Online Appendix for:
"Gender Identity, Race, and Ethnicity-based Discrimination in Access to Mental Health Care: Evidence from an Audit Correspondence Field Experiment"

Luca Fumarco
Masaryk University

Benjamin Harrell
Vanderbilt University

Patrick Button
Tulane University

David Schwegman
American University

E Dils
YouthForce NOLA

August 6, 2023

Table of Contents:

Online Appendix A: Ethics in Audit Studies

Compared to laboratory experiments (where there is informed consent) and studies that use observational data, field experiments raise unique ethical concerns regarding the use of deception and the time costs imposed on participants. To obtain an unbiased estimate of discrimination devoid of any observational effects or social desirability bias, this study requires random assignment and deception (Grohs, Adams, and Knill 2016). However, per our Institutional Review Board[1]- approved protocol, we took several steps to reduce any study participants' risk.

The primary risk to the participants is the time cost imposed on them. However, responding to these inquiries is a normal part of their business activity. Reading and responding to an inquiry takes, based on the authors' average time, between three and four minutes. Thus, this cost is minimal.

Furthermore, to ensure that we do not compromise respondents' anonymity, we only collect information that is (1) essential to the study and (2) willingly placed online by study participants. We do not collect detailed, identifiable information such as the names or full addresses of the MHPs. We only collect the zip code of the MHPs. Any MHP demographic information was encrypted and, per IRB guidelines, no identifiable individual-level information will be released. Descriptive statistics will be aggregated at least to the ZIP code level.

References Not Cited in the Main Paper

Grohs, Stephan, Christian Adam, and Christoph Knill. 2016. "Are Some Citizens More Equal than Others? Evidence from a Field Experiment." *Public Administration Review* 76 (1): 155–64. https://doi.org/10.1111/puar.12439.

[1] This project was approved by Tulane University's Institutional Review Board (Ref # 2019-1122) and it was pre-registered at the American Economic Association's registry for randomized controlled trials (RCT ID: AEARCTR-0006560).

Online Appendix B: Robustness Checks

Table B1: Robustness Test-Differences in Positive Response Rates, Results for Aggregated Groups and by Mental Health Concern (Probit Model Marginal Effects)

	Linear Probability Model (1)	Probit Average Marginal Effects (2)
Transgender or Non-binary	0.0260	0.0236
	(0.0405)	(0.0419)
African American	-0.1302***	-0.1366***
	(0.0364)	(0.0394)
Hispanic	-0.1072**	-0.1045**
	(0.0481)	(0.0479)
Depression	0.0925	0.1012*
	(0.0570)	(0.0568)
Anxiety	0.0114	0.0184
	(0.0505)	(0.0493)
State fixed effects:	X	X
Week sent fixed effects:	X	X
Day of the week sent fixed effects:	X	X
N	1,000	1,000
Adjusted R^2	0.0421	
Pseudo R^2		0.0870

Notes. Regression estimates based on equation (1). The mean positive response rate for the excluded group (cisgender White prospective patients) is 61.5%. Standard errors, clustered at the patient level and average marginal effects standard errors calculated via delta method, both in parentheses. * $p < 0.10$, ** $p < 0.05$, *** $p < 0.01$.

Table B2. Alternative Positive Response Rates by Gender Identity

Response Rates by Trans/Cis Status:	Positive	Negative	Total		
Cisgender	71.3% (342)	28.7% (138)	480		
Transgender or Non-binary	63.1% (328)	36.9% (192)	520		
Total	67.0% (670)	33.0% (330)	1,000		
Test of independence, p-value	0.006				
Response Rates by Gender Identity:					
Cisgender Men	71.9% (223)	28.1% (87)	310		
Cisgender Women	70.0% (119)	30.0% (51)	170		
Transgender Men	58.6% (82)	41.4% (58)	140		
Transgender Women	67.1% (114)	32.9% (56)	170		
Non-binary	62.9% (132)	37.1% (78)	210		
Tests of independence, p-values	Cis men	Cis women	Trans men	Trans women	Non-binary
Cisgender Men	…				
Cisgender Women	0.655	…			
Transgender Men	0.005	0.036	…		
Transgender Women	0.265	0.561	0.124	…	
Non-binary	0.029	0.145	0.422	0.395	…

Notes: Our alternative positive response rate codes responses as positive if the MHP's response was an appointment offer, call or consultation offer, screening questions, or referral. P-values come from a t-test (two-sided).

Table B3. Alternative Positive Response Rates by Race or Ethnicity

	Positive	Negative	Total
White	68.6% (343)	31.4% (157)	500
African American	67.8% (183)	32.2% (87)	270
Hispanic	62.6% (144)	37.4% (86)	230
Total	67.0% (670)	33.0% (330)	1,000

Tests of independence, p-values	White	African American	Hispanic
White	…	…	…
African American	0.815	…	…
Hispanic	0.111	0.227	…

Notes: Our alternative positive response rate codes responses as positive if the MHP's response was an appointment offer, call or consultation offer, screening questions, or referral. P-values come from a t-test (two-sided).

Table B4. Alternative Positive Response by Race or Ethnicity, for Cisgender and Transgender or Non-Binary Patients Separately

Response rates for cisgender only:	Positive	Negative	Total
White	72.7% (189)	27.3% (71)	260
African American	72.9% (102)	27.1% (38)	140
Hispanic	63.8% (51)	36.2% (29)	80
Total	67.0% (670)	33.0% (330)	480
Test of independence, p-values	White	African American	Hispanic
White	…	…	…
African American	0.972	…	…
Hispanic	0.126	0.159	…
Response rates for transgender or non-binary only:			
White	64.2% (154)	35.8% (86)	240
African American	62.3% (81)	37.7% (49)	130
Hispanic	62.0% (93)	38.0% (57)	150
Total			520
Test of independence, p-values	White	African American	Hispanic
White	…	…	…
African American	0.724	…	…
Hispanic	0.667	0.958	…

Transgender or non-binary vs. Cisgender - Tests of independence, p-values	Cisgender White	Cisgender African American	Cisgender Hispanic
Transgender or Non-binary White	0.040	…	…
Transgender or Non-binary African American	0.036	0.064	…
Transgender or Non-binary Hispanic	0.024	…	0.795

Notes: Our alternative positive response rate codes responses as positive if the MHP's response was an appointment offer, call or consultation offer, screening questions, or referral. P-values come from a t-test (two-sided).

Table B5: Differences in Alternative Positive Response Rates, Results for Aggregated Groups and by Mental Health Concern

	(1)	(2)	(3)	(4)	(5)
Transgender or Non-binary	-0.0764**	-0.0656*	-0.0378	-0.0287	-0.0096
	(0.0370)	(0.0357)	(0.0386)	(0.0401)	(0.0407)
African American	-0.0081	-0.0107	-0.0618*	-0.0656*	-0.0771**
	(0.0408)	(0.0404)	(0.0364)	(0.0382)	(0.0354)
Hispanic	-0.0468	-0.0565	-0.0852	-0.1043*	-0.1273**
	(0.0477)	(0.0460)	(0.0543)	(0.0528)	(0.0572)
Depression	…	0.0267	0.0696	0.0850	0.1164*
		(0.0382)	(0.0488)	(0.0518)	(0.0637)
Anxiety	…	-0.0586	0.0124	0.0332	0.0450
		(0.0531)	(0.0570)	(0.0557)	(0.0582)
State fixed effects:			X	X	X
Week sent fixed effects:				X	X
Day of the week sent fixed effects:					X
N	1,000	1,000	1,000	1,000	1,000
Adjusted R^2	0.0061	0.0093	0.0260	0.0261	0.0268

Notes: Our alternative positive response rate codes responses as positive if the MHP's response was an appointment offer, call or consultation offer, screening questions, or referral. Regression estimates based on the linear probability model in equation (1). The mean positive response rate for the excluded group (cisgender White men) is 68.3%. Standard errors, clustered at the patient level, in parentheses. * $p < 0.10$, ** $p < 0.05$, *** $p < 0.01$.

Table B6: Differences in Alternative Positive Response Rates, Results by Gender Identity

	(1)	(2)	(3)	(4)
Transgender or Non-binary	-0.0096	…	…	…
	(0.0407)			
…Binary transgender	…	-0.0140	…	…
		(0.0425)		
…Trans Women	…	…	0.0286	0.0407
			(0.0659)	(0.0696)
…Trans Men	…	…	-0.0678	-0.0629
			(0.0581)	(0.0594)
…Non-binary	…	0.0014	0.0009	…
		(0.0764)	(0.0762)	
…Non-binary feminine first name	…	…	…	-0.0282
				(0.0949)
…Non-binary masculine first name	…	…	…	0.0487
				(0.1144)
Cisgender women	…	…	-0.0068	-0.0074
			(0.0620)	(0.0627)
African American	-0.0771**	-0.0765**	-0.0631	-0.0591
	(0.0354)	(0.0349)	(0.0402)	(0.0408)
Hispanic	-0.1273**	-0.1273**	-0.1028*	-0.1096**
	(0.0572)	(0.0566)	(0.0524)	(0.0539)
N	1,000	1,000	1,000	1,000
Adjusted R^2	0.0268	0.0258	0.0251	0.0245

Notes: Our alternative positive response rate codes responses as positive if the MHP's response was an appointment offer, call or consultation offer, screening questions, or referral. All regressions include the controls in column (5) of Table 5: mental health concern (depression, anxiety, stress), state fixed effects, day of the week sent fixed effects, and week sent fixed effects. Column (1) repeats the results from column (5) in Table B5 for ease of interpretation. The mean positive response rate for the excluded group (cisgender White men) is 68.3%. Standard errors, clustered at the patient level, in parentheses. * $p < 0.10$, ** $p < 0.05$, *** $p < 0.01$.

Table B7: Differences in Alternative Positive Response Rates, Intersectional Results by Trans/Cisgender Status and Race/Ethnicity

	(1)	(2)
Transgender or Non-binary	-0.0096	…
	(0.0407)	
…and White	…	0.0969
		(0.0638)
…and African American	…	-0.1058*
		(0.0554)
…and Hispanic	…	-0.1157*
		(0.0676)
Cisgender		
…and African American	…	0.0558
		(0.0680)
…and Hispanic	…	-0.0050
		(0.0740)
All African American	-0.0771**	…
	(0.0354)	
All Hispanic	-0.1273**	…
	(0.0572)	
N	1,000	1,000
Adjusted R^2	0.0268	0.0302

Notes: Our alternative positive response rate codes responses as positive if the MHP's response was an appointment offer, call or consultation offer, screening questions, or referral. All regressions include the controls in column (5) of Table 5a: mental health concern (depression, anxiety, stress), state fixed effects, day of the week sent fixed effects, and week sent fixed effects. Column (1) repeats the results from column (5) in Table B5 for ease of interpretation. The mean positive response rate for the excluded group (cisgender White men) is 68.3%. Standard errors, clustered at the patient level, in parentheses. * $p < 0.10$, ** $p < 0.05$, *** $p < 0.01$.

Table B8: Differences in Alternative Positive Response Rates, Intersectional Results by Gender Identity and Race/Ethnicity

	(1)
Transgender Women	
…and White	0.1856**
	(0.0794)
…and African American	-0.0220
	(0.1290)
…and Hispanic	-0.2042*
	(0.1157)
Transgender Men	
…and White	0.1106
	(0.1562)
…and African American	0.0100
	(0.0732)
…and Hispanic	-0.1630
	(0.1191)
Non-binary	
…and White	0.0690
	(0.0926)
…and African American	-0.1949
	(0.1273)
…and Hispanic	-0.0019
	(0.0974)
Cisgender Women	
…and White	0.3626***
	(0.1100)
…and African American	-0.0241
	(0.1295)
…and Hispanic	0.1015
	(0.1374)
Cisgender Men	
…and African American	0.2510**
	(0.0959)
…and Hispanic	0.0008
	(0.0886)
N	1,000
Adjusted R^2	0.0351

Notes: See notes to Table A6. The mean positive response rate for the excluded group (cisgender White men) is 68.3%. Standard errors, clustered at the patient level, in parentheses. * $p < 0.10$, ** $p < 0.05$, *** $p < 0.01$.

Appendix Table B9: Differences in Positive Response Rates, Results for Aggregated Groups and by Mental Health Concern

VARIABLES	(1) Basic Model	(2) Preferred Model (with State FEs)	(3) Preferred Model (Southern states only)	(4) Preferred Model (no Southern States)
Transgender or non-binary	-0.0761**	0.0260	-0.1460**	-0.0216
	(0.0375)	(0.0405)	(0.0658)	(0.0551)
African American	-0.0243	-0.1302***	-0.0100	-0.0855
	(0.0444)	(0.0364)	(0.0685)	(0.0584)
Hispanic	-0.0191	-0.1072**	-0.0395	-0.1562**
	(0.0462)	(0.0481)	(0.1015)	(0.0744)
Depression		0.0925	0.0157	-0.0547
		(0.0570)	(0.0824)	(0.0755)
Anxiety		0.0114	0.0099	-0.1732**
		(0.0505)	(0.0828)	(0.0675)
Observations	1,000	1,000	368	632
R-squared	0.0066	0.1131	0.0774	0.0470
Adj. R-squared	0.00360	0.0421	0.0129	0.00934

Notes: Regression estimates based on the linear probability model in equation (1). Standard errors, clustered at the patient level, in parentheses. * $p < 0.10$, ** $p < 0.05$, *** $p < 0.01$.

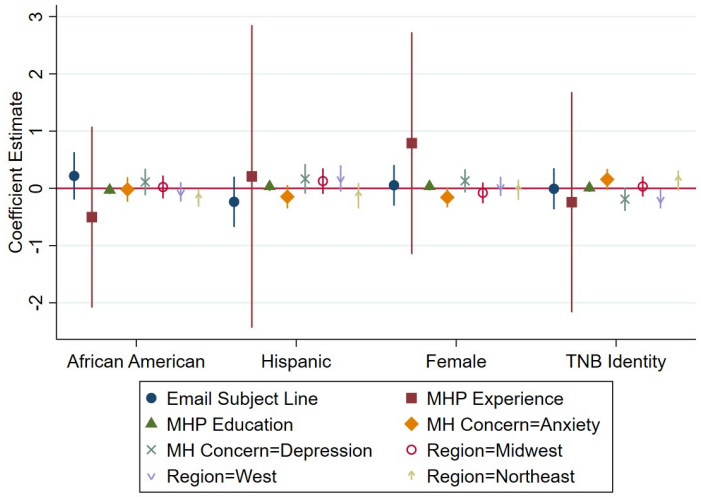
Appendix Table B10: Differences in Positive Response Rates, Intersectional Results by Trans/Cisgender Status and Race/Ethnicity

	(1) Preferred Model	(2) Preferred Model (Southern States Only)	(3) Preferred Model (No Southern States)
TNB & White	0.1196**	-0.2035*	0.2799***
	(0.0526)	(0.1109)	(0.0731)
TNB & Hispanic	-0.0430	0.3678	-0.0672
	(0.0604)	(0.3551)	(0.0957)
TNB & African American	-0.1337**	0.0532	0.0733
	(0.0546)	(0.2264)	(0.0917)
Cisgender & Hispanic	-0.0243	-0.3673	-0.0274
	(0.0625)	(0.5853)	(0.1000)
Cisgender & African American	0.0008	0.1691	-0.0849
	(0.0572)	(0.1377)	(0.1103)
Observations	1,000	368	632
R-squared	0.1174	0.1393	0.1385
Adj. R-squared	0.0447	0.0310	0.0513

Notes: Regression estimates based on the linear probability model in equation (1). Standard errors, clustered at the patient level, in parentheses. * $p < 0.10$, ** $p < 0.05$, *** $p < 0.01$.

Appendix Figure B1: Covariate Balance and Test of Independence

(a)



(b)

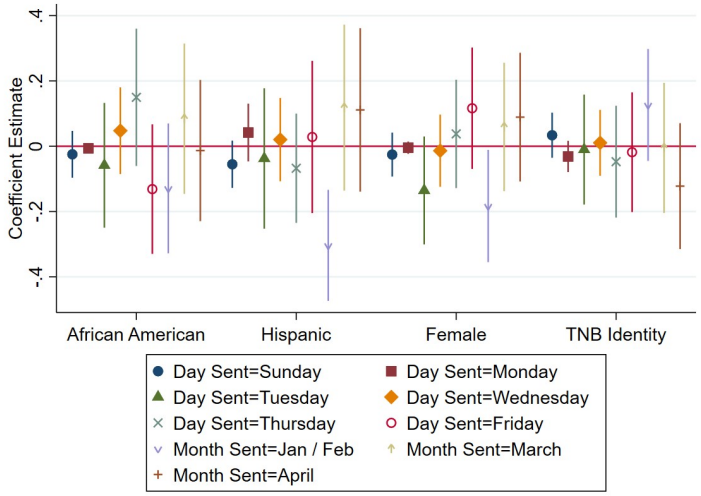


Figure notes: To test for balance of covariates in our model, we present **Online Appendix Figure B1**, which plots the estimated coefficients of several OLS models of the following form:

$$Outcome_i = \beta_0 + \beta_1 AfricanAmerican_i + \beta_2 Hispanic_i + \beta_3 Female_i + \beta_4 TNB_i + \varepsilon_i$$

These OLS models have the (respective) dependent variables ($Outcome_i$) of "Email Subject Line" (a discrete variable indicating which of the three randomized subject lines the MHP's inquiry email received), "MHP Education" (a dummy variable that returns a 1 if the MHP has doctoral-level training and 0 otherwise), and "MHP Experience" (a discrete variable indicating the number of years an MHP reports on their profile).

We also include as outcomes dummy variables for mental health concern (Anxiety and Depression, both relative to Stress), the U.S. Census Region (west, Midwest, and West, all relative to South), the day of the week the email was sent (with reference day of Saturday) and the month in which the email was sent (with may being the reference month and January and February combined since we only emailed on the last two days of January. We cluster the standard errors of these regressions, as in the paper, at the patient level. 95% confidence intervals are plotted with point estimates.

Again, the results of these regressions are plotted in RF1 panels (a) and (b). With the exception of a few outliers the vast majority of confidence intervals cross 0, hence these panels show that the results of our empirical exercise, plotted for reviewers, provides clear evidence that characteristics are distributed randomly and that our design is internally valid.

Online Appendix C: COVID-19 Analyses

Table C1: State-Level COVID-19 Intensity (Cases and Deaths) and Appointment Offer Rates

	(1)	(2)	(3)	(4)
Daily cases	-0.0747*	…	…	…
	(0.0436)			
Daily deaths	0.0510	…	…	…
	(0.0499)			
1-week lagged daily cases	…	-0.0560	…	…
		(0.0833)		
1-week lagged daily deaths	…	0.0784	…	…
		(0.0737)		
2-week lagged daily cases	…	…	0.0545	…
			(0.1201)	
2-week lagged daily deaths	…	…	0.1468	…
			(0.1262)	
3-week lagged daily cases	…	…	…	-0.0108
				(0.1356)
3-week lagged daily deaths	…	…	…	0.1881
				(0.1498)
N	1,000	1,000	1,000	1,000
Adjusted R^2	0.0442	0.0433	0.0433	0.0432

Notes: Regressions based on the regression in Table 7, column (2), but with these daily case and death variables added. Standard Errors, clustered at the state level, in parentheses. * $p < 0.10$, ** $p < 0.05$, *** $p < 0.01$.

Table C2: State-Level COVID-19 Intensity (Weekly Excess Deaths) and Appointment Offer Rates

	(1)	(2)	(3)	(4)
Weekly excess deaths	-0.0484	…	…	…
	(0.0348)			
1-week lagged weekly excess deaths	…	-0.0257	…	…
		(0.0308)		
2-week lagged weekly excess deaths	…	…	0.0081	…
			(0.0228)	
3-week lagged weekly excess deaths	…	…	…	-0.0115
				(0.0277)
N	1,000	1,000	1,000	1,000
Adjusted R^2	0.0453	0.0441	0.0438	0.0438

Notes: Regressions based on the regression in Table 7, column (2), but with these daily case and death variables added. Standard Errors, clustered at the state level, in parentheses. * $p < 0.10$, ** $p < 0.05$, *** $p < 0.01$.

Table C3: Moderating Effects of State-Level COVID-19 Intensity (Cases and Deaths) on Discrimination

	(1)	(2)	(3)	(4)
TNB	0.1078*	0.1082*	0.1477**	-0.2309
	(0.0625)	(0.0621)	(0.0658)	(0.1943)
African American	-0.0169	-0.0117	-0.0016	-0.3833*
	(0.0595)	(0.0650)	(0.0677)	(0.1909)
Hispanic	0.0332	0.0432	0.0419	-0.3307*
	(0.0598)	(0.0547)	(0.0678)	(0.1934)
TNB x African	-0.2267**	-0.2297**	-0.2602***	0.1640
American or Hispanic	(0.0901)	(0.0876)	(0.0939)	(0.2329)
COVID-19 daily cases	-0.0810*	-0.0795	-0.0449	-1.7000**
	(0.0439)	(0.0517)	(0.2803)	(0.7930)
COVID-19 daily deaths	0.0766	0.0502	-0.0667	2.6330**
	(0.0501)	(0.0697)	(0.3607)	(1.2536)
African American x	…	…	0.0327	1.5099**
…COVID-19 daily cases			(0.2552)	(0.6950)
	…	…	0.0827	-2.4625**
…COVID-19 daily deaths			(0.3509)	(1.1769)
Hispanic x	…	…	0.0865	1.7524**
…COVID-19 daily cases			(0.2371)	(0.7797)
	…	…	-0.1386	-2.9013**
…COVID-19 daily deaths			(0.2810)	(1.2379)
TNB x	…	…	-0.3242	1.4038*
…COVID-19 daily cases			(0.2198)	(0.7744)
	…	…	0.3716	-2.4233*
…COVID-19 daily deaths			(0.2218)	(1.2111)
African American or	…	0.0980	…	-1.7098**
Hispanic x TNB x		(0.1564)		(0.7004)
…COVID-19 daily cases				
	…	-0.0255	…	2.8734**
…COVID-19 daily deaths		(0.1256)		(1.1668)
N	1,000	1,000	1,000	1,000
Adjusted R^2	0.0452	0.0443	0.0450	0.0482

Notes: Regression includes state, day of week, and week sent fixed effects. TNB=Transgender or Non-Binary. Standard Errors, clustered at the state level, in parentheses. * $p < 0.10$, ** $p < 0.05$, *** $p < 0.01$.

Table C4: Moderating Effects of State-Level COVID-19 Intensity (Weekly Excess Deaths) on Discrimination

	(1)	(2)	(3)	(4)
TNB	0.1073*	0.1094*	0.1378**	0.1458*
	(0.0591)	(0.0564)	(0.0592)	(0.0750)
African American	-0.0021	0.0056	0.0315	0.0386
	(0.0574)	(0.0618)	(0.0600)	(0.0722)
Hispanic	0.0549	0.0516	0.0906	0.0989
	(0.0612)	(0.0613)	(0.0657)	(0.0778)
TNB x African American or Hispanic	-0.2158**	-0.2118**	-0.2596***	-0.2688***
	(0.0893)	(0.0848)	(0.0890)	(0.0933)
Weekly excess deaths	-0.0527	-0.0764**	-0.1491**	-0.1809
	(0.0349)	(0.0340)	(0.0698)	(0.1961)
African American x weekly excess deaths	…	…	0.1488***	0.1875
			(0.0394)	(0.1951)
Hispanic x weekly excess deaths	…	…	0.0634	0.0974
			(0.0631)	(0.1977)
TNB x weekly excess deaths	…	…	0.0762	0.1102
			(0.0522)	(0.2026)
African American or Hispanic x TNB x weekly excess deaths		0.1070***		-0.0416
		(0.0378)		(0.2049)
N	1,000	1,000	1,000	1,000
Adjusted R^2	0.0460	0.0481	0.0477	0.0467

Notes: Regression includes state, day of week, and week sent fixed effects. TNB=Transgender or Nonbinary
Standard Errors, clustered at the state level, in parentheses. * $p < 0.10$, ** $p < 0.05$, *** $p < 0.01$.

Online Appendix D: Signaling Transgender Status

Our method of signaling transgender or non-binary (TNB) status is to include the following phrase in our appointment request emails: *"I am [a transgender woman]/[a transgender man]/[non-binary], and while I am not looking for a therapist that specializes in trans issues, I am looking for a therapist who is [trans friendly]/[a trans ally]."* We believe this statement is common in practice, making this signal more externally valid. For a TNB individual seeking mental health services, finding a therapist who will not discriminate against them (trans-friendly or allied therapist) or stop them from being transgender is essential. Disclosing transgender status and inquiring about trans-friendly services is common and recommended by experts who provide advice on how to find trans-affirming care (see Kassel (2018), Voutilainen et. al. (2018), and Allen et. al. (2017)).

However, there could be concerns that the request for a trans-friendly or trans-allied therapist, despite being a common and well-motived request, could send some other unintended signal or otherwise elicit an unintended response. This concern is not unique to our study and is common, and likely more of a concern, in other audit field experiments.[2] Here we discuss two different ways that our mental of signaling TNB status could signal something other than TNB status or lead to an unintended response. First, our TNB signal could imply that the prospective patient needs trans-specific care. Second, our TNB signal could elicit MHPs to react more

[2] Most of these studies signal minority status (e.g., disability, sexual orientation) through a volunteer experience mentioned on the resume and/or cover letter (see, e.g., Tilcsik 2011; Ameri et al. 2018; Namingit 2017; Button and Walker 2020). For example, Tilcsik (2011) signals sexual orientation through a leadership position with a campus gay student organization. However, this experience can signal two additional things: the experience shows leadership experience, and the experience may suggest being more politically progressive. For the control group, Tilcsik (2011) uses a similar leadership experience, but with the "Progressive and Socialist Alliance". Our study avoids having to pick a control group since the natural control groups is no mention of transgender or cisgender status.

positively to show that they are "trans friendly." For both these concerns, we discuss to what extent they could affect our results and how we deal with them.

Possible Bias from Signaling Trans-Specific Issues.

While our appointment requests mention common mental health concerns (anxiety or depression), with no mention of these being TNB-specific, the MHP could assume that the concern is still TNB-specific, or that the prospective patient is really looking for a trans-specialist rather than just someone who is "trans friendly." In some cases, this could lead to increased referral or rejection rates (either explicitly rejecting the TNB prospective patient or being more likely to ignore the email request).

Some could see this issue of assuming TNB people need a specialist, even for typical mental health concerns, biasing estimates in favor of showing more discrimination. We argue that this situation is a common barrier to care for TNB people, and thus, using this signal of TNB status captures this important barrier to care.[3] We also argue that our approach of coding MHP responses, and the nature of MHP responses in our study, suggest that we correctly categorize MHP responses even if they assume that trans-specific care is required.[4]

---

[3] Researchers note that assumptions that TNB people need trans-specialists, even in the numerous cases where their concerns are not trans-specific, frequently lead to barriers in access to quality mental health care (see, e.g., Benson 2013). Non-academic evidence also supports this phenomenon, showing that often TNB clients are made to feel like the reason they are suffering from other mental illnesses is their gender identity despite that not being seen by these TNB patients as relevant. See, e.g., https://19thnews.org/2021/06/transgender-people-mental-health-services-meet-needs-difficult/ and https://www.vice.com/en/article/59jmza/the-unique-problems-trans-people-face-when-finding-a-therapist (both accessed July 30, 2022). These barriers to care faced by TNB individuals still persist, despite multiple professional and academic advice articles pointing out the fact that a good amount of TNB folks seeks therapy for reasons unrelated to their gender identity.

[4] The assumption that TNB people require specialists could reduce access to mental health care in two ways. For discriminatory MHPs, they can use the fact that they are not specialists as a pretext for not offering an appointment. This makes it easier for them to reject the patient, either explicitly through a rejection response, or implicitly through ignoring the email. We correctly capture this as a negative outcome. For non-discriminatory, non-specialist MHPs, our pilot study, Button et al. (2020), shows that they typically react to the TNB prospective patient requests by offering a referral to a trans-specialist *in addition to* offering an appointment or consultation. These are correctly coded as positive outcomes since they include the appointment or consultation offer. In the rarer case that the non-discriminatory, trans-friendly MHP offered a referral, but no appointment offer, then we do code this as a positive response in our robustness checks that modify the definition of what we consider a positive response. Our results are

Possible Bias from Motivating MHPs to Respond More Positively.

The second concern with our signal of TNB status is that the MHP could be motivated to respond positively after reading the "trans friendly" request. This could happen through a form of social desirability bias. The MHP could be motivated to show that they are "trans friendly" by responding more often or more positively than they normally would. For many, this "trans friendly" request would be viewed as common and externally valid for TNB individuals, and therefore and effect that it has on responses would be considered a normal part of the mental health care search and capture common experiences of TNB prospective patients. However, since a "trans friendly" request, while common, is not used for all appointment requests by TNB patients in practice, this social desirability bias could underestimate discrimination. While is difficult to know how common this "social desirability" reaction would be, it is important to stress that it does seem to be only potentially relevant for White TNB prospective patients only, as African American and Hispanic TNB prospective patients face significant discrimination. If they do in fact get this social desirability benefit from the TNB signal, then our estimates of discrimination against African American and Hispanic TNB prospective patients would be even higher.

References Not Cited in the Main Paper

Ameri, Mason, Lisa Schur, Meera Adya, F. Scott Bentley, Patrick McKay, and Douglas Kruse. 2018. "The Disability Employment Puzzle: A Field Experiment on Employer Hiring Behavior." *ILR Review* 71 (2): 329–64. https://doi.org/10.1177/0019793917717474.

Button, Patrick, and Brigham Walker. 2020. "Employment Discrimination Against Indigenous Peoples in the United States: Evidence from a Field Experiment." *Labour Economics* 65(August):101851. https://doi.org/10.1016/j.labeco.2020.101851.

Namingit, Sheryll, William Blankenau, and Benjamin Schwab. 2017. "Sick and Tell: A Field Experiment Analyzing the Effects of an Illness-Related Employment Gap on the Callback Rate." Working Paper.

Tilcsik, András. 2011. "Pride and Prejudice: Employment Discrimination against Openly Gay Men in the United States." *American Journal of Sociology* 117 (2): 586–626. https://doi.org/10.1086/661653.

robust to alternative codings of a positive response that treat referrals as a positive outcome either in all cases or in cases where the referral appears to be in good faith, such as to a specialist.