SOGIE: Inclusivity in Behavioral Health Treatment Service Provision

Sexual Orientation | **Gender Identity** | **Expression**

SOGIE is an inclusive acronym to help us understand an often under-represented and under-served aspect of everyone's identity. By better understanding SOGIE, and by improving our language and label use, we can improve access to behavioral health care services, service delivery, and ultimately improve behavioral health outcomes. This handout includes six sections that provide an overview of key considerations that you can use to develop SOGIE-inclusive services.

1 Understanding how language, labels, and definitions of SOGIE terms lay a foundation for how we communicate, and in effect, treat individuals, both personally and professionally **(see Figure 1).**

2 LGBTQIA+ populations have unique assets and needs that impact how they access and receive care **(see Figure 2).**

3 With a deep understanding of language and the unique population, analyze your service delivery points of entry/initial contact to develop inclusive visual and verbal practices **(see Figure 3).**

4 Develop opportunities to invite identity-based disclosure during screening and intake through thoughtful consideration of why, who/when, and how to ask about a client's SOGIE **(see Figure 4).**

5 Ensure identity-based disclosures are meaningfully documented and communicated across care teams **(see Figure 5).**

6 Take steps to create SOGIE-inclusive behavioral health treatment service provision using the provided checklist below **(see Figure 6).**

This handout is intended for county behavioral health staff, mental health providers, social workers, and clinicians.

This handout is supplementary to a two-part webinar series developed for county behavioral health staff, mental health providers, social workers, and clinicians to help understand how SOGIE-inclusivity can be integrated into behavioral health treatment provision in order to improve behavioral health outcomes. The first webinar in the series provided an overview of gender and sexual diversity, and the interactions between SOGIE, behavioral health outcomes, and the ability to access services. The second webinar in the series provided training on implementing SOGIE-inclusive strategies, practices, and protocols for ensuring that LGBTQIA+ clients experience welcoming and responsive care, thereby increasing the likelihood of continued engagement with needed behavioral health services.

__What is SOGIE and Why Inclusivity Matters to Behavioral Health Outcomes__
View the recording here: https://attendee.gotowebinar.com/recording/680445287379125259

__How to Integrate SOGIE-Inclusivity Into Behavioral Health Treatment Service Provision__
View the recording here: https://attendee.gotowebinar.com/recording/869563486689508880

Handout created by __Bird and Bee Education and The Social Changery__. Handout is intended for teaching/clinical purposes only. If you wish to duplicate or distribute this handout beyond fair use please contact the authors for permission.

This webinar series and hand-out is part of statewide efforts to prevent suicide, reduce stigma and discrimination related to mental illness, and to promote the mental health and wellness of students. These initiatives are funded by counties through the Mental Health Services Act (Prop 63) and administered by the California Mental Health Services Authority (CalMHSA).

Figure 1: SOGIE Terms, Definitions, and Considerations in Putting These Terms Into Practice

Term	Definition	Considerations
SOGIE	Acronym that refers to Sexual Orientation, Gender Identity, and Expression	A more inclusive term that centers all identities, because every person has a sexual orientation, a gender identity, and way that gender expresses.
LGBTQ+	Acronym used as an umbrella term for all sexual and gender minority identities.	Changes to this acronym over time have reflected the increasing visibility and recognition of diverse identities and communities. However, it can also function to subtly center cisgender and heterosexual identities as normative, while othering sexual and gender minority identities by grouping them together under this one, aggregate label.
Sex	Designations made by the medical community at birth, based on observable physical traits.	Sex, inclusive of intersex characteristics, actually falls along *a continuum of naturally occurring variations*, rather than into the two discrete categories of female or male. **Some terms/labels used to describe sex:** • *Intersex* • *Differences of Sex Development/DSD* • *Sex assigned at Birth, AFAB/AMAB (assigned female/male at birth)* • *Sex Designation, DFAB/DMAB (designated female/male at birth)*
Gender Identity	How a person experiences gender internally, as female, male, another gender or combination of genders, or no gender at all, irrespective of sex assigned at birth.	Some terms/labels used to describe gender identity: • **Cisgender/Cis:** when gender identity aligns with the sex assigned at birth. • **Transgender/Trans**: when gender identity doesn't necessarily align with the sex assigned at birth. May also self-describe as *(Trans) woman or man, MTF/FTM (male to female/female to male), transfeminine or transmasculine.* • **Nonbinary/NB/enby:** when gender identity doesn't fit into the binary model of gender. May also self-describe as genderqueer, gender fluid, bi-, tri-, poly-, or pangender, demiboy/demigirl. • **Agender/Nongender:** existing outside gender constructs entirely. • **Questioning**

Figure 1: SOGIE Terms, Definitions, and Considerations In Putting These Terms Into Practice

Term	Definition	Considerations
Gender Expression	How a person displays gender externally, via their appearance, mannerisms, interests, and other subjective gender markers.	Gender expression is highly contextual, based on cultural, geographic, and temporal gender norms. It exists independently and is not predictive of sexual orientation or gender identity. Some terms/labels used to describe gender expression: • *Gender nonconforming/GNC* • *Androgynous/Androgyne* • *Crossdresser* • *Drag king/queen*
Sexual Orientation	Gender(s) to which a person feels attracted.	Functions independently of gender identity. People who are cis, trans, and nonbinary can identify with any sexual orientation. Some terms/labels used to describe sexual orientation: • *Heterosexual/Straight* • *Lesbian/Gay, Same-sex attracted* • *Bisexual* • *Pansexual* • *Queer* • *Questioning*
Sexual Identity	A broader category that includes sexual orientation, as well as whether, and to what degree, a person might experience attractions to others.	Attractions may be experienced as emotional/romantic, physical/sexual, on all or none of those levels. Some terms/labels used to describe sexual identity: • *Demisexual/Demi* • *Asexual/Ace* • *Aromantic/Aro*

These terms frequently change as the language that communities and individuals use to self-describe continues to evolve. This list is not intended to be exhaustive or representative of all individuals or communities. This list and content therein is presented as a way to begin to understand the diversity of gender and sexual minority identities and the multiplicity of terms and labels used to describe them.

Figure 2: Assets and Needs for Behavioral Health Services for LGBTQIA+ Populations

Assets and Strengths	Needs and Challenges
Individual: - Embracing nonconformity: including being open to other perspectives and challenge societally-held beliefs - Awareness/recognition of own resilience - Compassion and empathy towards others - Breadth of gendered perspectives and experiences: more nuanced understanding of gender norms and roles **Community:** - Protective factors: when identity is supported within family, peer group, school/work, community - Identity-based community: shared identities can provide support	- Social-emotional stressors: higher rates across this population, including internalized and intra-community stressors - Social determinants of health: greater risk across this population, including across all five domains - Toxic stress and trauma: higher rates across this population, even higher for LGBTQIA+ people of color - Mental health disparities: higher rates of experiencing mental health challenges of all kinds **Notes:** *Needs and challenges are not endemic to LGBTQIA+ identity and are not always experienced Rather, they reflect the disproportionate impact of identity-based stigma, discrimination, toxic stress, and trauma*

In addition to considering population-level assets and needs, we also need to consider systemic pre-existing barriers to care that often occur in one-on-one interactions, and are collectively compounding in impact. These barriers further decrease the likelihood of LGBTQIA+ individuals accessing and/or continuing to engage with services. These include:

Cisnormativity and Heteronormativity: repeatedly being misgendered, deadnamed, presumed heterosexual;

Transphobia and Homophobia: encountering stigma, discrimination, hostility, ignorance, specifically in health care settings; and

Socioeconomic and Administrative: economic insecurity, issues with name, gender, or marital status on legal documents.

Figure 3: Initial Points of Contact: Best Practices to Ensure Continued Engagement of Marginalized LGBTQ+ Clients

1. Identify and map your system's initial points of contact: places where first interactions with clients occur. These may include:

a. Hotlines, inquiry phone calls, scheduling phone calls

b. Walk-ins, front reception visits, office visits

c. Home and site visits

d. Virtual visits

2. Based on these points of contact, locate where you can improve the welcome experience visually. Implement the following best practices to create a positive visual welcome for LGBTQIA+ clients.

Best Practice #1:

Include inclusive images, such as visually gender diverse people in photos, and symbols or images of inclusivity and community pride.

Best Practice #2:

Visibly post nondiscrimination policies.

Best Practice #3:

Include LGBTQIA+ resources on tables, bulletin boards, websites, etc.

Best Practice #4:

Make sharing individual pronouns visually explicit; for example, on staff name tags/badges, business cards, buttons staff can wear, name plates on doors/desks, and with a sign at reception inviting people to share their pronouns (e.g. "Please tell us your pronouns so that we may better serve you!").

THEY/THEM
SHE/THEY

Best Practice #5:

Create inclusive restrooms, such as gender neutral or all gender restrooms. It doesn't need to be all restrooms, and if it isn't, then visually post where inclusive restrooms can be located.

ALL GENDER RESTROOM

Best Practice #6:

Designate, train, or recruit an LGBTQIA+ client liaison/advocate and make this person's information and designation easily accessible. Providing a liaison who is comfortable with and well-informed about SOGIE-related feedback, needs, or concerns (either personally or professionally) provides a safe space for LGBTQIA+ clients, and can be significant in those clients' service experience.

3. Based on the initial points of contact, locate where you can improve the welcome experience verbally. Consider all your initial points of contact that include a verbal element, such as a hotline, regular phone lines, reception, outreach teams, direct service staff, and support service staff. Seemingly small details can make a significant difference. Deadnaming or misgendering may seem to be a small mistake to the person making it, but for the client, it may be the fifth time that day that they have that experience. Furthermore, using a client's correct name and gender can be what makes the difference in them coming back for continued care. Consider the following elements to create a positive verbal welcome experience for LGBTQ+ clients.

Best Practice #1: Offer your own pronouns when introducing yourself in person or on the phone.

"Hi, I'm _____ and I use _____ pronouns."

Best Practice #2: Avoid using gendered language based on voice, appearance or gender expression. This includes assuming pronouns or using "sir/ma'am", "mister/miss", or "guys", etc. Gendered references/language are not inherently bad; however, using gendered language before information has been shared about a person's identity reinforces cisnormative and heteronormative assumptions and can create negative experiences or harm. Start by observing yourself to identify when you use gendered language. Find small actions to help you change your habits, such as posting a list of gender neutral terms next to your phone or practice adding your pronouns in video meetings and in-person introductions.

AVOID SIR & MA'AM | MR. & MISS | GUYS UNTIL YOU KNOW

Best Practice #4: Check records carefully for name, gender, or pronoun changes before calling a client or greeting them at reception. This is particularly important when multiple staff may be making reminder calls, checking in clients, etc., and when multiple record systems may be being used. It's best to ask the client if you're not sure.

HE/HIM   SHE/HER   THEY/THEM
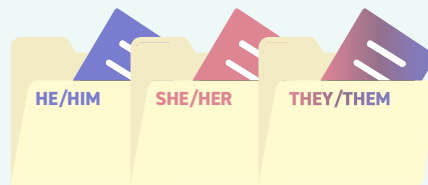
Best Practice #5: Provide an opening for details about names, pronouns, or identities to be shared or further clarified. This can be as simple as "if there is anything you'd like us to know about the name or pronouns you use or your identity, please feel free to share at any time".

"Feel free to share anything you'd like us to know about your identity or pronouns."

Best Practice #6: When you make a SOGIE-related mistake, apologize, ask for clarification, and then move on. A lengthy explanation or process is usually not needed, unless the client requests further discussion.

Own the error. → Apologies, that was my mistake.

Ask for clarification → How I should address you moving forward?

Figure 4: Opportunities to Invite Identity-Based Disclosure During Screening and Intake

Develop opportunities to invite identity-based disclosure during screening and intake through thoughtful consideration of why, who, when, and how to ask SOGIE-related questions.

?

Why ask? What value is there in asking about SOGIE?

- Studies show that the vast majority of clients would like to be asked about sexual issues.[1]
- Whether clients are requesting services directly related to their SOGIE, or are seeking help for other behavioral health concerns, providing SOGIE-informed services, as described in Figure 3, that reflect and affirm all aspects of a client's identity is significantly impactful and increases the likelihood that clients will continue to engage with systems of care.

Who to ask?

- Historically, people tend to ask in response to signals from the client, such as verbal references (refers to their "partner") or visual cues (gender nonconforming appearance). Verbal references and visual cues are not always accurate.
- Instead, we recommend that everyone is asked. Inviting and providing an opportunity for all clients to share about their SOGIE (something every person has) ensures inclusivity, minimizes assumptions and omissions, encourages continued engagement, empowers clients, reduces stigma and shame, and decreases unconscious bias.
- Overwhelmingly, people are supportive of being asked SOGIE-related questions in health care settings, especially when it is a generalized practice implemented throughout the system.[2]

When to ask? What things should you consider when determining when to ask?

- The conversation begins before you actually speak with clients. It begins with the initial points of contact and welcome that they receive, and includes visual and verbal cues, as described in Figure 3. These cues lay the groundwork before the conversation begins.
- Consider and address safety needs first. Crisis needs must often be addressed immediately. In addition, providing transparency about why you are asking about their SOGIE can help avert potential safety concerns about sharing, such as what might end up in records/documentation that could affect clients in the future.
- Establishing rapport might be needed before clients feel safe to share. If a client is seeking services related to their SOGIE, they may feel comfortable enough or simply feel a pressing need to disclose identity-based information right away, whether or not a rapport has been established. At the same time, disclosures that are supportively received can contribute to developing that rapport. Practices that invite sharing early in the relationship and inform clients that they can share at any time address both of these considerations.
- Consider the timing of the ask. Review your informed consent process to determine when it would be appropriate to integrate SOGIE questions. For example, it may fit well to invite disclosure when you're talking about confidentiality and how records/documents may be shared. Additionally, consider the question cluster. Do not put identity questions on forms next to questions about trauma or violence history that may have negative connotations/experiences. Identity should always be framed as a potential asset.
- Be thoughtful and intentional about the progression for inviting disclosure in new relationships:
  - Seed SOGIE dialogue ahead of direct questions
  - Invite open-ended self-disclosure
  - Ask directly, as relevant, when not volunteered (such as for forms)
  - Explicitly request permission and input on whether and how to document disclosures
- A good way to introduce SOGIE and disclosure in existing and ongoing relationships is to share why you're asking now. For example, you just attended a training on the subject, or your department is updating your forms and process to be more inclusive.

How to ask?

Start with yourself - understand clearly the value of asking:

- To provide sensitive, responsive, and appropriate services/referrals
- To increase and monitor diversity, access, and inclusivity
- To fulfill insurance or legal requirements (understanding what data needs to be collected and how it is used)
- To collect and report data (understanding for whom and why)

Be transparent about the reasons you're asking with clients:

- Share reasons why questions are being asked (as they are being asked)
- Describe privacy practices and reporting requirements
- Restate commitment to nondiscrimination when asking
- Indicate that questions are asking to all clients, and not specific to them
- Re-ask, and state why, as people's SOGIE can change over time
- Make it optional whenever possible, include "unsure" or "prefer not to answer"

Take time to prepare yourself and take ownership of your role in the conversation:

- What would your reasons for asking about a client's SOGIE be?
- How would you share your rationale with the client to make it transparent?
- What language feels natural for you to ask about SOGIE?
- When in your screening or intake process might you seed SOGIE inquiry, invite disclosure, or ask questions directly?
- In what ways do you feel clearer and more confident about why, who, when, and how to ask about clients' gender and sexuality?
- What hesitations or concerns do you still have?

[1]*Source: Taking Routine Histories of Sexual Health: A System-Wide Approach for Health Centers, November 2015*
[2]*Source: Collecting Sexual Orientation and Gender Identity Data in Electronic Health Records, Fenway Institute*

Figure 5: Ensuring Meaningful Documentation and Communication for Clients' Identity-Based Disclosures

Consider all the possible points of transition where clients' information is being shared or transferred. These points of transition provide opportunities for meaningful communication between teams, departments, or agencies. Additionally, they constitute vulnerabilities for information to get lost or misrepresented. What occurs at each of these points impacts the clients experience and ultimately their continued care.

Ways To Adapt Existing Forms

Next to "Name", add "Name used" or "Name of record, if different."

Name → "Name Used"
"Name of Record"
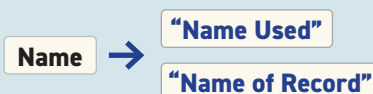
Next to Gender, add "Current gender" and/or "Sex assigned at birth, if different."

Gender → "Current Gender"
"Sex Assigned at Birth, if Different"

If not on the form, write in "Pronouns" and/or "Identifies as", "SO/GI".

Pronouns _____ and/or "Identifies as" _____
"SO/GI" _____

Use sections such as "Aliases" or "Comments" in order to document notes about SOGIE.

If form does not provide a check box option that matches what the client has told you, **explain it to the client**—describe what options are available on the form, explain the purpose of the form and options (i.e. determined by the state/funder), and give the client the choice of which box to check.

Document where you can (in a comment box) that the client does not identify that way, but checked the box that was reasonably close.

Use "other" option whenever available to write in any gender or sexual identities that are not included in the option list.

Add information about gender identity and sexual orientation in the psychosocial history, cultural formulation, family, and/or relationship sections of records.

Add information about gender transitions in the medical sections of records.

Figure 6: Steps to Take to Create SOGIE-Inclusive Behavioral Health Treatment Service Provision

☑ **Identify strengths and assets** within your organization – existing individuals, departments, practices, and policies that are currently working to promote equity and inclusivity for sexual and gender minority clients.

☑ **Identify issues, concerns, challenges and needs** – where is your organization struggling, unsure what practices to implement, feedback received, etc.

☑ Identify client **entry points.**

☑ Assess SOGIE-inclusivity in **visual welcome:** physical, digital, print.

☑ Assess SOGIE-inclusivity in **verbal welcome:** with reception, sign-in, providers.

☑ **Designate** and/or train personnel to act as **LGBTQIA+ client liaisons.**

☑ **Identify opportunities** during assessment/intake for SOGIE inquiry.

☑ **Establish procedures and protocols** for inviting SOGIE-related disclosures.

☑ **Empower clients:** explain question rationale, documentation needs and choices.

Presenters

Ronit Matabuena

Ronit Matabuena | Lev, MA, has been educating children, teens, families, and professionals in public, nonprofit, and private institutional settings for more than 30 years. She is the Founder of Bird and Bee Education, an experienced SOGIE Trainer and Sexuality Health Educator, and formerly a public school teacher. With a strong social justice and education reform background, Ronit is fiercely committed to creating safe, inclusive, relevant, and empowering environments for learners of every age.

Education/Credentials
Master's degree in Education with a "Special Interest" in Sexuality Education from San Francisco State University
Multiple- and Single-subject teaching credentials
Bachelors of Science with Honors from UC Berkeley

Lisa Smusz

Lisa Smusz | MS, LPCC, has more than 20 years of senior level experience in developing, executing, and evaluating public health initiatives on local, statewide, national, and international projects. Ms. Smusz is widely regarded as a subject matter expert in mental health stigma reduction, and has served as a SME for California's Mental Health Movement Each Mind Matters, international stigma reduction campaigns, and the Harvard University Global Health Delivery Project as an Expert Panelist on Addressing Mental Health Stigma. Ms. Smusz has been interviewed by television, radio, and print news media outlets for her expertise on mental health and stigma issues; and has extensive experience working with college-age young adults, and culturally responsive approaches to promoting public and mental health in diverse communities. For the past 16 years, Lisa has headed a highly successful consulting firm providing strategic counsel, advocacy, and subject matter expertise to public health and educational organizations across California. Lisa is also an Instructor at California State University, East Bay where she has been teaching for the past 17 years. Ms. Smusz teaches graduate level coursework for future Marriage and Family Therapists, School Psychologists, and School Counselors as well as undergraduate coursework in women's studies and social justice coursework.

Education/Credentials
Member of the 2022 Global Health Delivery cohort at Harvard TH Chan School of Public Health
Licensed Professional Clinical Counselor (LPCC 298)
Masters of Science in Educational Psychology/Counseling from California State University, Hayward
Bachelors of Science in Bio-Psychology from California Polytechnic State University at San Luis Obispo