within and across LGBTQ communities; therefore, a good practice is to ask if the individual identifies their gender as intersex without defining the term for them. That allows respondents to self-identify without judgment as to the legitimacy of how they perceive themselves.

One of the community-based findings from “First, Do No Harm” was that

**“Many community members, however, add an “I” to the acronym (e.g. LGBTQI or LGBTIQ) to represent intersex and some, but not all, intersex individuals identify as part of LGBTQ communities. [Community Survey] respondents were therefore asked if they believe they have an intersex condition, with 3% reporting they do. Only 21 of these individuals (less than 1% of the entire CS sample) were able to state their intersex condition had been diagnosed by a medical provider. Of those who believe they have an intersex condition but have not been diagnosed, almost two-thirds are part of the Trans Spectrum group.”**

Intersex people appear to make up 1-3% of the LGBTQ community in California, and a 2015 survey of people born with atypical sex characteristics in Australia found that 52% identified as non-heterosexual, compared to 3.4% of the general population that identified as non-heterosexual in the Williams Institute analysis of 2012 Gallup poll data discussed above (Jones, Hart, Carpenter, Ansara, Leonard, & Lucke, 2016). Here is how intersex people identified their gender identity in the Australian sample:

Gender Identity of People Born with Atypical Sex Characteristics, N=272		Percent
Female		52%
Male		23%

Gender Identity of People Born with Atypical Sex Characteristics, N=272	
	Percent
Various Other Options	25%

Here is how intersex people identified their sexual orientation in the Australian sample:

Sexual Orientation of People Born with Atypical Sex Characteristics, N=272	
	Percent
Heterosexual	48%
Bisexual	22%
Queer	15%
Lesbian	12%
Questioning	11%
Pansexual	10%
Asexual	10%
Prefer no label	10%
Gay	6%
Another label	4%

### Emerging Terms for Gender Identity and Expression

Emerging terms for transgender and gender nonconforming people go beyond the options identified during CRDP Phase I, and will continue to expand over time as historical, socially-determined binary understandings of gender are replaced with non-binary, more fluid perceptions of how diverse individuals experience their gender over time. In February 2014, Facebook started allowing members to select a “custom” gender label outside “female” and “male.” In an article in The Daily Beast dated February 15, 2014, two researchers from The Center for Sexual Health Promotion at Indiana University's School of Public Health provided definitions of some of the emerging labels for gender that people using Facebook used to describe themselves. Here are the terms; their definitions are listed in Appendix A.

Agender	Cisgender Male	Male to Female/MTF	Trans Male
Androgyne/Androgynous	Cisgender Man	Neither	Trans Person
Bigender	Cisgender Woman	Neutrois	Trans*
Cis	Female to Male/FTM	Non-binary (or Enby)	Trans*Female
Cis Female	Gender Fluid	Other	Trans*Male
Cis Male	Gender Nonconforming	Pangender	Trans*Person
Cis Man	Gender Questioning	Transgender	Transsexual
Cis Woman	Gender Variant	Trans Man	Transmasculine
Cisgender	Genderqueer	Trans Woman	Transfeminine
Cisgender Female	Intersex	Trans Female	Two-spirit

It may be impractical for many mental health prevention and early intervention service providers to list all known labels for gender identity on all data collection instruments. While all options need not be in the response set, there must always be an option for people to label their gender using their preferred terms. Asking “Something else (please specify): \_\_\_\_\_” is more culturally competent than asking “Other (please specify): \_\_\_\_\_” to a community that has historically been otherized by the dominant

culture when seeking health services. Reflecting your understanding of trans communities through linguistically appropriate intake and data collection – and maintaining that linguistic standard throughout service provision including the proper use of preferred pronouns and names – will increase program engagement, retention, and outcomes.

## Recommendations for Collecting Data on Gender Identity

The following recommendations for sexual orientation and gender identity (SOGI) data collection are based on collaborative discussions between the CRDP LGBTQ Grantees, the CRDP LGBTQ TA Center, the CRDP Statewide evaluator, and the Office of Health Equity. Except where noted, they were adopted as the CRDP cross-site evaluation core measures on sexual orientation and gender identity which all 35 CRDP grantees were required to include in their evaluation plans. The CRDP LGBTQ TA Center reviewed available research literature on the topic and provided initial recommendations, the Statewide evaluator commented on those recommendations based on their own review of the literature and on cross-cultural considerations for grantees serving other populations through CRDP funding and focus group discussions with LGBTQ-serving grantees funded through CRDP.

Identifying program participants who identify as transgender requires a simple question such as “What is your gender identity?” However, some people who have transitioned from their birth to their authentic gender do not identify as transgender, have changed all legal identification documents to reflect their authentic gender, and identify as their authentic gender. For program evaluators to also determine which or how many program participants have transitioned their gender and do not identify as transgender, a second question needs to be asked about sex at birth.

The most common best practice for asking about sex assigned at birth asks refers to the original birth certificate that is generated for all live births in the US. Because individuals can legally change the sex on their birth certificate and by extension driver’s licenses, passports, marriage certificates, and other legal documentation, it is important to refer to the original document in this context. In regions serving a significant number of immigrants without birth certificates, as is the case of many grantees included in the CRDP initiative, the cross-site evaluation measure on sex assigned at birth does not assume the existence of a birth certificate, and instead refers to how the infant was labeled by those involved in the infant’s birth.

### ***Sex Assigned at Birth: Adult CRDP Cross-Site Measure Not Assuming a Birth Certificate Exists***

**When I was born, the person who delivered me<sup>2</sup> (e.g., doctor, nurse/midwife, family members), thought I was a: (Choose the one best answer.)**

- Male/Boy
- Female/Girl
- Intersex (they were unsure about my sex at birth)
- I am not sure about my sex assigned at birth
- My assigned sex at birth (please specify): \_\_\_\_\_
- I do not wish to answer the question

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<sup>2</sup> Another way to frame this question is to ask for the sex on an original birth certificate. However, asking about birth certificates does not work with immigrant community members coming from countries where birth certificates are not issued.

### ***Sex Assigned at Birth: Preferred Language for Most Programs Serving Adults with Birth Certificates***

For regions where all program participants would have a birth certificate, the preferred wording would refer to options on the legal document:

**What was the sex listed on your original birth certificate? (Select the one best answer.)**

- Female
- Male
- Intersex
- Unknown
- Decline to state

### ***Gender Identity: CRDP Cross-Site Measure for Adults***

The following instructions were developed for respondent populations who are unfamiliar with the term “gender identity.” For programs serving primarily transgender and gender nonconforming people, shorter instructions are provided below.

***Gender Identity Instructions: We use terms like “male” or “female” or “trans” as a short-hand way to capture the gender of individuals. We fully understand, however, that people use a wide range of labels – some prefer other terms such as Genderfluid, Agender, Enby, Androgynous, etc. To help us understand you personally, please tell us the term that you personally prefer to describe your gender. There are no right or wrong answers to these questions. Please be honest and answer as you really think and feel.***

**When it comes to my gender identity, I think of myself as<sup>3</sup>: (Choose all that apply.)**

- Man/Male
- Woman/Female
- Transgender/Trans
- Trans Man/Trans male
- Trans women/Trans female
- Genderqueer/Gender non-conforming
- Non-binary (not exclusively male or female)
- Two Spirit
- Intersex (between/across male and female)
- I am not sure about my gender identity
- I do not have a gender/ gender identity
- I do not wish to answer this question
- My gender identity is (please specify): \_\_\_\_\_

### ***Gender Identity: Measures for Programs Serving Primarily LGBTQ Adults***

For programs serving a primarily LGBTQ population, different instructions and more options should be provided as follows:

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<sup>3</sup> An alternative to “I think of myself as” is “I am.” The first phrase acknowledges the social construction and subjective aspects of gender, while the second phrase acknowledges the inherent and objective aspects of gender. Whichever option is chosen should be used for measures of both gender identity and sexual orientation, as both are subjective as well as objective.

***Gender Identity Instructions: To help us understand you personally, please tell us the term that best describes your gender. There are no right or wrong answers to these questions. Please be honest and answer as you really think and feel.***

**My gender identity is: (Select all that apply.)**

- Female/Woman
- Male/Man
- Trans Woman/MtF<sup>4</sup>
- Trans Man/FtM
- Genderqueer
- Gender Nonconforming
- Genderfluid
- Intersex
- Two Spirit
- Agender
- Androgynous
- Questioning
- Femme
- Enby (Non-Binary)
- My gender: \_\_\_\_\_
- Decline to state

### ***Recommendations for Providers Serving Children and Adolescents***

While multiple biological and social theories exist to understand how and precisely when gender identity is developed, it is widely agreed that one's core gender identity is established by age three (Kalbfleisch & Cody, 1995; Gallagher & Kaufman, 2005). After age three, gender identity is extremely difficult to change, and attempts to reassign gender identity can result in gender dysphoria – clinically significant distress based not on being transgender itself, but on learned discontent with one's own gender identity. After age three, one model of gender identity development proposes additional stages (Martin & Ruble, 2004):

1. Through socialization, children under five learn about the characteristics of gender that are specific to their culture.
2. From about 5-7, children consolidate their perceived gender in a rigid form.
3. After this peak of rigidity, gender fluidity returns and socially-determined gender roles relax.

For most providers serving children 11 and under, we recommend a simplified version of the two-step method used above with involvement of the child's parent or guardian when appropriate and/or necessary:

**What was the sex listed on your child's original birth certificate? (Select the one best answer.)**

- Female

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<sup>4</sup> "FtM" and "MtF" refer to "Female to Male" and "Male to Female." They are not included in the CRDP cross-site measures, but they are useful with organizations serving individuals that are unfamiliar with transgender identities. While these terms reinforce a gender binary that does not reflect the experience of many transmasculine and transfeminine individuals, they are useful for the many people who may, for example, think a transwomen transitioned from female at birth to male.



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- Male
- Intersex (my child has a variation in sexual development or my child's gender was unclear)
- Decline to state

For programs serving people who may not have a birth certificate, the CRDP cross-site evaluation measures are preferable:

**When your child was born, the person who delivered them (e.g., doctor, nurse/midwife, family members), thought my child was a: (Select the one best answer.)**

- Male/boy
- Female/Girl
- Intersex (they were unsure about my child's sex at birth)
- I am not sure about my child's sex assigned at birth
- My child's assigned sex at birth (please specify) \_\_\_\_\_
- I do not wish to answer this question

For all programs, the second step in determining gender identity is to ask directly:

**Does your child think of themselves as: (Select all that apply.)**

- A boy/male
- A girl/female
- Transgender/trans
- Trans boy / trans male
- Trans girl / trans female
- Gender expansive
- Genderqueer
- Gender non-conforming
- Non-binary (not exclusively male or female)
- Two Spirit
- Intersex (between and across male and female)
- I am not sure about my child's gender identity
- My child does not have a gender / gender identity
- Their gender: \_\_\_\_\_

A shorter option for this question is:

**Does your child think of themselves as: (Select all that apply.)**

- A boy/male
- A girl/female
- Gender expansive
- Transgender/trans
- My child's gender: \_\_\_\_\_

For providers serving adolescents age 12-17, we recommend using the CRDP Cross-Site Measures of Gender Identity for Adults listed above. The Williams Institute has several recommendations on the topic related to defining terms, analyzing data, and survey administration (The GenIUSS Group, 2014). The survey instrument should use plain and simple language, and if data is collected in school settings then gender identity questions should be placed in the middle of the survey and not at the beginning where peers can see their responses. Defining terms for adolescents will help them differentiate terms

often conflated such as sex and gender, and clarify meanings of terms like transgender, masculine, and feminine. When analyzing the data, keep in mind that youth who were gender non-conforming in childhood may not adopt alternative gender labels until mid- to late-adolescence. Independently from gender identity, cisgender lesbian, gay, and bisexual youth are at heightened risk of harassment and violence based on gender nonconforming behavior. It can be useful in many environments serving the PEI mental health needs of LGBTQ youth to include questions about their experiences of discrimination based on gender expression as described below.

## ***Sexual Orientation***

### Sexual Orientation Terms from National Samples

The National Health Interview Survey (NHIS) has been administered annually through personal household interviews by the U.S. Census bureau since 1957 and is the primary source of information on the nation's health collected federally. The findings are instrumental in providing data to the Centers for Disease Control and Prevention to track health status, health care access, and progress toward achieving national health objectives. Although questions on gender identity were not included in the 2013 NHIS, for the first time in a large-scale government survey, sexual orientation was addressed in the 2013 NHIS. The implications of that survey on LGBTQ health were explored in a report published in 2014 by the Department of Health and Human Service's Division of Health Interview Statistics (Ward et al, 2014). How sexual orientation was framed linguistically and the data collection modality (in-person interview) impacted survey findings in ways instructive to identifying best practices for conducting needs assessments with LGBTQ populations.

The sexual orientation question included in the 2013 NHIS read, "**Which of the following best represents how you think of yourself?**" Response options varied slightly by respondent gender.

For male respondents, they were:

- Gay,
- Straight, that is, not gay,
- Bisexual,
- Something else, and
- I don't know the answer.

For female respondents, the response options were:

- Lesbian or gay,
- Straight, that is, not lesbian or gay,
- Bisexual,
- Something else, and
- I don't know the answer.

Based on the NHIS construction of sexual orientation in a national sample of 34,557 adults age 18 or older, the presence of LGBQ people within the general population was estimated as follows:

Sexual Orientation in National Sample 2013 National Health Interview Survey, N=34,557		Percent		
Straight (Not Gay or Lesbian)		96.6%		
Gay or Lesbian	1.6%	2.3%	3.4%	
Bisexual	0.7%			
"Something else," "I don't know the answer," or refused to answer		1.1%		

Using this in-person, in-home interview format, the NHIS found only 2.3% of the population openly identified as lesbian, gay, or bisexual. The way straight was defined as "not gay or lesbian" resulted in an undercount of bisexuality – bisexuals are also "not gay or lesbian" but this was not stated in the response set. Anybody rejecting potentially stigmatizing terms like "gay" or "lesbian" to describe themselves, even if they engage in same-sex behavior, will be more likely to select "straight" if bisexuality is not accurately defined as an option to being gay or lesbian. Another, bigger problem with the NIH's NHIS construction of sexual orientation identities was that the response set left 1 in 3 non-heterosexuals in an unspecified category. Without any data on who those people are and what labels they used to describe their sexual orientation, it is impossible to calculate differences in health care access and outcomes for 33% of the non-heterosexual population. For example, it is impossible for this national survey to corroborate or refute findings from smaller studies that found people who used the label "Queer" were more likely to experience mental health disparities directly related to their sexual orientation or gender identity/expression. "Something else" should allow the respondent to provide their own label for their sexual orientation, and not be clumped into an amorphous "other" category.

This outcome can be contrasted with an earlier report from 2011 from the Williams Institute on Sexual Orientation and Gender Identity Law and Public Policy. In live interviews conducted over the phone, 120,000 American adults were asked **"Do you, personally, identify as lesbian, gay, bisexual, or transgender?"** Here are their responses:

Sexual Orientation and Gender Identity in National Sample, 2011 Gallup Poll, N=120,000		Percent
Straight		96.2%
Gay or Lesbian		1.7%
Bisexual		1.8%
Transgender		0.3%

The findings of an October 2012 analysis of Gallup data collected June – September 2012 using the same data collection strategy and linguistics that was also published by the Williams Institute found that 3.4% of US adults identify as LGBT. Results varied by age, race, and ethnicity. More than six percent (6.4%) of young adults age 18-29 identified as LGBT, whereas only 1.9% of seniors over 65 identified as LGBT. Racial and ethnic minorities were more likely to identify as non-heterosexual: 4.0% of Latinos and 4.6% of African Americans compared to 3.2% of Caucasians.

Sexual Orientation and Gender Identity in National Sample, 2012 Gallup Poll, N=120,000		Percent
Straight/Heterosexual in total sample		96.6%
LGBT in total sample		3.4%
LGBT among 18-29 year olds		6.4%

Sexual Orientation and Gender Identity in National Sample, 2012 Gallup Poll, N=120,000	Percent
LGBT among 65+	1.9%
LGBT among Caucasians	3.2%
LGBT among Latinos	4.0%
LGBT among African Americans	4.6%

### Sexual Orientation Terms Used by Trans Spectrum Californians, CRDP Phase I

The community-participatory survey conducted during CRDP Phase I that was discussed above also provides information on how Trans Spectrum individuals in California identify their sexual orientation. Most trans respondents identified within the lesbian, gay, bisexual, or queer spectrum. Although gender identity and sexual orientation are two separate aspects of human nature, intersectional identities between the two aspects should be understood by service providers and included in needs assessment planning and program evaluation. Trans Spectrum respondents reported their sexual orientation as follows:

Sexual Orientation Among Trans Spectrum Individuals in LGBTQ Online Survey, N = 453	Percent
Queer	32%
Lesbian	25%
Bisexual/Pansexual	22%
Heterosexual/Straight	10%
Gay	9%
Questioning their sexual orientation	1%

### MWM & WSW: Sexual Behavior

Other labels have been imposed on community members from the academic or medical establishment. During the early period of the AIDS epidemic, the prevention and treatment needs of men who identify as heterosexual and have sex with men (MSM) or with men and women (MSMW) gained attention in public health circles. Similar labels have been created for women who identify as heterosexual and have sex with women (WSW) or with women and men (WSWM).

MSM/MSMW and WSW/WSWM continue to be commonly used in public health when addressing behavioral risks. For purposes of population needs assessment and program evaluation, if you serve heterosexuals whom you know engage in same-sex behavior, you can group them with gays/lesbians/bisexuals in some analyses, group them with heterosexuals in other analyses, and keep them as a separate group in yet other analyses.

Sexual history can be used along with sexual orientation as a tool to understand the mental health PEI needs of community members with low engagement in the broader LGBTQ community, including those with intersectional needs that heighten anti-LGBTQ stigma. These questions must be asked with sensitivity to the community member’s cultural beliefs about sex, monogamy, non-monogamy, and other potentially taboo topics.

### ***Recommendations for Collecting Sexual History Data***

Collecting sexual history data can be a window into a community member's sexuality that can be obtained without the use of potentially stigmatizing labels such as lesbian, gay, bisexual, transgender, or queer. Because it is not uncommon for people to experiment when younger with a sexual identity they later decide does not fit, it is best to limit the question to a discrete, recent period of time – such as the past 1, 2, or 5 years, with 5 being the recommended cutoff. This is how we recommend the question be phrased:

**Over the past 5 (or 1 or 2) years, whom have you had sex with? (Select all that apply.)**

- Female/Woman
- Male/Man
- Trans Woman/MtF
- Trans Man/FtM
- Another gender: \_\_\_\_\_
- Decline to state

If somebody who identifies as straight/heterosexual reports same-sex sexual behavior, this may be used to inform service provision, but it should not be used to challenge or redefine their sexual identity and should not be disclosed to anybody without explicit permission from the client obtained without coercion. Nor should you refer to somebody who self-identifies as heterosexual as something else among program staff when the community member is outside of hearing range.

The same principles apply with someone who identifies as gay/lesbian and reports opposite-sex sexual behavior. If they have concerns about their sexuality that they want to discuss with program staff, then it is appropriate to address; however, if they do not indicate it is a problem, it would be inappropriate for program staff to treat it as if it were or should be a problem.

It is often the case that the most marginalized, vulnerable, and already stigmatized individuals are most reticent to openly identify with another potentially stigmatizing identity due to basic survival concerns. It is also not unusual for sexual orientation (attractions) and sexual behavior (actions) to not align with sexual identity (labels).

### **Other Terms Used within the LGBTQ Spectrum**

As stated above, SOGI labels continue to evolve and the recommendations in this guideline are limited to the time and place they were created. What is considered culturally responsive in 2017 may no longer be acceptable in 2027 – just as the term “homosexual” has gone out of use in most regions of the nation for most LGBTQ community members. Labels will continue to vary based on how individuals experience their sexuality and gender, and that experience is influenced by multiple factors such as age, gender, socioeconomic status, educational level, disability, religious or spiritual practice, race/ethnicity, and sex assigned at birth (Wierzalis, Barret, Pope & Rankins, 2006).

#### ***Same Gender Loving (SGL)***

Some African American men and others favor the term “same gender loving” over “gay.” The term has origin in the historic lack of inclusion of African American men in white dominant gay communities.

#### ***Two Spirit (T-S)***

The term Two Spirit is used by people who embody the gender spirit of both men and women. The term has origin in the traditions of the indigenous nations and peoples of North America.

### ***LGBTQQIA***

Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Intersex, and Allies (or Asexual). This is one of many acronyms coined to be inclusive of all stakeholders or service participants in the community.

### ***LGBTQQIAAP***

Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Intersex, Asexual, Allies and Pansexual. This is one of many acronyms coined to be inclusive of all stakeholders or service participants in the community.

### ***LGBTQ+***

As the variety and richness of identities for gender and sexual orientation continue to grow and evolve, LGBTQ-serving organizations increasingly add “+” to the list of people as shorthand to acknowledge the multitude of personal identities used by those they serve. However, some individuals who identify within the spectrum of sexual and gender diversity but do not identify as L G B T or Q may not appreciate being clumped with others as an arithmetic symbol and would prefer more accurate acronyms to feel included.

### ***SGM: Sexual and Gender Minority***

Like MSM and WSW, SGM was coined by academic and health professionals to refer to the community when the community was in the process of expanding the number of identities beyond “LGBT” to acknowledge a wider spectrum of community members. The term “SGM” is favored by the National Institutes of Health as a more stable umbrella term for purposes of academic discussion. The definition from the NIH FY 2016-2020 Strategic Plan to Advance Research on the Health and Well-being of Sexual and Gender Minorities:

**“Sexual and Gender Minority” is an umbrella term that encompasses lesbian, gay, bisexual, and transgender (LGBT) people, as well as those whose sexual orientation and/or gender identity varies, those who may not self-identify as LGBT (e.g., Queer, Questioning, Two-Spirit, Asexual, men who have sex with men [MSM], Gender-variant), or those who have a specific medical condition affecting reproductive development (e.g., individuals with differences or disorders of sex development [DSD], who sometimes identify as intersex).**

Like MSM and WSW, the term “SGM” is not used by community members; the community is moving towards the use of “LGBTQ+” to indicate the inclusion of diverse identities.

## **Recommendations for Collecting Data on Sexual Orientation**

### ***Measuring Sexual Orientation in Adults for Most Programs***

***Sexual Orientation Instructions<sup>5</sup>: Everyone has a sexual orientation. Some people are straight and are attracted to people of another gender. For example, a straight woman is attracted to men and prefers to date or have sex with men. Other people are gay or lesbian and are attracted to people of the same gender. For example, a gay man is attracted to other men and prefers to date or have sex with other men. Still other people are bisexual and are attracted to both men and women. Some people are attracted to people of all genders including those who do not define their gender within the binary***

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<sup>5</sup> As with the instructions for gender identity, these instructions are written for service populations that are not familiar with “sexual orientation” as a term. Respondents from programs serving primarily LGBTQ populations will not need to have sexual orientation defined for them.

***“male or female” framework. Others are unsure about their attractions or are just not attracted to anyone. Just to be clear, who you are attracted to and prefer to date or have sex with is called sexual orientation.***

**What is your sexual orientation?<sup>6</sup> (Choose all that apply.)**

- Straight/heterosexual
- Gay
- Lesbian
- Bisexual
- Queer
- Pansexual/Non-monosexual (I am attracted to all genders)
- Asexual (I am not attracted to anyone sexually)
- I am not attracted to anyone romantically
- I am not sure who I am attracted to sexually
- I am not sure who I am attracted to romantically
- Something else (please specify): \_\_\_\_\_
- I do not wish to answer this question

***Measuring Sexual Orientation in Adults for Programs Serving LGBTQ Communities Specifically or Areas with High Concentrations of LGBTQ Individuals***

For mental health PEI service providers who focus services on LGBTQ communities, or serve regions with a high concentration of LGBTQ individuals, we recommend the following identifiers be included during intake and any time demographic data is being collected.

**My sexual orientation is: (Select the one best answer.)**

- Lesbian
- Gay
- Bisexual
- Queer
- Questioning
- Straight/Heterosexual
- Asexual
- Pansexual
- Same Gender Loving
- Demisexual
- Fluid
- Graysexual
- Unsure
- Decline to state
- My sexual orientation: \_\_\_\_\_

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<sup>6</sup> An alternative to “My sexual orientation is” would be “When it comes to my sexual orientation, I think of myself as.” The first phrase acknowledges the inherent and objective aspects of sexual orientation, while the second phrase acknowledges the social construction and subjective aspects of sexual orientation. When collecting data on both sexual orientation and gender identity, the same construction should be used as both aspects of personhood have subjective and objective elements.

***Recommendations for Collecting Sexual Orientation Data for Providers Serving Adolescents***

Over the past two decades, research into adolescent sexual orientation has created a diversity of views related to measurement and development (Saewyc, 2011). There is no current consensus among researchers about how best to measure sexual orientation during the age of 12-17 – whether the variable is sexual/erotic feelings, romantic and emotional attractions, or sexual behavior. There is also debate as to the stability of sexual orientation among youth over time. Most sexual orientation measures include only identity, attraction, or behavior. What can be said is that youth are coming out as LGBTQ at earlier stages of adolescence than in previous generations, and that there are strong cultural influences involved that would impact measurement of self-identification.

The CRDP LGBTQ TA Center will make recommendations on additional guidelines for surveying youth about sexual orientation as additional community-based participatory research can occur among diverse CRDP grantees serving adolescent LGBTQ populations.

***Recommendations for Collecting Sexual Orientation Data for Providers Serving Children***

For providers serving children 11 and under, it is recommended that data on sexual orientation not be collected due to developmental considerations. While young children have established an internal sense of gender by age three making gender identity a valid measure for children, sexuality develops during adolescence and cannot be measured accurately before then.

## Measures of Discrimination and Other Influences on Program Outcomes

Other influences on the impact of mental health prevention and early intervention services for LGBTQ populations relate to the type and degree of personal experiences with discrimination.

***Discrimination Based on Gender***

**How much do the following people in your life accept or reject your gender? Choose the one best answer.**

	<b>Totally reject</b>	<b>Somewhat reject</b>	<b>Neutral</b>	<b>Somewhat accept</b>	<b>Totally accept</b>	<b>Not applicable</b>
Parents/Guardians	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Siblings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Extended family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Partner(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coworkers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neighbors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical providers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental health providers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



### ***Discrimination Based on Sexual Orientation***

How much do the following people in your life accept or reject your sexual orientation? Choose the one best answer.

	Totally reject	Somewhat reject	Neutral	Somewhat accept	Totally accept	Not applicable
Parents/Guardians	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Siblings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Extended family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Partner(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coworkers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neighbors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical providers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental health providers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### ***Discrimination Based on Gender Expression***

During focus group discussions with CRDP LGBTQ grantees, it was agreed that if assessed, the impact of gender expression on mental health prevention and early intervention outcomes should address both how a respondent thinks about their own gender expression, and about how others think about the respondent’s gender expression.

**A person’s appearance, style, dress, or mannerisms (such as the way they walk or talk) may affect the way they think of themselves. On average, how would you describe your appearance, style, dress, or mannerisms? (Choose all that apply.)**

- Very feminine
- Mostly feminine
- Somewhat feminine
- Equally masculine and feminine
- Somewhat masculine
- Mostly masculine
- Very masculine
- Androgynous, non-binary, and/or gender nonconforming
- Neither masculine nor feminine

**A person’s appearance, style, dress, or mannerisms (such as the way they walk or talk) may affect the way other people think of them. On average, how do you think other people would describe your appearance, style, dress, or mannerisms? (Choose all that apply.)**

- Very feminine
- Mostly feminine
- Somewhat feminine
- Equally masculine and feminine
- Somewhat masculine

- Mostly masculine
- Very masculine
- Androgynous, non-binary, and/or gender nonconforming
- Neither masculine nor feminine

### ***Discrimination Based on Multiple Factors***

If included, both parts of the following question should be asked.

**a. In your day-to-day life how often have any of the following things happened to you? (Would you say almost everyday, at least once a week, a few times a month, a few times a year, less than once a year, never?)**

	Almost everyday	At least once a week	A few times a month	A few times a year	Less than once a year	Never
You are treated with less courtesy than other people.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
You are treated with less respect than other people.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
You receive poorer service than other people at restaurants or stores.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
People act as if they think you are not smart.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
People act as if they are afraid of you.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
People act as if they think you are dishonest.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
People act as if you are not as good as they are.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
You are called names or insulted.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
You are threatened or harassed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**b. What do you think was the main<sup>7</sup> reason for this/these experience(s)? Would you say...?**

- |  |  |
|--|--|
| <input type="checkbox"/> Your race or ethnicity  | <input type="checkbox"/> Your religion                 |
| <input type="checkbox"/> Your gender             | <input type="checkbox"/> Your immigration status       |
| <input type="checkbox"/> Your skin color/tone    | <input type="checkbox"/> Other (Please specify): _____ |
| <input type="checkbox"/> Your sexual orientation | <input type="checkbox"/> Don't know                    |
| <input type="checkbox"/> Your language or accent | <input type="checkbox"/> Refused                       |

### ***Other Demographic Factors***

In addition to SOGI demographics, multiple cultural factors influence the success or failure of mental health PEI services for LGBTQ individuals, families, and communities. Community needs assessments,

<sup>7</sup> Another way to ask this question that better acknowledges the role of intersectional identities is to delete the word "main" and add "Choose all that apply."

intake forms, evaluation data collection instruments, differential data analysis, and the reporting of findings to service communities should be inclusive and reflective of measures of cultural influence. Data can be used to identify disparities in service utilization and mental health outcomes, and to identify service gaps, program successes, and appropriate resources for sustainability.

In addition to traditions, beliefs and values passed on to individuals in their families and communities of origin, how individuals see themselves and how they interact with others is influenced by their gender, their class, family traditions, where they go to school, where they worship, the community they live in, and where they work. Culture is learned, informed by the philosophical/spiritual or religious teachings an individual and/or their family and friends adhere to, those they share intimate life experiences with, and for some, learning and developing a practice consistent with how they want to grow as a person. Culture is instrumental in expressing who you are and how you present yourself to the world. African Americans, working-class people, those of immigrant or indigenous heritage, along with distinct regions in the United States have multiple cultures of their own.

Intersectional factors such as age, religious/spiritual practices, geography, socioeconomic status, race/ethnicity, language, education level, and level of acculturation influence program awareness, engagement, retention, and outcomes. The way these intersectional cultural factors influence outcomes is through differences in how mental health and wellness is perceived, how sexual orientation is experienced, how sexual identity is expressed or concealed including terms used, how sexual behavior is discussed including privacy and confidentiality concerns, how gender identity is experienced, and how gender is expressed. Therefore, it is important to include data on those variables as part of the core demographic set that is considered during community needs assessments, collected on intake forms, and included as part of the analysis of evaluation data. This data is also a core component needed by providers to tailor services to address the cultural needs of everybody served. Which intersectional data is most significant to the community a program aims to serve can be identified using traditional searches of published academic studies and locally-obtained health-related data as well as employing community-based sources such as focus groups, key informant interviews, and public opinion polling of convenience samples within LGBTQ gathering places.

## Collecting Data with LGBTQ Cultural Competence

### *Creating a Safe Start*

Providing a safe and welcoming environment is critical when engaging the LGBTQ community, especially when asking about potentially stigmatizing personal information. The following strategies can help establish a welcoming and safe space for members of the community:

- Ensure that symbols of LGBTQ inclusion are visible.
- Provide privacy when collecting data.
- Ensure responses are kept confidential and inform respondents about your confidentiality policy and practice.
- Utilize openly LGBTQ staff or volunteers when implementing evaluation data collection.
- Ensure that staff and volunteers who engage evaluation participants regularly receive LGBTQ cultural competency training and supervision, including how to meet the needs of community members with identities that intersect multiple disparities groups.

- Include LGBTQ representatives in your Board of Directors and management, and ensure they represent the entire community racially, geographically, ethnically, across the gender and sexual spectrum, etc.

During key informant interviews or focus group sessions, community members can be asked what a program can do organizationally to increase participant's sense of trust. Examples may include assurances that participant information will be kept confidential and used solely to improve the quality of PEI services you will be providing. Find out how they would like this information to be obtained from them – the timing, location, and personnel involved.

A commonly used strategy in collecting quantitative data is the use of oversampling to ensure you have sufficient data to analyze the needs of intersectional populations. Oversampling involves collecting a disproportionate amount of data from intersectional population groups so the number of those cases can be analyzed statistically, and then applying data weighting procedures to the final sample so the oversampled groups are brought back to their proportional representation in the total population.

For example, if you want to ensure your program addresses the needs of LGBTQ community members who are transgender and African American, and your community needs survey only collected data on 5 trans spectrum members out of 100 cases total, you should focus additional data collection in areas where African American trans spectrum members can be found until you achieve the sample size required based on the confidence interval and population mean for your community of focus. One way to focus data collection on intersectional populations is to have community members forward survey participation data to their intersectional peer networks either online or through word of mouth.

## ***Selecting an Appropriate Method***

The method used to collect data from LGBTQ populations will impact responses, as demonstrated in the summary of national SOGI data discussed above.

### **Online vs In-Person Surveys for Needs Assessment**

If you are conducting a public opinion poll during your community needs assessment phase of program and evaluation planning, the technique most likely to result in authentic SOGI self-disclosure is an anonymous online survey (Aspinall, 2009). People may not feel free to answer potentially stigmatizing information in front of other family members as may occur during a telephone or in-person interview at home. Any type of person-to-person interview may not be perceived as fully confidential and anonymous, and people will likely conceal their true identities. This is most evident among those living in conservative, anti-LGBTQ climates.

### **Outcome Data**

Outcome data can be collected from program participants and comparison group members using either pencil and paper or a tablet device that uploads data directly to the internet. Either method works as long as privacy and confidentiality are assured, although program participants are more likely to have developed trust in the provider collecting data and be more willing to share potentially stigmatizing responses.

## ***Instrument Design***

The location of SOGI questions in a data collection instrument may impact participant responses. They should not be on the cover page where privacy may be at risk during the handling of the completed forms by office staff. It is best to include SOGI questions in the demographic section mixed among less stigmatizing questions related to race, ethnicity, and language. Explanations should be provided about why SOGI questions are included, and how they will be used to improve program services. SOGI instructions should also reaffirm that the information will be kept in strict confidence.

## ***Influences on Self Disclosure***

Not all clients will be willing to disclose their authentic sexual orientation and gender identity to program staff prior to developing trusting personal relationships with them, especially within communities where LGBTQ identities are stigmatized. Likewise, if the data is being collected in a public setting, such as a common waiting area, via the community member's home telephone, or if no guarantees are made that the data will remain confidential, LGBTQ clients may not self-identify authentically. As summarized in the CRDP Phase I LGBTQ Population Report "First, Do No Harm":

**Data collection and analysis should not be predicated on the assumption that LGBTQ individuals will self-identify on intake forms or interviews. Due attention should also be given in the design of these systems to the need for anonymity among many LGBTQ individuals.**

Nevertheless, it is important to include the questions on intake forms so that comparative program engagement and retention can be evaluated as much as possible across different populations from the very beginning of program involvement. One solution is to collect the data once at intake, and again a month or so later (depending on the frequency and quality of program involvement) after the program has established a trusting relationship with the client that includes confidentiality when helpful.

Discussing non-heterosexual sex – or any sex at all – is not acceptable in many cultures, especially with a relative stranger. Influences on self-disclosure include marital status, religion or spiritual practice, age, sociopolitical climate, acculturation to Western constructions of sexuality and gender, geographic region, race/ethnicity, socioeconomic status, housing status, household composition, veteran or military status, immigration or refugee status, disability, language and literacy, and connectedness to LGBTQ communities.

If collecting information on sexual behavior is important to how you will provide program services, or a facet of how you'll evaluate the impact of program services on differential population outcomes gleaned from your needs assessment, it must be done with cultural competence. The data collector should be trained in the skill of trust building, be trustworthy, and preferably be from the same community as the person from whom sensitive sexual data is being collected. Informing the community member about why you need to ask about sexual behavior, how the information will be kept confidential, and how it will be used to improve and evaluate program services are essential first steps. Ensuring the data collection is done in a private, secure location without family members present is also essential to obtaining authentic data on sexual history.

## Analyzing and Reporting Findings to LGBTQ Community Stakeholders

The analysis of outcome data stems from a hypothesis that relates directly to the theory of change and the logic model as operationalized through the evaluation plan. Informed by these conceptual documents, what overarching themes are reflected in the questions you posed to participants? Returning to your evaluation questions, do they capture the experiences of program participants? Do they measure a behavior you hoped to change, knowledge you hoped to transfer, or some other change in attitudes, beliefs, intentions, or other outcome your community defines as desirable?

Looking at the information you gathered, how often something happened, or how they appear on a scatter gram (where they concentrate) both can offer a clue as to how responses and potentially questions can be associated or possibly relate to one another. For example, you noticed in looking at the data that young bisexual male participants who attended multiple program activities also reported feeling less isolated and secondly gained a feeling of belonging. This is an example of a descriptive analysis. A possible hypothesis that may have guided your observation can be “The more a participant attends program activities, the more they will experience positive impact.” The impact in this example is not limited to an increase in knowledge or change in behavior but includes a more global feeling of belonging and less isolation.

During analysis, demographic data indicative of culture should be used to help understand where your program is most and least effective, and for whom. If you included oversampling of intersectional populations to assess the success of their utilization program services, you will need to weight your data before drawing conclusions from the entire dataset. However, you can analyze the intersectional data directly and draw conclusions on the responsiveness of your program to the cultural and individual needs of the full community you serve.

Including qualitative data in your analysis provides information that can fill in the gaps in quantitative findings about what is working, what is not working, and why. In analyzing information gotten through focus groups and structured interviews, it is common practice to audio/video record and subsequently transcribe the proceedings of these meetings. Participant observation or field notes can be used to supplement the material gathered more formally in the focus group or interview. These focus group discussions and interviews can be focused on a set of questions that are geared towards the design or components of the intervention, or they can be open ended allowing for discussion to evolve organically among participants on key topic areas.

No matter the approach, the next step is to organize the information and look for common themes in the words or phrases expressed by participants. Observations from the meeting can be noted such as commitments, consensus conclusions, allegiances, and tensions. Associations can be drawn between behaviors, words, or themes that resonated among those present. Allegiances or commitments made and priorities identified can be examined for significance. Information captured can inform how an intervention should be delivered, or how program staff should approach a concern or anticipate challenges in delivering the intervention. Evaluators can also use qualitative information to develop a hypothesis as to potential underlying motivators to engage and retain participants, identify potential barriers in effectively communicating the intervention material, and provide insight into what to anticipate when convening representatives of a community identified as the focus of the intervention. Descriptive and formative research are sources of information not usually captured in quantitative surveys. Qualitative data can be the basis for ensuring an intervention is relevant and responsive to the group’s needs and norms.

Continuing to engage community partners and members as you analyze and disseminate findings from your program evaluation will also help ground your work in the perceived needs and desired outcomes of the communities you serve.

### ***Data Utilization for Program Services***

Data trends should be analyzed to identify mental health disparities, gaps in services, successes in service provision, and to support appropriate resource allocation (Mikalson, no date). Process and outcome data should be analyzed together to assess the cultural and linguistic competence of program outreach and services to individuals and groups.

### ***Reporting Findings to Community Stakeholders***

Convening a Community Advisory Board (CAB) while you were engaging in community participatory evaluation activities such as key informant interviews, focus groups, and public opinion polls is a good strategy to lay the foundation for reporting program findings back to the community you serve. The CAB can provide expertise and community knowledge of the populations of focus, serve as cultural brokers, help interpret findings, provide a link to relevant community resources, and serve as trusted opinion leaders in the community. A CAB can also help program staff understand which formats and platforms are best to communicate results to the stakeholder community. Examples include:

- First-person narratives of program impact that tell a compelling, accessible story of program benefits for individual participants.
- Pictograms and charts that make complex quantitative data more broadly understandable.
- Social media used to communicate results in a format that is easily forwarded to others in a cascade effect that maximizes stakeholder engagement with program results.
- Community town halls that provide an opportunity for program stakeholders, staff, management, volunteers, and evaluators to share program activities and outcomes in an interactive forum.

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## Appendix A: Emerging Gender Expansive Terms

Source: Debby Herbenick, PhD & Aleta Baldwin, MA.

<http://www.thedailybeast.com/articles/2014/02/15/the-complete-glossary-of-facebook-s-51-gender-options.html>

**Agender** - Someone who does not identify with any sort of gender identity. This term may also be used by someone who intentionally has no recognizable gender presentation. Some people use similar terms such as “genderless” and “gender neutral”.

**Androgyne/Androgynous** - someone who neither identifies with, nor presents as, a man or woman. Being “androgynous” can refer to having both masculine and feminine qualities. This term has Latin roots: Andro- meaning “man” and -gyne, meaning “woman.” Some androgynes may identify as “gender benders”, meaning that they are intentionally “bending” (or challenging/transgressing) societal gender roles.

**Bigender**- someone who identifies as both a man and a woman. A Bigender identity is a combination of these two genders, but not necessarily a 50/50 combination, as these genders are often felt – and expressed - fully. Similar to individuals who identify as gender fluid, bigender people may present as men, as women, or as gender-neutral ways on different days.

**Cis**- all of these terms capture that a person is not trans or does not have a gender diverse identity or presentation.

**Cis Female** (see also Cis Woman, Cisgender Female, Cisgender Woman); a female who identifies as a woman/has a feminine gender identity.

**Cis Male** (see also Cis Man, Cisgender Male, Cisgender Man); a male who identifies as a man/has a masculine gender identity.

**Cis Man** (see Cis Male)

**Cis Woman** (see Cis Female)

**Cisgender**: A person who has the gender identity commonly associated with their biological sex (e.g., someone who is assigned as a female at birth and who lives as a woman).

**Cisgender Female** (see Cis Female)

**Cisgender Male** (see Cis Male)

**Cisgender Man** (see Cis Male)

**Cisgender Woman** (see Cis Female)

**Female to Male/ FTM**- a trans person who was assigned female sex, and now lives as a man and has a masculine gender identity. This person may or may not have altered his physical body with surgery, hormones, or other modifications (e.g., voice training to develop a deeper spoken voice). FTM is an abbreviation of female to male. Generally uses masculine pronouns (e.g., “he” or “his”) or gender neutral pronouns.

**Gender Fluid**- someone whose gender identity and presentation are not confined to only one gender category. Gender fluid people may have dynamic or fluctuating understandings of their gender, moving between categories as feels right. For example, a gender fluid person might feel more like a man one day and more like a woman on another day, or that neither term is a good fit.

**Gender Nonconforming-** Someone who looks and/or behaves in ways that don't conform to, or are atypical of, society's expectations of how a person of that gender should look or behave. (See also [this excellent article](#) by Dr. Eric Grollman about gender conformity & gender non-conformity).

**Gender Questioning-** Someone who may be questioning their gender or gender identity, and/or considering other ways of experiencing or expressing their gender or gender presentation.

**Gender Variant-** an umbrella term that refers to anyone who, for any reason, does not have a cisgender identity (which includes the trans\* umbrella). Others acknowledge concerns with this term as it implies that such genders are "deviations" from a standard gender, and reinforces the "naturalness" of the two-gender system. Some prefer the terms "**gender diverse**" or "**gender-nonconforming.**"

**Genderqueer-** Someone who identifies outside of, or wishes to challenge, the two-gender (i.e., man/woman) system; may identify as multiple genders, a combination of genders, or "between" genders. People who use this term may feel that they are reclaiming the word "queer", which has historically been used as a slur against gay men and women. This term is used more often by younger generations doing the "reclaiming" and less often by slightly older generations who may have personally experienced the term "queer" as a slur.

**Intersex-** Generally refers to someone whose chromosomes, gonads (i.e., ovaries or testes), hormonal profiles, and anatomy challenge conventional concepts about what "male" or "female" bodies should look like. Some intersex conditions are apparent at birth, while others are noticed around puberty or later (if ever). Some individuals no longer use the term "intersex conditions" and instead prefer "disorders of sex development." (See [ISNA.org.](#)) Others identify as intersex and do not have bodies the medical establishment would label "intersex."

**Male to Female/MTF-** a trans person who was assigned male sex (likely at birth), and now lives as a woman and has a feminine gender identity. This person may or may not have altered her physical body with surgery, hormones, or other modification (e.g., voice training, electrolysis, etc). MTF is an abbreviation of "Male To Female". Generally uses female pronouns (e.g., "she" or "her") or gender neutral pronouns.

**Neither-** Not putting a label on one's gender.

**Neutrois-** An umbrella term within the bigger umbrella terms of transgender or genderqueer. Includes people who do not identify within the binary gender system (i.e., man/woman). According to [Neutrois.com](#), some common Neutrois identities include agender neither-gender, and gender-less.

**Non-binary-** Similar to genderqueer, this is a way of describing one's gender as outside the two-gender (i.e., man/woman) system and/or challenging that system.

**Other-** Choosing to not provide a commonly recognized label to one's gender. When used by someone to describe themselves, this may feel like a freeing way of describing (or not specifically describing) their gender. The term "other" should not be used to refer to people whose gender you can't quite understand or place.

**Pangender-** "Pan" means every, or all, and this is another identity label such like genderqueer or neutrois that challenges binary gender and is inclusive of gender diverse people.

**Transgender-** an umbrella term that includes all people who have genders not traditionally associated with their assigned sex. People who identify as transgender may or may not have altered their bodies through surgery and/or hormones. Some examples:

**Trans Man** (see FTM above); Although some people write the term as “transman” (no space between trans and man) or trans-man (note the hyphen), some advocate for a space to be included between “trans” and “man” in order to indicate that the person is a man and that the “trans” part may not be a defining characteristic or central to his identity.

**Trans Woman** (see MTF above) Although some people write the term as “transwoman” (no space between trans and woman) or trans-woman (note the hyphen), some advocate for a space to be included between “trans” and “woman” in order to indicate that the person is a woman and that the “trans” part may not be a defining characteristic or central to her identity.

**Trans Female** (see MTF above)

**Trans Male** (see FTM above)

**Trans Person** (see transgender above); another way of saying someone is a transgender person. (Note that “transgender” tends to be preferred over “transgendered”).

**Trans\*** is an inclusive term, referring to the many ways one can transcend or even transgress gender or gender norms (e.g., it includes individuals who may identify as transgender, transsexual, gender diverse, etc). In many cases the asterisk (\*) is not followed by a sex or gender term – it’s just written as Trans\* - to indicate that not all trans people identify with an established sex or gender label. Another option is to write it as:

**Trans\*Person** (see transgender above)

Other times, a sex or gender label may be used:

**Trans\*Female** (see MTF)

**Trans\*Male** (see FTM)

**Trans\*Man** (see FTM)

**Trans\*Woman** (see MTF)

**Transsexual person** - For many people this term indicates that a person has made lasting changes to their physical body, specifically their sexual anatomy (e.g., genitals and/or breasts or chest), through surgery. For some, the term “transsexual” is a problematic term because of its history of pathology or association with a psychological disorder. To get the operations necessary for sexual reassignment surgeries or gender confirming surgeries, people long needed a psychiatric diagnosis (historically, that diagnosis was “transsexualism”) and recommendations from mental health professionals. The term “transsexual” tends to be used less often by younger generations of trans persons.

**Transsexual Woman** – Someone who was assigned male sex at birth who has most likely transitioned (such as through surgery and/or hormones) to living as a woman.

**Transsexual Man** – Someone who was assigned female at birth who has most likely transitioned (such as through surgery and/or hormones) to living as a man.

**Transsexual Female** (see Transsexual Woman)

**Transsexual Male** (see Transsexual Man)

**Transgender** is an umbrella term which includes all people who have genders not traditionally associated with their sex at birth. **Transgender person** can also be used. This may (but does not necessarily) include:

**Transgender Female** (see MTF)

**Transgender Male (see FTM)**

**Transgender Man (see FTM)**

**Transgender Woman (see MTF)**

**Transmasculine-** Someone assigned a female sex at birth and who identifies as masculine, but may not identify wholly as a man. Often, you'll encounter the phrase "masculine of center" to indicate where people who identify as transmasculine see themselves in relation to other genders.

**Transfeminine-** Someone assigned a male sex at birth who identifies as feminine, but may not identify wholly as a woman. Often, you'll encounter the phrase "feminine of center" to indicate where people who identify as transfeminine see themselves in relation to other genders.

**Two-spirit-** This term likely originated with the Zuni tribe of North America, though two-spirit persons have been documented in numerous tribes. Native Americans, who have both masculine and feminine characteristics and presentations, have distinct roles in their tribes, and they are seen as a third gender. (Recently, [Germany](#) and [Nepal](#) adopted a third gender option for citizens to select).