

"Over the years, society, family and work have caused internal homophobia that I deal with all the time. The fear of being treated poorly because I am lesbian is always present."

"I have had a cardiologist tell me he did not approve of me, my partner, or our lifestyle but he would still treat me. Needless to say, I did not feel very confident in his care and found a new doctor as soon as I could."

"I feel people in my neighborhood need greater access to quality, affordable health care. Often, LGBT access to health care has nothing to do with queer specific issues, but rather with how we are treated during routine medical examinations. Having well-informed and sensitive staff would probably help other minorities with high incidences of violence or threat, such as immigrants."

"I've found the experience of looking at schools for my children to be similar to the 'coming out' process of my youth. Schools and children's organized activities still do not have a uniform approach to 'alternative families.' Greater education of the professionals in these arenas would be helpful. We have consistently gone into the classroom to expose the other children to our family in an effort to not have our children be put in the position of explaining or defending our family."

"I'm a deaf person, and I am a gay man. I live in a great community, but there are some people who are still uneducated about deaf culture and deaf people's needs. When I request to have an interpreter, some health professionals assume an attitude of, 'This guy is deaf and can't speak. How do I communicate?' I find this attitude to be ridiculous on their parts, because I know how to assert myself and request an interpreter."

"I have a partner who has a good job with health insurance, and yet I am on Medicaid because his job won't give me benefits. I have a serious chronic illness and can't work so I need my Medicaid. If we had legal marriage, I would not need to use public assistance to meet my health care needs."

"My partner is a trans person who is male to female. We have encountered a lot of issues related to trans care. The largest issue being the ability for insurance companies to deny health services to a trans person if the services are thought of as female services, such as gynecological, uterine, breast and ovarian cancer care."

"In all of my life, there has been only one professional health care office that has an in-take form that includes 'partnered' for LGBT designation. I believe that medical offices should be explicit about supporting partners in relation to loved ones. No one understands the isolation and fears it causes when they don't."

"My constant concern is how my partner and I can have children and have one of us take even a small amount of time off work to care for them while still keeping us all insured with health coverage. This would be a HUGE advantage of marriage. Even if we don't have children, it would be a big load off my mind to know that I could insure her (or her insure me) if she ever wanted or needed to stop working for any reason."

"Women need specialized sex education aimed at women who have sex with women that is not condom-based."

LGBT HEALTH AND HUMAN SERVICES NEEDS IN NEW YORK STATE

REPORT PREPARED BY SOMJEN FRAZER
FOR THE EMPIRE STATE PRIDE AGENDA FOUNDATION
AND THE NEW YORK STATE LESBIAN, GAY, BISEXUAL AND
TRANSGENDER HEALTH AND HUMAN SERVICES NETWORK

Contents

Executive Summary	1
Introduction	2
Methodology	3
LGBT Population Size and Demographics	4
Population-based Estimates of LGBT Demographics	4
LGBT Demographics in the Needs Assessment Survey	4
Findings	6
Insurance and Sources of Healthcare	6
Barriers to Healthcare Access	6
Geography and Transportation	7
Mental Illness and Access to Mental Healthcare	8
Substance Abuse	9
Housing	10
Social Support and Social Isolation	10
Violence	11
Specific Populations	12
Transgender and Gender Non-conforming People	12
People of Color	13
Youth	14
Seniors	15
Families	16
Next Steps	17
Works Cited	19
Acknowledgements	19

The quotes on the front and back cover of this document are from Needs Assessment survey respondents' answers to the question 'What is the most pressing health and human service need for LGBT people in New York State?' The quotes have been lightly edited for grammar, confidentiality and design.

Executive Summary

This assessment of LGBT Health and Human Service Needs in New York State (“the Needs Assessment”) was designed to examine existing data sources, identify gaps in data and collect original data in order to establish the most pressing needs and gaps for lesbian, gay, bisexual and transgender (LGBT) non-HIV health and human services in New York State. To that end, New York State Department of Health and New York City Department of Health and Mental Hygiene surveys were analyzed, 60 experts in LGBT health and human services were interviewed (individually or in groups) and nearly 3,500 LGBT people took an online or paper survey about their health and human service needs.

Here are some key findings:

- About 4.1% of the general population self-identifies as lesbian, gay or bisexual on government-funded, population-based surveys. Less is known about transgender identity; however, one survey estimates about 300,000 self-identified transgender people live in New York State.
- Lesbian, gay, bisexual and transgender (LGBT) people have poor access to healthcare because of lower rates of insurance and utilization of primary care. For example, the New York City Department of Health and Mental Hygiene’s Community Health Survey (2007) estimates that 20.6% of lesbian and gay and 23.5% of bisexual people lack insurance, while only 14.9% of heterosexual people do.
- Lack of culturally competent providers is a major barrier to healthcare for LGBT people, with nearly 40% of people in the Needs Assessment survey saying there were not enough health professionals who are adequately trained and competent to deliver healthcare to LGBT people. Geographic isolation is also significant barrier to healthcare for LGBT people living outside major urban areas.
- LGBT people face homophobia and transphobia in their everyday lives, and are more likely to experience depression and lack of access to adequate mental healthcare. Youth, transgender and gender non-conforming people and Black and Hispanic LGBT people were the more likely to be depressed and less likely to have adequate access to mental healthcare.
- Homelessness and inadequate housing are significant barriers to health and welfare for LGBT people. Nearly 14% of respondents were currently or formerly homeless.
- Loneliness and social isolation were particular problems for LGBT people who did not live or work in Manhattan. Social isolation has negative health outcomes, and those who attended events at LGBT centers were less likely to be lonely.
- Hate violence is an important problem in the LGBT community, with 13% reporting they had experienced anti-LGBT sexual assault or violence serious enough to send them to the hospital.
- Transgender and gender non-conforming people are more likely to experience barriers to healthcare, homelessness, violence and other negative health outcomes.
- People of color need culturally sensitive services both within the LGBT community and in mainstream settings. They reported lower incomes, more barriers to healthcare and more depression and loneliness than white people.
- LGBT youth are more likely than non-LGBT youth to experience negative health outcomes such as smoking, substance abuse, violence and risk behavior, as well as suicide.
- Many LGBT seniors are resilient, while others are at risk for social isolation. LGBT seniors are particularly vulnerable to financial exploitation and neglect.
- LGBT people build families in a variety of ways, and these families need support and recognition.

Introduction

This document reports the findings of the first statewide LGBT Health and Human Services Needs Assessment in New York State. A needs assessment is a research process that identifies the gaps and disparities for a specific population, in this case, lesbian, gay, bisexual and transgender (LGBT) people. Needs assessments are helpful in targeting programs and funding to the areas of greatest need, as well as understanding the size and character of the gap between the needs of the LGBT population and those of non-LGBT people. There is a serious lack of data on this population, and this needs assessment aims to begin to fill that gap.

The Needs Assessment was funded by the New York State Department of Health. The Empire State Pride Agenda Foundation contracted the report to an independent consultant.

The Empire State Pride Agenda Foundation is the non-partisan 501(c)(3) research, education and advocacy organization affiliated with the Empire State Pride Agenda, Inc., New York's statewide civil rights organization committed to achieving full equality and justice for lesbian, gay, bisexual and transgender (LGBT) New Yorkers and our families

The Pride Agenda Foundation supports and administers the New York State Lesbian, Gay, Bisexual and Transgender Health and Human Services Network (the Network), a coalition of over fifty LGBT-specific and LGBT-supportive nonprofit groups and organizations that provide non-HIV health and social services to LGBT New Yorkers and their families.

Although the Needs Assessment was created in close collaboration with the Network and the Pride Agenda Foundation, the findings and conclusions in this document are solely those of the consultant.

Human services, for the purposes of this report, are anything that enhances health or welfare that is delivered by a professional.

Lesbian and gay people are people who are romantically and/or sexually attracted to and/or sexually active with people of the same gender. Bisexual people are attracted to and/or sexually active with people of both genders.¹

Sexual orientation generally refers to people's sexual identity, behavior or attraction. Sexual orientation was recognized through self-identification in the Needs Assessment survey and, unless otherwise noted, in the other data sources as well.

Transgender is a word commonly used to describe people who live in a gender different from the one assigned to them at birth. People often use this word to describe not only people who have changed their gender through surgery or cross-gender hormone therapy, but also people who have non-medical gender transitions or identify as transgender but do not seek to change their gender legally or medically.

Gender non-conforming people are people who express their genders differently from society's expectations, reject 'male' and 'female' as the only gender possibilities, and/or blend genders. Gender non-conforming people in the Needs Assessment survey identified their genders in a variety of ways. In addition to 'gender non-conforming,' they also identified as 'genderqueer,' 'gender blending' and 'gender bending,' as well as in a variety of other ways.

Homophobia refers to hatred or fear of lesbian, gay or bisexual people. Transphobia refers to hatred or fear of transgender people.

Methodology

This report engages four pre-existing, population-based, publically-available data sources and two sources of original data.² In addition, data are contextualized by scholarly literature where it is available. Existing data sources included the statewide NYS Department of Health Adult Tobacco Survey (ATS) from 2004, which included questions on sexual orientation and gender identity, as well as tobacco use and insurance status. Two sources of NYC Department of Health and Mental Hygiene New York City-specific data were also used, including the NYC Community Health Survey (CHS) of adults and the Youth Risk Behavior Survey (YRBS) of high school students. Both are from 2007.³ The CHS and YRBS both collect data not only on sexual orientation, but also on the risk behaviors, health status, insurance status and other health information of respondents. Neither collects information on transgender identity.

Although these data sources include important information about the health status and risk factors of LGBT people, further data focused on LGBT-specific issues were also needed in order to complete the Needs Assessment. To that end, two stages of original data collection were conducted. First, ten focus groups and two individual interviews were conducted with 60 key informants who have particular expertise in LGBT health and human services from throughout the state of New York. The focus groups and interviews discussed a wide range of health and human service needs, with particular attention to primary care, mental health and counseling, substance abuse, social support and social isolation, criminal justice issues and specific populations such as youth, people of color, transgender people and seniors. There were six general focus groups, and one focus group each on the following topics: youth, substance abuse, seniors and people of color.

Finally, 3,772 LGBT people took an online and paper survey of health and human service needs, conducted from April 6-22, 2009 with a final sample of 3,441 people.⁴ The survey was distributed to LGBT people throughout New York State, using the LGBT Health and Human Services Network and recruiting online as well as in-person. It included demographic questions as well as sections on healthcare access, violence, health and human service needs, mental health and barriers to care.

LGBT Population Size and Demographics

POPULATION-BASED ESTIMATES OF LGBT DEMOGRAPHICS

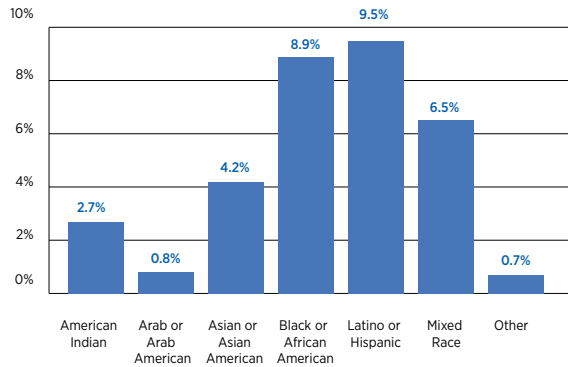
Estimates of the size of the LGBT population in New York State vary. In 2004, the New York State Department of Health's Adult Tobacco Survey included questions on sexual orientation and gender identity. It suggested that 2.6% of adults in New York State are lesbian, gay or bisexual, while 2.1% are transgender. In 2007, the New York City Department of Health and Mental Hygiene's Community Health Survey estimated that 4.1% of people in New York City identify as lesbian, gay or bisexual; however, this survey did not ask about transgender identities.

National estimates suggest that 4.1% of the population identifies as lesbian, gay or bisexual (Mosher et al., 2005). However, a larger number have had sex with someone of the same gender or experience same-sex attractions. For example, one study found that 7% of males and 14% of females reported some attraction to the same sex.⁵

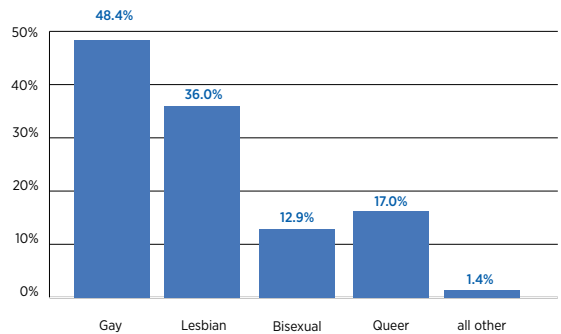
LGBT DEMOGRAPHICS IN THE NEEDS ASSESSMENT SURVEY

The Needs Assessment survey sample was diverse compared to previous samples of the LGBT community, which tend to be white and urban (Mayer et al., 2008). A total of 8.9% of respondents identified as Black or African American and 9.5% identified as Latino or Hispanic; 80.5% identified as white. Please note that people in this survey could be mixed race and could be Hispanic or non-Hispanic in addition to selecting a race. Because respondents could select more than one race or ethnic category, the racial and ethnic categories do not sum to 100%.

LGBT People of Color in the Needs Assessment Survey



Sexual Orientation in the Needs Assessment Survey



Among survey respondents, 46.4% identified as female, 45.7% identified as male and 8.0% identified as transgender or gender non-conforming.⁶ Male and female refer to respondents who only selected male or female, while some transgender or gender non-conforming respondents might also have been male or female.

The average age of respondents was 41, with most respondents in the 25-44 year old category (44.1%) and 21.1% in the 45-54 age category. In addition, 13.2% were youth (18-24) and 21.5% were over 55.

For some of the demographic questions, including race and sexual orientation, respondents could check all that apply. Results may not sum to 100%.

A total of 11.9% of the survey respondents were in poverty, having no income or household income below \$10,000.

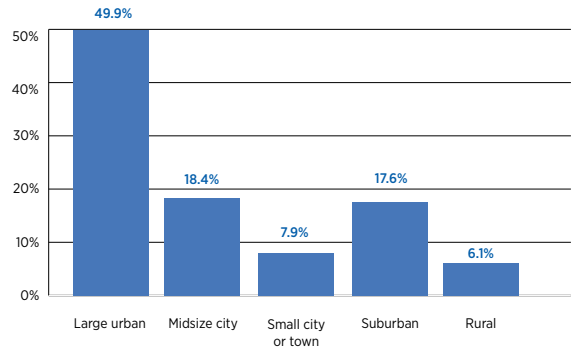
People in the Needs Assessment survey were partnered in a variety of ways, with 41.4% saying that they were not partnered, 53.7% reporting being partnered with or married to someone of the same gender and 4.9% partnered with or married to someone of a different gender.⁷ Overall, 12.9% had children living with them.

A total of 11.9% of the survey respondents were in poverty, having no income or household income below \$10,000. However, high income people were also represented, with 20.8% of the respondents having a household income above \$100,000. Overall, 19.5% said that they did not have enough income to meet their basic needs, while 40.0% had just enough and 40.5% had more than enough.

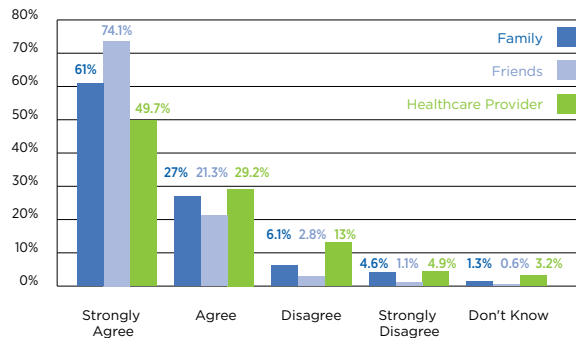
Regarding employment status, 18.3% of the respondents were students. 57.7% were employed fulltime and 12.8% worked part time (respondents could be employed and a student). In addition, 13.5% said they were neither employed nor a student.

There was geographic diversity in the group of people who responded to the Needs Assessment survey as well. Less than half (49.9%) said that they lived in large urban areas; for example, 37.9%, of the sample lived or worked in Manhattan. There were 18.4% living in mid-sized cities, 17.6% living in suburbs and 7.1% living in small towns, while 6.1% said they lived in rural areas.

Geographic Diversity among Needs Assessment Survey Respondents



LGBT People's Responses to 'I am 'out' to my family, friends or healthcare providers' in the Needs Assessment Survey



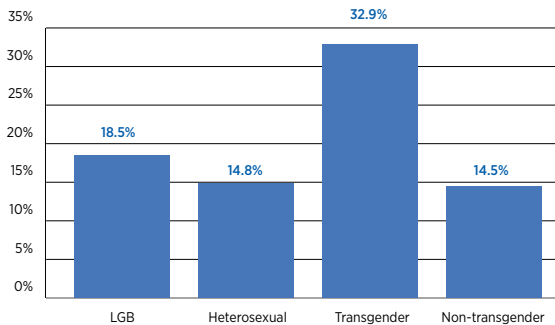
People who responded to the Needs Assessment survey were very 'out' to friends, family and healthcare providers. They were also highly visible as LGBT, with 9.1% saying that people can always tell they are LGBT and 40.1% saying that people can sometimes tell. Only 14.9% said people can never tell.

Findings

INSURANCE AND SOURCES OF HEALTHCARE

Many studies have noted that LGBT people have poorer access to healthcare than their non-LGBT counterparts (Cochran et al., 2001; Kerker et al., 2006; Mayer et al., 2008; Roberts et al., 2004; Valanis et al., 2000). For example, according to an analysis of a large population-based sample of women in New York City, women who have sex with women are much less likely to obtain mammograms or Pap tests (for cervical cancer) than women who have sex with men (Kerker et al., 2006).

People Who Lacked Insurance by Sexual Orientation and Gender Identity in the NYS Adult Tobacco Survey (2004)



In both New York City and New York State, LGBT people experience lower rates of health insurance than non-LGBT people. Only 14.9% of heterosexual people in the NYC Community Health Survey (CHS) were uninsured, while 20.6% of gay and lesbian people and 23.5% of bisexual people had no health insurance. NYS Adult Tobacco Survey data (shown in the graph above) indicates that 18.5% of LGB people and 14.8% of heterosexual people were insured, and also that 32.9% of transgender people lacked insurance, compared to 14.5% of non-transgender people. In the Needs Assessment survey, only 7.9% of people who answered questions about insurance said they had no insurance.

In addition to having insurance, having and using a primary care provider is important to healthcare access. According to NYC Community Health Survey data, 28.3% of lesbian and gay people in the sample did not have a primary care provider, compared to 17.4% of heterosexual people. However, 4.8% of those in the Needs Assessment survey did not have a regular source of non-emergency care, or used the emergency room as a usual source of care.

Overall, 42% of people said that community fear or dislike of LGBT people was a problem for them in accessing healthcare.

These perceived barriers are not without reason. Studies consistently find that LGBT people have more negative interactions with their doctors and are less satisfied with the care they receive.

Similarly, according to the NYC Youth Risk Behavior Survey, young people who identify as gay/lesbian (24.5%), or bisexual (22.3%) are more likely than those who are heterosexual (18.1%) to NOT have had a physical in a doctor's office, which means that they have less access to healthcare. One staff member at an LGBT homeless youth organization explained, "Most of the young people when they come to us, they were getting care through the parent/legal guardian and are no longer [living] with that person. They were getting it from ACS [Administration for Children's Services] or another city system and are not in those systems anymore. When they come to us, some haven't seen a doctor in years."

BARRIERS TO HEALTHCARE ACCESS

LGBT people face numerous barriers to care, some LGBT-specific and some as a result of their lower rates of insurance and engagement in primary care, as mentioned in the previous section (Mayer et al., 2008). These perceived barriers are not without reason. Studies consistently find that LGBT people have more negative interactions with their doctors

and are less satisfied with the care they receive than non-LGBT people (White & Dull, 1997). Lesbian, gay and bisexual people, and particularly men who have sex with men but do not identify as gay, are unlikely to disclose their sexual identity and behavior to their doctors (Bernstein et al., 2008; Carr et al., 1999).

Among those barriers measured in the survey, the most important one was financial, with 43.2% of people reporting that this was somewhat or a major problem for them.⁸ This was followed closely by “community fear or dislike of LGBT people” (41.7%). Finally, cultural competency was an important barrier to healthcare for people who took the survey, with 39.8% of people saying that there are ‘not enough health professionals who are adequately trained and competent to deliver healthcare to LGBT people.’ As will be discussed in further sections on mental healthcare, barriers to mental health were an issue to over one-third of those surveyed.

Cultural competency—the ability to work sensitively with LGBT people of diverse backgrounds—was one of the strongest themes in the key informant focus groups. As the director of one LGBT center said, “It’s getting culturally competent services that’s the key...Not all service providers are good at dealing with these issues. A lot of service providers don’t allow on forms that you live in a domestic partnership situation or are married to a same sex [partner]...How do you know when you are dealing with a service provider who is LGBT friendly?”

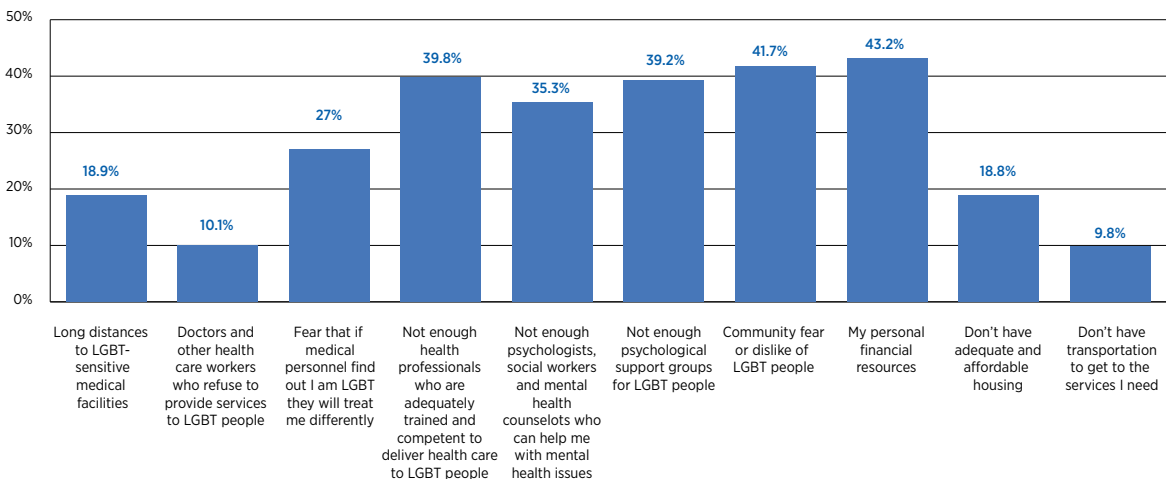
One staff member at an organization that serves LGBT seniors pointed out that concerns about cultural competency were not limited to doctors. “I think many helping professionals don’t even realize there are LGBTQ elders and...let’s not forget the people in the trenches, LPNs. We go to doctors and ‘high level professionals,’ but we don’t necessarily look to train the folks who are really doing the work. Those are the people that need the training the most.”

The LGBT people who participated in the Needs Assessment are very interested in utilizing LGBT-specific services as well as service providers who are culturally competent in LGBT issues. Nearly 50% have used health and human services specifically targeted to LGBT people and nearly three-quarters said they would select their providers mostly or solely from a list of culturally competent providers (if such a list were available).

GEOGRAPHY AND TRANSPORTATION

Studies suggest that the lack of LGBT social networks and lack of LGBT-community-specific healthcare limit access for rural LGBT people (Willing et al., 2006). The Needs Assessment survey showed that LGBT people who do not live or work in Manhattan are much more likely to have difficulty accessing health and human services because of issues of distance and transportation. For example, 21.8% of those who did not live or work in Manhattan said that distance was an issue for accessing

Percent of LGBT People in the Needs Assessment Survey Who Said the Following Barriers Were Problems or Major Problems in Accessing Healthcare



healthcare, while only 14.0% of those who did live or work in Manhattan did. The number of people saying distance was a problem rose to 29.1% for those in rural areas, 25.4% of those in small towns and 23.0% of those in suburbs. Similarly, transportation was more of an issue for people outside of large urban areas.

Several staff members from LGBT organizations outside of NYC spoke about how difficult transportation and geographic isolation are for LGBT youth. One said, “There are youth who drive an hour and a half to get to a youth program,” while another pointed out that for some youth, that isn’t an option, “[I]f you’re a 15-year old you don’t have a friend who can drive you. Your nearest clinic may be an hour away...” Where programs do exist, rural transportation options may not be extensive enough to serve needs. As two staff members from an organization outside of NYC pointed out, “We have transportation services, our van picks up kids at various parts of the island,” but “...our van can only pick up 15 kids. The island is huge. That is something that needs to be taken a look at,...it’s the barrier to access to services.”

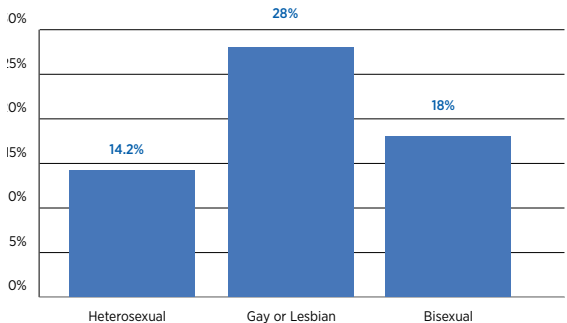
Lack of access to services may be even more of a problem for marginalized populations within the LGBT community. Two staff members at an LGBT program outside of NYC said, “LGBT people of color who live and work outside Manhattan and other major urban areas face particular challenges...it may be different from [NYC]...where things are progressed. Here, demographics are different, geography is different...[The geography we serve] is racially...segregated, and that is a huge issue.”

MENTAL ILLNESS AND ACCESS TO MENTAL HEALTHCARE

Studies have long found that LGBT people are more likely to experience depression, anxiety and other mental illnesses (Balsam et al., 2005; Cochran et al., 2003; King et al., 2008). Some studies have also suggested that this is due to the greater stress that LGBT people experience (Meyer et al., 2008). According to the Community Health Survey, in New York City, LGB people are much more likely to have a history of depression than heterosexual people. Among the CHS respondents, 28.0% of gay and lesbian people had been depressed, compared to 14.2% of heterosexual people.

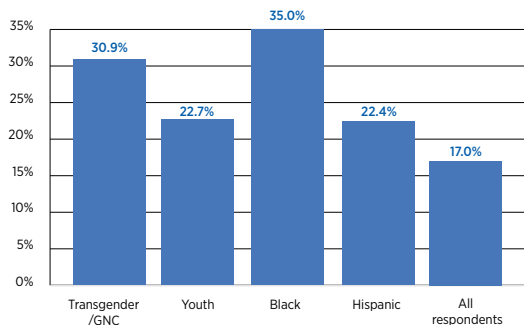
In New York City, gay and lesbian people were twice as likely to have a history of depression as heterosexual people.

Depression among Adults by Sexual Orientation in the NYC Community Health Survey (2007)



A total of 16.7% of those who took the Needs Assessment survey had current probable depression, according to the PHQ (Patient Health Questionnaire), a validated, two-item instrument for measuring depression in epidemiological studies (Gilbody et al., 2007). Black and Hispanic respondents, as well as those who were in the youngest age group (18-24) and those who identified as transgender or gender non-conforming, were most likely to have probable depression than were other respondents.⁹

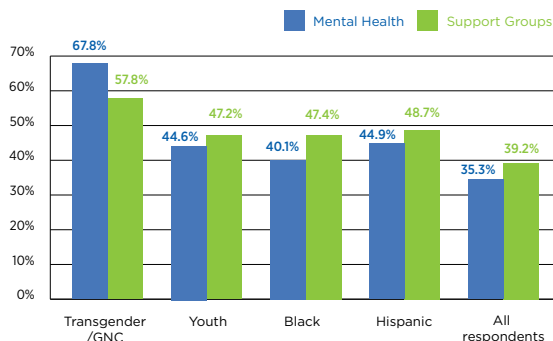
Depression among Transgender, Youth, Black, Hispanic and All Respondents to the Needs Assessment Survey



The same groups at most risk for depression—youth, transgender people and Black and Hispanic people—were those least able to access mental health and support group services.

In addition to experiencing a greater mental health burden, LGBT people have less access to mental health services. In the Needs Assessment survey, 35.3% identified lack of mental health services and 39.2% identified lack of support groups as being a problem or major problem in accessing care. Black and Hispanic respondents, as well as those who were in the youngest age group (18-24) and those who identified as transgender or gender non-conforming, were most likely to have difficulty accessing mental health and support group services.

Lack of Access to Mental Healthcare Among Transgender, Youth, Black, Hispanic and All Respondents to the Needs Assessment Survey



One staff member at an LGBT-specific mental health treatment center said, “[Our center] started...because we couldn’t get services anywhere else. It’s important to me to know who’s being served and what barriers have they met in the non-LGBT specific setting. Our people are people who live with nothing and in cycles of hospitalization. They’re released into an outpatient

care system that is completely unprepared to deal with their needs. They’re harassed. They go off their meds, spiral down, and 8-10 weeks, they’re back in the hospital. To break that cycle is what we do. The question I always get is, why does it have to be two systems? Why can’t LGBT people with mental illness just go and get treated in these programs?”

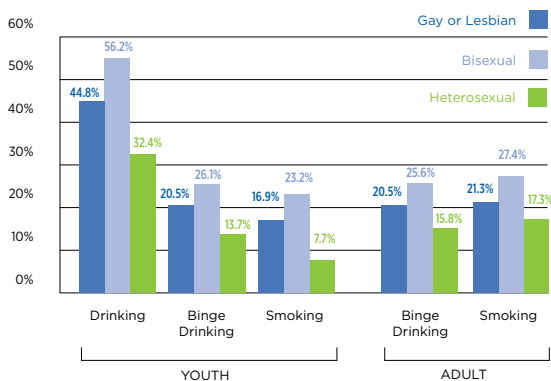
One service provider who works with LGBT urban youth of color describes some of these barriers, saying, “A lot of [youth] suffer from PTSD, ADD. It’s hard getting them diagnosed because our psychiatrist is only there part time. In order for us to move them into stabilized and supportive housing, these programs want psychosocial profiles that can only be done by a psychiatrist. It’s hard getting them done, there aren’t too many programs that specifically do [this] . . .”

Another provider, a physician who works with both youth and adults, echoed that there are cultural competency issues in LGBT mental health care, adding that there are additional barriers in cultural competency around race and ethnicity as well: “General stigma around mental health services to begin with, particularly for communities of color, Caribbean youth we serve. ‘I’m not crazy,’ ‘That’s something white people do.’ How it’s packaged and promoted is a big piece of it. In places where you may find it available, somebody has to have insurance to access it. [And you need] provider competence.”

SUBSTANCE ABUSE

Research suggests that some LGBT people smoke, drink or use other drugs to cope with the stigma and violence they experience. Smoking, which may lead to lung cancer and other health problems, is elevated among LGBT people (Gruskin & Gordon, 2007; Tang et al., 2004). Alcohol abuse is more common among lesbian and bisexual women than heterosexual women (Burgard et al., 2005) and some studies also find this is true for men (King et al., 2008). Finally, illegal drug use and dependence are more common among LGBT people than non-LGBT people (King et al., 2008).

Substance Abuse among Youth (YRBS) and Adults (CHS) in New York City by Sexual Orientation



In New York City, the Community Health Survey shows that adult LGB people are more likely to smoke and binge drink, and the Youth Risk Behavior Survey shows that LGB youth are more likely to smoke, drink and binge drink.

As one substance abuse counselor who works at an LGBT-specific health center explained, substance abuse issues vary within the LGB community, saying, “We’ve become very sophisticated in trying to figure out the interdependency of queer behavior, HIV, substance abuse. . . . There’s more development and sophistication around identifying...high risk behavior for men. For lesbians, we haven’t figured out the bridges.”

HOUSING

Studies suggest that as many as 42% of homeless youth are LGBT (Ray, 2006). In the Needs Assessment survey, nearly 14% of respondents were currently or formerly homeless and 19% of respondents said that inadequate or unaffordable housing was an issue in accessing healthcare. Transgender or gender non-

“Housing is healthcare.”

conforming people and Black and Hispanic people are much more likely to have ever been homeless.

Key informants who participated in focus groups recognized the importance of housing to health and human services. One staff member of an urban program for LGBT homeless youth said, “For us, [the most pressing health and human service need] is housing... housing is healthcare. Once we’ve housed people who are unstably housed, their lifestyle changes. If they are engaging in unprotected sex, involved in street work... once they become steadily housed, they are more open to protecting themselves and using condoms. Once they become housed, they become more adherent to medical treatment. When they are on the street, they are not adherent to their medical regimens with HIV, etc. They feel more in control, and they have somewhere to live. It’s more comforting and allows them to deal with other stuff.” Another provider, a physician who works with LGBT youth of color said, “As a physician, I’d go out on a limb and say [the most pressing issue is] it’s stable housing for LGBT youth, particularly trans youth.”

SOCIAL SUPPORT AND SOCIAL ISOLATION

Social isolation has been found to have negative effects on health, especially among older adults (Cornwell & Waite, 2009). The Needs Assessment found that the average score on the loneliness scale was 5.36 (out of 9), higher than in previous population-based studies (Hughes et al., 2004). There was a small but significant negative correlation between age and loneliness, with younger people saying they were more lonely. Transgender and gender non-conforming people and people who do not live or work in Manhattan were also significantly more lonely. People who go to events at LGBT centers were less likely to say they were lonely.

Many participants in focus groups and interviews suggested that loneliness and social isolation were pressing health and human service needs that their organization works to alleviate. One director of an LGBT center said: “It’s important to qualify socialization and isolation as a determinant of positive overall well-being, health, self-esteem. I know there are measures of satisfaction in life with happiness and health...”

“[LGBT people] definitely need the socialization, the interaction with other LGBT people. They need that sense of gay culture in order to be well.”

People who go to events at LGBT centers were less likely to say they were lonely.

We get a lot of people who don't necessarily see themselves as needing 'hard' services like counseling, HIV treatment, but they definitely need the socialization, the interaction with other LGBT people. They need that sense of gay culture in order to be well...It's hard to define this other thing for people to get in a room and have coffee and cake...share their lives with one another and their families, their children."

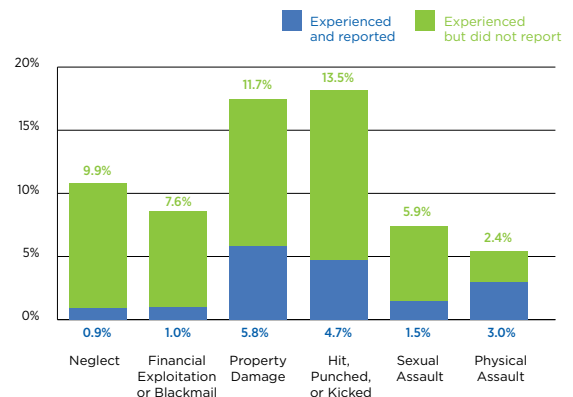
Another staff member at an urban LGBT health organization said, "Our federal, state and local dollars for HIV prevention are primarily spent on individual and group kinds of interventions, which are proven to be effective. However, they are very costly. If you do outreach to the numbers who need to be reached... community kinds of intervention, building community support, trying to impact the values and norms of the community is a much bigger, tougher thing. However, the yield is greater. It's harder to evaluate, and therefore gets less attention and less funding...We see a huge desire among gay men for a community connection. Research has suggested that those who have a connection to a community have better health outcomes. That comes in all ways. African American guys...play a game of spades, just to bring a sense of community and community support."

VIOLENCE

Hate violence remains a large problem for the LGBT community. For example, in 2007, there were 403 anti-LGBT incidents documented in New York City alone (National Coalition of Anti-Violence Programs, 2008).

In the Needs Assessment, 13.0% of those who answered questions about hate violence reported having been victims of homophobic or transphobic physical or sexual assault.

Experiences of Homophobic Violence and Reporting to the Police in the Needs Assessment Survey



Despite the high rates of violence, these incidents often go unreported to the police. Verbal abuse, for example, is almost never reported to the police. Although 5% of the sample experienced homophobic verbal abuse and reported it, 62.9% experienced it and did not report it.

Further, there is some evidence that LGBT people are more likely to be victims of domestic violence than non-LGBT people (Olson et al., 2008). Data from New York City suggest that this is true locally as well. For example, the 2006 NYC Community Health Survey shows 4.5% of lesbian or gay and 7.1% of bisexual people report fearing violence from an intimate partner, compared with 2.3% of heterosexuals.

In the Needs Assessment survey, 26.4% of respondents reported experiencing intimate partner violence; less than one-quarter of this was reported to the police. Similarly, 21.3% reported experiencing stalking, with less than a quarter of those who experienced it reporting to the police.

An executive director of a senior organization in upstate New York suggested why rates of reporting are so low, saying, "I run into so many people that are used to being treated crappy, they don't even report it. That is about coming up in a time when things were so much worse [for people who are now LGBT seniors]. Mistrust of police in terms of reporting. In terms of same-sex domestic violence, I think it's an issue throughout society...Attitudes from other eras play into about how things should be."

A staff member from another LGBT program suggested that for some participants, violence was ongoing and from many sources, saying, “Life [for LGBT seniors] has been rough...[one of the participants in our program] was married to an abusive husband who beat her, came out as a lesbian and was mugged three times as a waitress.”

SPECIFIC POPULATIONS

Transgender and Gender Non-conforming People

The NYS Adult Tobacco Survey estimates that there are about 300,000 transgender people living in New York State. There is very little information about the non-HIV-related health and human service needs of transgender and gender non-conforming people (Mayer et al., 2008). Some preliminary research suggests that transgender people are less likely to be insured and more likely to be unemployed and very low income. In both the NYS Adult Tobacco Survey and the Needs Assessment survey, transgender people were much more likely to be uninsured. In the Needs Assessment survey, transgender and gender non-conforming people were almost twice as likely as non-transgender people to be very low income (20.7% as opposed to 11.1%, for household income under \$10,000 per year). Among respondents to the Needs Assessment survey, younger people were more likely to

Overall, 28.4% of transgender and gender non-conforming people had experienced a serious physical or sexual assault motivated by homophobia or transphobia.

Three times as many transgender and gender-nonconforming people said that they were currently (3.7%) or formerly (29.6%) homeless as were non-transgender people.

The Adult Tobacco Survey estimates that there are about 300,000 transgender people living in New York State.

identify as transgender or gender nonconforming than older people. Transgender and gender non-conforming people were also less likely to identify their race as white.

Needs Assessment survey data show that transgender and gender non-conforming people are much more likely to experience barriers to healthcare. More than three times as many transgender and gender-nonconforming people said that they were worried doctors would refuse them care. Among transgender and gender non-conforming respondents, 73.4%, or twice as many as non-transgender people, said that lack of well-trained providers was a problem for them in accessing healthcare. Twice as many (56.3%) said that fear of being treated badly kept them from accessing healthcare. A total of 60.2% of transgender and gender non-conforming respondents said that community stigma or fear of LGBT people was a problem in attempting to access services. Finally, nearly twice as many transgender and gender non-conforming people said that housing was a problem for them in accessing healthcare. Three times as many transgender and gender-nonconforming people said that they were currently (3.7%) or formerly (29.6%) homeless as were non-transgender people.

Stigma and homelessness are both significant barriers to care for transgender and gender non-conforming people in accessing appropriate, sensitive healthcare services. Lack of information about specific health needs is also a barrier. As one staff member of an LGBT center outside of New York City observed, “[It’s hard to find] healthcare information for transsexuals in terms of hormones, therapy, proper way to get and administer hormones and the risk of doing it the wrong way [is very important]. Trying to get them on the street vs. from a physician.” Another person who works at a transgender-specific organization said, “In trans communities, some of that research is totally missing...research around hormone therapy over a long time. . . [There are] no longitudinal [over time] studies. What causes a lot of people not to access healthcare is because there aren’t really any reliable sources, so

people just don't go because they're afraid of being outted, afraid of accessing any kind of healthcare at all."

Transgender and gender non-conforming people are much more likely to be victims of hate violence than are people who conform to gender norms. Overall, 28.4% of transgender and gender non-conforming people had experienced a serious physical or sexual assault motivated by homophobia or transphobia.

People of Color

In the Needs Assessment survey, people who were Black (24.4%), Hispanic (21.7%), American Indian (26.3%) or mixed race (19.7%) were more likely to report lower incomes (under \$10,000 per year for their household) and to report that their incomes were not sufficient to meet their basic needs than were other racial and ethnic groups. American Indian respondents were least likely to report that they had health insurance (72.2%). Black respondents were more likely to report that they had children living with them (21.0%) than were other racial or ethnic groups. People of color were more likely to live in urban areas. They were also less likely to be employed and less likely to be partnered than were white respondents.

LGBT people of color experience more barriers to healthcare access related to refusal of care and stigma than do white people. For example, only 7.6% of white people indicated that 'Doctors and other healthcare workers who refuse to provide services to LGBT people' was a problem in accessing healthcare for them, while 21.6% of Hispanic respondents, 18.3% of Black respondents, 31.6% of American Indian respondents and 14.0% of mixed-race respondents said this was a problem.

People of color scored higher on the loneliness scale and were more likely to have probable depression and difficulty accessing mental health and support group services. Nearly half of the American Indian respondents had probable depression, as did one-quarter of Black respondents. As one staff member at an LGBT mental health organization said, "Why can't LGBT people with mental illness just go and get treated in [mainstream] programs?...An African American woman might prefer to go to an organization that is run by African American women. But she shouldn't have to."

One reason that high rates of barriers to care were reported may be because current LGBT-specific and

19.3% of Black people and 20.0% of Latino people who filled out the Needs Assessment survey had been physically or sexually assaulted because of homophobia or transphobia, compared to 10.9% of white people.

general services do not provide culturally sensitive services to the full range of people of color. Focus group participants were also particularly aware of LGBT people of color who are not members of those larger racial or ethnic groups most often targeted for services. As one staff member said, "API [Asian Pacific Islander] organizations need to be more LGBT sensitive, and LGBT orgs need to be more API sensitive. API are not usually thought of as people of color." Another echoed this, saying, "It's a misnomer that all people of color organizations are Black. It's amazing within the LGBT community, when we were creating an aging curriculum, lack of awareness of diversity within our communities. I come from a Caribbean background. I understand Caribbean homophobia. There aren't many white Americans who can go into a Caribbean space and speak the same language. When creating cultural competency curriculum or trainings, you have to be sensitive to the needs of target audience." Finally, a member of a two-spirit organization said, "For the two-spirit community, we are not being represented in the LGBT larger movement. We are not visible unless it's us that's doing it."

This type of sensitivity is necessary, according to key informants, because LGBT issues play out differently in families of different backgrounds. One staff member at an HIV prevention program that works with youth of color explained this, saying, "A lot of our youth are first generation from Caribbean. [There are] huge cultural issues around being gay, coming from a Caribbean family...if they're gay and HIV positive, there's tons of stigma...and a big disconnect between ability to be open in community. Creates a lot of isolation... There's a big difference between young gay white

kids in NYC who access services and where young gay kids of color access services...Providing services that empower young gay men and women of color is important. A lot [of kids of color] deal with racial, cultural, stigma issues. That leads to other social needs.”

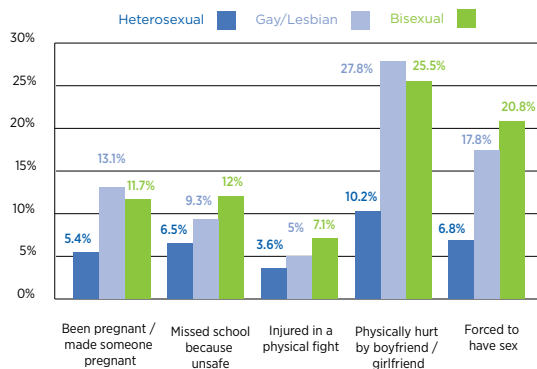
Finally, LGBT people of color face more hate violence than LGBT people who are not of color. For example, 19.3% of Black people and 20.0% of Latino people who filled out the Needs Assessment survey had been physically or sexually assaulted because of homophobia or transphobia, compared to 10.9% of white people. Many of these incidents went unreported to the police.

Youth

Scholarly literature has established that LGBT youth are at risk for a variety of negative health outcomes, including smoking, substance abuse, drinking and risk behaviors, as well as experiences of suicide and violence and unsafe sex (Goodenow et al., 2002; Goodenow et al., 2008; Russell & Joyner, 2001; Saewyc et al., 1999). Although many LGBT youth show remarkable resilience, the stress they experience from homophobia, bullying and family rejection often leads to increased risk behavior.

In New York City, LGB youth are more likely to have been pregnant or made someone pregnant, to have missed school or been injured in a physical fight, to have been physically hurt by an intimate partner or forced to have sex.

Youth Risk Behaviors and Negative Outcomes in the NYC Youth Risk Behavior Survey (2007) by Sexual Orientation



“We know of a case where in Wayne County, social services couldn’t deal with a 13-year-old boy who wants to sew and decorate, and they sent him to Monroe County. What he needs is a sewing machine, not to be shipped off to a different county.”

The Needs Assessment survey included 13% of respondents between the ages of 18 and 24. Because the survey could not ask questions of people under 18, the survey results on youth are limited to those who were in this young adult category.

Young adults aged 18-24 were more than six times as likely to report that they are currently homeless than were older adults in this sample. Several key informants who participated in focus groups or interviews suggested that homelessness for LGBT youth is one of the most pressing health and human services issues. A staff member at an LGBT health center explained that homelessness and poverty have specific negative consequences for LGBT youth, saying, “Homelessness [is something] we see a lot among young clients we work with. One of the things we hear recently in terms of the economy is that based on the difficulty getting part-time jobs, people looking for summer jobs, it looks like there may be more young people turning to sex work this year, this spring and this summer, than have in the past...How do we support them in a way that doesn’t encounter violence and protects their health?”

The Needs Assessment survey shows that 53.9% of young people (18-24) say that affording healthcare is a major barrier for them. As another staff member at a center for LGBT homeless youth emphasized, “When they [youth] come to us, some haven’t seen a doctor in years.” For young people who are not living with parents, healthcare services may be unaffordable. As another staff member said, “Younger people tend to have these \$10 an hour jobs. It’s hard for them to afford [even] low fee services. They may not be getting health insurance for working these jobs.”

Even when youth are connected to services, these services must be LGBT-sensitive in order to be helpful. The director of an LGBT center in upstate New York articulated her frustrations with the social service system, saying, “[We know of a] case where in Wayne County, [social services] couldn’t deal with a 13-year-old boy who wants to sew and decorate, and they sent him to Monroe County. What he needs is a sewing machine, not to be shipped off to a different county.” Another staff person at a different LGBT center said, “When a young person is placed [in foster care], LGBT or perceived, if they are a victim of harassment or bullying, often times they’re the one that gets moved for their protection. Rather than dealing with the issue of violence of perpetrators, the victim of the behavior gets punishment.”

Finally, youth of color face specific issues around access to care and services, and some of those needs are different for youth of color who live outside of major urban areas. As the director of a program for LGBT people of faith suggested, “[The most pressing health and human service need is] the lack of services for LGBT young adults. Age category 18-30 of color in the communities that are more underserved [are] marginalized by other variables in terms of poverty [and] unemployment...[They benefit] if they feel comfortable going to health providers because of all the stigma and barriers they face.” As a staff member at a program working in a New York City suburb explained, “The [suburban] youth are predominately Caucasian and have tremendous services. They have all sorts of social, familial, and scholastic support. As opposed to...youth [of color], who have dropped out of school because of harassment, who aren’t getting services met, they’re having a hard time coming out to families.”

Seniors

Research on LGBT seniors suggests that they, like youth, have unique needs. Particularly because they are more likely to age alone than heterosexuals and are heavily involved in caregiving, many of those needs involve social support as well as needs that might be expected for someone who is aging (Cahill et al., 2000; Coon, 2003; Hash, 2006).

According to the NYC Community Health Survey, in New York City alone there are at least 8,000 LGBT seniors at risk for social isolation. Social

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Older LGBT people who lived in small towns or did not go to events at LGBT centers were significantly more lonely.

isolation has many different causes, many of them rooted in LGBT seniors’ histories living in an intolerant social world. The senior issues focus group agreed that the most pressing health and human service need for LGBT seniors is social isolation. One staff member at an LGBT aging organization explained, “[Social Isolation] means a lot of things in various manifestations. Some others can speak to this better than I can because it has to do with living in other urban areas. People not trusting services or not being able to access. Being suspicious of not being treated well, especially as people get old and frail. People just distancing themselves from community creates huge disparities in terms of health. Isolation is the big umbrella...The most pressing [problem related to social isolation]... is the internalized homophobia which can lead to the isolation, lead to alcoholism, abuse of alcohol, suicide. ”

Sixteen percent of people who took the survey identified that they were age 55-64 and 6% said that they were over 65. Older adults sometimes need assistance in accessing healthcare and assuring their own well-being as they age. However, the group of seniors who took this survey had strong resources in dealing with barriers to healthcare; they rated each of the barriers less of a problem than did younger respondents. On the other hand, over half of seniors said that they sometimes (36.1%) or often (22.1%) feel they lack companionship. Seniors in small towns were much more likely to say that they lacked companionship often (37.3%) than were seniors in cities. Older LGBT

LGBT seniors are vulnerable to financial exploitation and neglect.

people who lived in small towns or did not go to events at LGBT centers were significantly more lonely.

Seniors also confront ageism within the LGBT community, and homophobia and transphobia in non-LGBT senior-specific contexts. One staff member at an LGBT center pointed out, “Ageism is rampant in our society in general. Everybody ages. Hopefully we’ll all age. Within the LGBT community, it gets to another level. I see it in our program, there is a stigma attached to attending our program...We desexualize seniors. In fact, they’re still out there getting it on.”

Finally, LGBT seniors are vulnerable to financial exploitation and neglect. Of those 55 and older who took the survey, 8.3% had experienced neglect as a result of homophobia and 8.9% had experienced financial exploitation or blackmail. Very little of this abuse was reported.

Families

Over half of those who took the Needs Assessment survey are partnered, suggesting a high rate of family formation among LGBT adults in New York State. For many LGBT people, the ability to build a family is a pressing health and human service need. Of those who took the Needs Assessment survey, 13.1% have children living with them at least part time. LGBT people make families in a variety of ways (Weston, 1997), including connecting with other LGBT people of different generations, adopting and fostering children, pregnancy and surrogacy. However, in their efforts to form families, LGBT people may face many barriers as well as opportunities.

One participant in the focus groups who is also the director of an LGBT families program emphasized the opportunities created by LGBT desires to form families in non-traditional ways, saying, “In a foster care conversation, we just opened a flood-gate. We made one contact with a home-finder recruitment person from a private foster care agency in the Binghamton area [who told me], ‘I know LGBT parents make great parents, help me find those people and help me how to convince older kids in foster care that going in an

LGBT-parented home would be okay.’...Public welfare agency folks [are] talking about the process, trying to recruit queer adults into being foster adults and [tell them they] won’t find homophobia when they go to a DHS office.” However, she also acknowledged the challenges, saying, “We are not providing enough support for couples considering parenting, becoming parents, to really be prepared for what that means. I’m getting calls for referrals to attorneys, mediators to sort out break ups. Trying to check out mediation place to see how homophobic they are before I refer.”

Other challenges emerge in the healthcare context for LGBT people trying to form families. One key informant who works with LGBT people of color in faith communities told this story: “We have a 22 or 23 [year old] lesbian couple. One is pregnant. I said, ‘Has your partner attended any of the doctor appointments?’ [She said] ‘Not yet.’ I realized it’s taking me back. There are other issues. The doctor doesn’t know she’s a lesbian. He’s a reputable doctor. She doesn’t want to take the risk of the doctor not treating her in a professional manner. We spent some time looking at that...Issues came up around their own concerns of being a lesbian and a mother.”

Although there is very little quantitative data on this group, children of LGBT parents may have particular health and human service needs as well. Another staff member who works with families said, “I would say also services for our Family Pride organization that is for same-sex parents and their children. There is a great need...we can only combine all the children together, doesn’t matter if they’re newborn or 17. I see a great need for teenagers of LGBT parents to have groups to come together.”

“We have a 22 or 23 [year old] lesbian couple. One is pregnant. I said, ‘Has your partner attended any of the doctor appointments?’ [She said,] ‘Not yet.’”

Next Steps: Areas for Future Focus

Population Size and Demographics

Despite tremendous progress in LGBT inclusion in New York City, and the important information from the 2004 NYS Adult Tobacco Survey, statewide health surveys and other data collection need to consistently include reliable, valid questions about LGBT identity. Without further research, health and human services needs cannot be reliably tracked. Particular attention should be paid to the lack of data on transgender people. Restoring the question about transgender identity to the NYS Adult Tobacco Survey and other statewide surveys, and adding this question to the Community Health Survey in New York City would be important steps in that direction.

Insurance and Sources of Healthcare

Lack of insurance remains an issue for many LGBT people. Expanding access to affordable insurance and removing barriers to coverage for domestic partners and spouses would help cover uninsured LGBT people and narrow the coverage gap between LGBT and non-LGBT people. LGBT adults and youth also need to be engaged in primary care and have regular check-ups. Expanding access to LGBT-friendly providers and encouraging LGBT people to have a regular source of care will improve health.

Barriers to Healthcare Access

Cultural competency training for healthcare providers will help alleviate many of the barriers to care that were reported in the Needs Assessment. Further, advertising stating that providers have been trained would allow LGBT people to select these providers and utilize them.

Geography and Transportation

For non-urban LGBT people, especially youth of all races and adults and youth of color, transportation is crucial to the success of programs. Where transportation is non-existent or insufficient to meet needs, further transportation options (for example, vans and drivers to drive youth to programs) are necessary.

Increasing services to rural areas will alleviate social isolation and the health and human services problems that arise when LGBT people are isolated.

Mental Illness and Access to Mental Healthcare

Mental health services and support groups for LGBT people need to be expanded. Lack of these services was considered to be a pressing need for all LGBT people, and particularly for youth, transgender people and Black and Hispanic people.

Substance Abuse

Tobacco, alcohol and other drugs continue to take a disproportionate toll on the LGBT community. Further research is needed into the most effective ways to help prevent this and help those who are affected.

Housing and Homelessness

LGBT people are disproportionately affected by homelessness. Expansion of homeless services, LGBT sensitivity training for providers in the shelter system and an increase in LGBT-specific homeless services will help alleviate this problem.

Social Isolation

Loneliness and social isolation can have significant negative health impacts. LGBT centers and other community based organizations can help provide social programs and create spaces for people to meet.

Violence

Hate violence remains a problem for LGBT people. Services for victims and prevention programs need continued support. Further, hate violence often goes unreported. In order to improve reporting, it is important to ensure that police are adequately trained to work sensitively with victims.

Transgender and Gender Non-conforming People

Lowering barriers to healthcare and human services begins with more research on transgender and gender non-conforming people's specific healthcare needs. Healthcare providers can show people who do not identify as 'male' or 'female' that they are sensitive to these issues by changing their forms to include more than two gender options, or replacing check boxes with fill-in blanks. Because transgender and gender non-conforming people experience high rates of violence,

safe schools programs and protection from violence and prejudice in public places are particularly helpful to this group. These programs must be enforced and be gender-identity inclusive in order to be effective.

People of Color

LGBT people of color face unique challenges in accessing health and human services. They are more likely to experience poverty and homelessness.

LGBT services must be sensitive to the differences in culture among racial and ethnic groups and provide support that is culturally appropriate.

Youth

LGBT youth are vulnerable to violence, homelessness, risk behaviors and other negative health outcomes. Increasing social services targeted to LGBT youth can alleviate these disparities, while training social service providers who work with youth in cultural competency for LGBT issues will mean that youth who access services are provided adequate care.

Seniors

Seniors, especially those outside of major urban areas, need opportunities to socialize with other LGBT seniors. Seniors are often resilient and provide caregiving to other seniors; however, they need LGBT-sensitive health and human services options. LGBT services need to be sensitive to generational differences, with an understanding that many LGBT seniors came out at a time when being LGBT was more stigmatized and dangerous.

Families

LGBT people form families in a variety of ways; these families deserve support. LGBT people who want to be parents should be treated equally by adoption agencies and the foster care system.

- 1 People who identified their sexual orientation as 'same gender loving' or 'homosexual' were categorized with gay and lesbian people.
- 2 Population-based data is collected to represent the entire population and thus provides stronger estimates than data collected through convenience samples.
- 3 New York City Department of Health and Mental Hygiene. Epiquery: NYC Interactive Health Data System - Community Health Survey 2007 and Youth Risk Behavior Survey 2007. 6 May, 2009. nyc.gov/health/epiquery
- 4 People who reported an age under 18 or were missing zip codes (and did not live or work in Manhattan) or who reported non-New York State zip codes (and did not live or work in Manhattan) were excluded. People who identified as straight and non-transgender and whose birth sex matched their current gender identity were excluded. People with more than 50% missing data were excluded. The data were analyzed using SPSS.
- 5 This information can be found in tables 14 and 15 in: Mosher WD, Chandra A, Jones J. Sexual behavior and selected health measures: Men and women 15-44 years of age, United States, 2002 . Advance data from vital and health statistics; no 362. Hyattsville, MD: National Center for Health Statistics. 2005. Viewed on 6 May 2009 at: www.cdc.gov/nchs/data/ad/ad362.pdf
- 6 Transgender and gender non-conforming, as a category, included self-identified transgender people, people whose current gender identity was different from their birth sex and those who identified themselves as gender non-conforming, gender bending or similar. Although this category is diverse, it was considered one gender category in order to have a sufficient number of respondents for analysis.
- 7 It is not possible to know whether the married same-sex partners were married legally in another state or country or whether the partners simply consider themselves married.
- 8 The survey measured barriers to care using an LGBT-specific modification of an HIV barriers to care scale. The original scale can be found in Heckman, Somlai et. al. (1998) Barriers to care among persons living with HIV/AIDS in urban and rural areas. *AIDS Care* 10:3; 365-375.
- 9 Black and Hispanic race/ethnicity was alone or in any combination.

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Acknowledgements

Produced with funding from the New York State Department of Health, Division of Family Health. The opinions, results, findings and/or interpretations of data contained herein are the responsibility of the author and do not necessarily represent the opinions, interpretation or policy of the Department or State of New York.

Somjen Frazer would like to acknowledge the invaluable assistance of the Technical Assistance Committee of the LGBT Health and Human Services Network, including Barbara Warren, Christian Huygen, Harlan Pruden and Joanne Goodman. She would also like to thank Ross Levi and Kimberly Eisen for their excellent work representing the Empire State Pride Agenda Foundation. In addition, Tom Weber, Karen Taylor and Sunny Bjerk from SAGE provided advice and assistance with focus groups. Without Amanda Harris, project manager for the research and outreach, this work would not have been possible. All my thanks to Esther Baker for her qualitative research and copyediting. Finally, all those who participated in the research and shared stories in focus groups—this report is first and foremost for you and because of you.

Frazer, M. Somjen. (2009) LGBT Health and Human Services Needs in New York State. Empire State Pride Agenda Foundation: Albany, NY. URL. Access Date.

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"I could not find a gay primary care medical doctor in the suburbs and have to go to the city."

"Knowing where health care professionals stand on their beliefs and attitudes would be extremely helpful in choosing doctors—especially when planning a family."

"I would love to go to an LGBT-friendly doctor, but I don't know where to find one. My current primary care provider did not discriminate against me, but she knew very little about lesbian sexual health concerns. It seems to be a very common problem. Many of our providers are not well-informed about queer women's health concerns."

"The most important health and human service need for LGBT people is fair, equal and personalized health care. Once I went to a local hospital, they didn't see me as a gay man at risk. My primary care physician should know how to treat me. I have found in most cases that only someone who cares about or is in the LGBT community knows how to treat me. This is unfair and unequal."

"I remember when I first became HIV positive not being able to find a support group that was not primarily a controlled study, and therefore it's own first priority. I was shocked at how callously I was told to apply for another group starting in 12 weeks or so when I felt I was in crisis then."

"Every New Yorker should be confident that they can access LGBT knowledgeable and sensitive health care when they need it. Health insurance should be more accessible, and transition-related health care should not be excluded by insurance companies."

"Pro-active welcoming and honest outreach in a central clearinghouse where all LGBT people can go, feel safe and enthusiastically supported, to obtain referrals to all health and human services resources available to them. Follow up should also be pro-active to ensure the LGBT person got right leads and the need is being addressed with redirection as needed."

"Most of the discrimination around healthcare that I receive is because I'm fat. I find it extremely difficult to find non fat-phobic medical services even within the LGBT community. I would like to see more of an effort made for sensitivity towards people of size in health and human services."

"Psychological counselors need to be trained in how to deal with LGBT issues considering the prevalence of mental issues among the LGBT population and the unique stressors within that population."

"It's important to have the HPV vaccine available to men and covered by insurance."