HEALTHY PEOPLE 2010

Companion Document for Lesbian, Gay, Bisexual, and Transgender (LGBT) Health



Companion Document for Lesbian, Gay, Bisexual, and Transgender (LGBT) Health

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Technical assistance and editing provided by IQ Solutions, Inc.
April, 2001

The development of this document received partial funding support from the Health Resources and Services Administration of the U.S. Department of Health and Human Services under purchase orders 00-0048 (P) and 01-0145 (P). The opinions expressed herein are those of the authors and do not necessarily reflect the official positions of the U.S. Department of Health and Human Services.

Suggested Citation:

Gay and Lesbian Medical Association and LGBT health experts. Healthy People 2010 Companion Document for Lesbian, Gay, Bisexual, and Transgender (LGBT) Health. San Francisco, CA: Gay and Lesbian Medical Association, 2001.

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The HP2010 Companion Document for LGBT Health is available for downloading or printing at the GLMA and National Coalition for LGBT Health Web sites. An order form for hard copies is available at the GLMA web site.

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Acknowledgments

The Healthy People 2010 Companion Document for LGBT Health is the product of a national collaborative effort that involved nearly 200 individuals, organizations, and agencies. The full list of contributors may be found in Appendix E: Contributors. In addition, several individuals and organizations provided strategic leadership and contributed significant time and resources.

IQ Solutions, Inc. drafted the document and provided editorial, design, and production services throughout the document development process. Nancy Kennedy of the Substance Abuse and Mental Health Services Administration (SAMHSA), DHHS, contributed immeasurably in editing and writing the document. The collaborative process was organized, planned, and coordinated by the Gay and Lesbian Medical Association. An outgrowth of this process was the formation of the National Coalition for LGBT Health by many of the contributing organizations. The National Coalition will continue to be a partner in the dissemination and implementation of the document.

Other organizations that provided staff and logistical support for the process include: Boston Public Health Commission; Columbia University Center for LGBT Health and the Lesbian Health Research Institute; Fenway Community Health; LLEGO, The National Latina/o Lesbian, Gay, Bisexual, and Transgender Organization; National Association for Lesbian and Gay Addiction Professionals; National Coalition for LGBT Health; National Gay and Lesbian Task Force; University of Pittsburgh Center for Research on Health and Sexual Orientation; and Virginia Commonwealth University Survey and Evaluation Research Laboratory.

The document could not have been written without the notable contributions of the following individuals: Deborah J. Aaron, Clinton Anderson, Sandi J. Armstrong, John Auerbach, Cornelius Baker, Valerie Bassett, Rodger L. Beatty, Deborah J. Bowen, Judy Bradford, Sean Camargo, Darren Carter, Bianca Cody Murphy, Blake Cornish, Patricia Dunn, L. Michael Gipson, Henia Handler, Irene Anne Jillson, Nancy Kennedy, Stewart Landers, Anne Lawrence, Jean Flatley McGuire, Alejandro Marcel, Nina Markovic, Kenneth H. Mayer, Marshall Miller, Craig Packer, Gerard Passannante, Fred D. Rachman, Marty Rouse, Lauretta A. Safford, Scout, Randall Sell, Anthony J. Silvestre, Jessica M. Xavier, and Frank Y. Wong.



A Healthy People 2010 Companion Document for Lesbian, Gay, Bisexual, and Transgender Health

Introduction

Healthy People 2010 is the prevention agenda for the Nation. It is designed to serve as a roadmap for improving the health of all people in the United States during the first decade of the 21st century. (More information is available online at www.health.gov/healthypeople.) Like the preceding Healthy People 2000 initiative—which was driven by an ambitious, yet achievable, 10-year strategy for improving the Nation's health by the end of the 20th century—Healthy People 2010 is committed to a single, overarching purpose: promoting health and preventing illness, disability, and premature death.

Federal program planners and health care policymakers recognize that all population groups neither share the same health status, nor have equal access to quality health care and related services. Vulnerable or underserved populations—people who, for a variety of reasons, do not have access to needed health care—face many barriers to health care. These barriers include having no health insurance, having inadequate health insurance coverage, having low income, living in isolated areas or in crowded inner cities where there may be a shortage of needed health care providers, facing discrimination, experiencing stigma, and encountering cultural barriers such as a lack of literacy and few culturally competent providers or culturally accessible health promotional or educational materials.

Healthy People 2010 is grounded in science, built through public consensus, and designed to measure progress.

The ability of health professionals and health plans to provide necessary and appropriate services in areas with the greatest need depends, to a large extent, on good information about the health needs of people served within communities as well as overall health status. Lesbian, gay, bisexual, and transgender (LGBT) populations have been among those for whom little or no national-level health data exist.[1, 2, 3, 4, 5] Some State-level data from CDC's Youth Risk Behavioral Surveillance System, a few household-based studies, many studies using convenience samples, and anecdotal information have indicated that LGBT populations, in addition to having the same basic health needs as the general population, have health disparities related to sexual orientation or gender identity. This Healthy People 2010 Companion Document contains most of the existing quantitative and qualitative research and information specific to LGBT health in the areas defined and

discusses the overall health status of LGBT people. Making the best use of available data, this document describes the barriers and recommends changes that will facilitate success in overcoming them.

Healthy People 2010 Companion Documents

Although Healthy People 2010 outlines the health goals for the Nation over the next 10 years and serves as a benchmark and guide for community-based program planning, such a document cannot meet the diverse needs of all people, especially of minority populations for whom adequate data are lacking. Healthy People 2010 Companion Documents, therefore, are intended to highlight or identify the objectives most relevant to selected populations or groups and to focus on practical strategic steps to improve the health of the population or to better manage chronic disease conditions. Companion Documents also are designed to make Healthy People 2010 and the information pertaining to targeted populations more useful to consumers, community health planners, health educators, people in health professions training, academics, and practicing health professionals at all levels of health care delivery. Over the next decade, a series of Healthy People 2010 Companion Documents on a broad range of health issues or focused on the health needs of selected populations are expected to be available.

The History Behind the Healthy People 2010 Initiative

Healthy People 2010 builds on other national health promotion and disease prevention initiatives pursued for more than two decades. Of the most recent, in 1979, Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention provided national goals for reducing premature deaths and preserving independence for older adults. In 1980, another report, Promoting Health/Preventing Disease: Objectives for the Nation, set forth 226 targeted health objectives for the Nation to achieve over the next 10 years.

Healthy People 2000: National Health Promotion and Disease Prevention Objectives, released in 1990, identified health improvement goals and objectives to be reached by the year 2000. The Healthy People 2010 initiative continues in the tradition and looks ahead to improve the overall health of the Nation for the first decade of the 21st century.

Healthy People 2010 represents the ideas and expertise of a diverse range of individuals, health professionals, and organizations concerned about the Nation's health. The Healthy People Consortium—an alliance of more than 350 national organizations and 250 State public health, mental health, substance abuse, and environmental agencies—conducted three national meetings. In addition, many individuals and organizations gave testimony about health priorities at five Healthy People 2010 regional meetings held across the country in late 1998. On two occasions—in 1997 and in 1998—the American public was given the opportunity to share thoughts and ideas and to comment specifically on the draft objectives. More than 11,000 comments on the draft materials were received by mail or via the Internet from individuals in every State, the District of Columbia, and Puerto Rico. These comments were all considered in the development and refinement of the objectives and the content of the chapters.

The Relationship Between Individual and Community Health

Over the years, it has become clear that individual health is closely linked to community health—the health of the community and the environment in which individuals live, work, and play. Likewise, community health is profoundly affected by the actions, collective beliefs, attitudes, and behaviors of everyone who lives in the community.

Community partnerships, particularly when they reach out to nontraditional partners, can be among the most effective tools for improving health in communities. For the past two decades, Healthy People has been used as a strategic management tool for the Federal Government, States, communities, and many other public- and private-sector partners. Virtually all States, the District of Columbia, and Guam have developed their own Healthy People plans modeled after the national plan. Most States have adapted the national objectives to meet their State-specific needs. Many communities have adapted Healthy People objectives and strategies in order to target their prioritized health needs.

Community health is profoundly affected by the collective beliefs, attitudes, and behaviors of everyone who lives in the community.

Therefore, the underlying premise of Healthy People 2010 is that the health of the individual is almost inseparable from the health of the larger community, and that the health of every community in every State and territory determines the overall health status of the Nation. That is why the vision for Healthy People 2010 is "Healthy People in Healthy Communities."

Systematic Approach to Health Improvement

Healthy People 2010, then, is about improving health—the health of each individual, the health of communities, and the health of the Nation. However, the Healthy People goals and objectives themselves cannot improve the health status of the Nation. Instead, they need to be recognized and utilized as part of a larger, systematic approach to health improvement composed of four key elements:

Goals

Objectives

Determinants of health

Health status

Successful community partnerships use a systematic approach to health improvement.

Whether this systematic approach is used to improve health on a national level, as in Healthy People 2010, or to organize community action around a particular health issue, such as promoting smoking cessation, the components remain the same. The goals provide a general focus and direction. The goals, in turn, serve as a guide for developing a set of objectives that will measure actual progress within a specified amount of time. The objectives focus on the determinants of health, which encompass the combined effects of factors influencing individual health or

well-being, community physical and social environments, and policies and interventions used to promote health, prevent disease, and ensure access to quality health care. Finally, health status also is a description of the health of the total population.

The Goals and Objectives of Healthy People 2010

Healthy People 2010 is designed to achieve two overarching goals:

Increase quality and years of healthy life

Eliminate health disparities

These two goals are supported by 467 specific objectives in 28 focus areas, or chapters. Each objective was developed with a target to be achieved by the year 2010. Three of the focus areas are cross-cutting: Access to Quality Health Services, Educational and Community-Based Programs, and Public Health Infrastructure. These three focus areas are overarching and, by their nature, overlap. They also link with all other focus areas. Each focus area is written as a stand-alone document within the larger document, with an introduction, background information, objectives with supporting text, and data templates for objectives for which data currently are available. Each objective and its supporting text are written so the objective or an identified group of objectives stands alone within the focus area.

Types of Objectives

There are two types of objectives in Healthy People 2010: measurable and developmental.

Measurable objectives provide direction for action. For measurable objectives, the current status of the objective is expressed with baseline data. The baseline represents the starting point for moving the Nation toward a desired end. The baselines are obtained from valid and reliable data from currently established, representative data systems at the national level and State level. National data are not a prerequisite to developing an objective, and where appropriate, State, private-sector, or organizational data systems may be used. The data source for each measurable objective is clearly identified and described extensively in the Tracking Healthy People 2010 document.

Developmental objectives provide a vision for a desired outcome or health status. Current national surveillance systems do not always provide data on these subjects, although new questions are being added to national surveys yearly. The purpose of developmental objectives is to identify areas of emerging importance and to drive the development of data systems to measure them. Most developmental objectives have a potential data source with reasonable expectation of data points by the year 2004. Not all data sets for all measurable objectives are complete with needed data. For example, those data areas for some subpopulations are labeled developmental, meaning the data are currently unavailable or not collected.

For persons defined by sexual orientation or gender identity, Healthy People 2010 includes 29 specific objectives for which sexual orientation is included in the data templates. These objectives occur within 9 of the 28 focus areas. (See table 1.)

However, for most of the 29 objectives, "DNC" appears in the data templates: DNC means that data specific to sexual orientation are not currently collected by the data system used to

Table 1. Healthy People 2010: Focus Areas

Sexual orientation included in one or more objective								
1	Access to Quality Health Services		11	Health Communication		20	Occupational Safety and Health	
2	Arthritis, Osteoporosis, and Chronic Back Conditions		12	Heart Disease and Stroke		21	Oral Health	
3	Cancer		13	HIV		22	Physical Activity and Fitness	
4	Chronic Kidney Disease		14	Immunization and Infectious Diseases		23	Public Health Infrastructure	
5	Diabetes		15	Injury and Violence Prevention		24	Respiratory Diseases	
6	Disability and Secondary Conditions		16	Maternal, Infant, and Child Health		25	Sexually Transmitted Diseases	
7	Educational and Community-Based Programs		17	Medical Product Safety		26	Substance Abuse	
8	Environmental Health		18	Mental Health and Mental Disorders		27	Tobacco Use	
9	Family Planning		19	Nutrition and Overweight		28	Vision and Hearing	
10	Food Safety							

track the objective.[6] With the exception of HIV/AIDS Surveillance System of the Centers for Disease Control and Prevention (CDC), which includes reporting new AIDS cases among adolescent and adult men who have sex with men, no other national survey or data collection system specifically identifies people by sexual orientation or gender identity.

Factors Influencing Health or Well-Being

There are major factors that influence, in a positive or negative manner, health or well-being. One of these factors, genetics, encompasses, in a varying or unique mixture, the biological inheritance of the individual and possible predisposition to specific diseases or disorders (e.g., sickle cell anemia or Tay-Sachs disease).[7] Heredity is considered the internal or host variable of health status. Genetic inheritance also may determine such aspects of individuals as metabolism and patterns of behavior. Some scholars, researchers, and others postulate that the causes of homosexuality are genetic.[8, 9, 10, 11]

Another major factor influencing health is the environment; this is characterized as external, in contrast to genetics as internal. The environment encompasses both the physical—including air and water quality, pollution, and quality of housing—and other factors that enhance or divest individual dignity in the ability to maintain self-respect.[12] Also included are such factors as the social environment—the ways in which we work, the people with whom we interact, and the environmental factors that enhance or deter the gratifications received from this socialization or lack thereof.[13] The social environment is the major determinant of an individual's psychological constitution.[14] In contrast to the genetic research mentioned, there are researchers and organizations who purport that the causes of homosexuality are probably environmental.[15, 16, 17]

Factors Influencing Health or Well-Being

- Genetics
- Environment
- Health services
- Habits or lifestyle

Another external cause or factor affecting health or well-being is the availability, quantity, and utilization of health services. Some individuals have equated this factor with that of the medical care system, a system undergoing rapid and dramatic changes as the processes of managed care saturate the private system and move rapidly into the public arena.[18] The health care system is, however, much broader than the medical system. (See Access to Quality Health Services focus area). Even with a narrow conceptualization of services, individual health is affected. Inappropriate utilization of the health care system occurs when either an individual or provider "medicalizes" an individual's life, reducing all problems to medical terms.[19]

One purpose of the Healthy People 2010 Companion Document for LGBT Health is to examine health care disparities and a lack of access to needed services related to sexual orientation or gender identity. The emphasis is on research and science, not anecdotes. Nevertheless, there are those who believe that LGBT people rarely face discrimination,[20] and some organizations continue to exist to prevent homosexuality[21] or, if homosexuality does occur, assist in its treatment.[22, 23]

This Healthy People 2010 Companion Document illustrates that most health care providers need additional education and training to offer culturally appropriate and linguistically accessible services. In 1987, Coleman published a relatively simple assessment tool to help map out or identify the sexual orientation of health care consumers that could be a mechanism for discussion of an uncomfortable topic for most individuals, LGBT or heterosexual.[24] The questionnaire considers the combination of sexual behavior, fantasies, feelings, and self-identification that contributes to sexual orientation or gender identity.

Another factor influencing health is habits or lifestyle, including such behavioral factors as the amount and quality of diet, exercise, sexual activity, work, reaction to stress, and use of alcohol, tobacco, and other drugs. An individual can be made ill by the way he or she lives; and both behavioral excesses and deficiencies are factors determining health, wellness, disorder, or disease.[25]

With repetition, behaviors become habitual. Those behaviors can become a categorical lifestyle when they dominate as normative behaviors. However, as the body cannot be separated from the mind, so behavior is intrinsically linked to the psyche. Thus, attitudes and values are even more influential than knowledge in determining behavior. The evidence for learning, which is also an internal process, is behavioral change that can be observed or measured.[26] This seemingly simplistic explanation is not meant to give an inaccurate appearance to the complexities of human behavior. Instead, the purpose is to establish the premise that behavior, especially harmful behavior, can be changed.

Sexual activity does not equal sexual orientation. However, the starting place of homophobia for many people is sexual activity equated with sexual orientation.[27] Several opinion surveys in the United States have shown that people who consider homosexuality a chosen behavior or lifestyle (as many as 40 percent of the U.S. population) have more negative opinions toward gays and lesbians and are less likely to favor nondiscrimination statutes, as compared to people who think that a person's sexual behavior is inborn or not a choice.[28] "Homosexual" was a term created by Karl Maria Kertbeny in 1869 in preference to "pederast," the derogatory term for men who had sex with men that was in common use at that time in Germany.[29] "Sodomy" was a term that St. Peter Damian coined around 1050.[30]

There is, then, a long history associated with homosexuality and gender identity, as well as specific terminology that has varied across time and place. Moreover, sexual orientation, as well as gender identity, is multidimensional with a great deal of variability. For example, many women who have sex with other women do not identify as lesbians,[31] and some self-identified gay men and lesbians are married to opposite-sex partners.[32, 33] Sexual orientation is commonly considered to have three dimensions: desire/attraction, behavior, and identity.[34, 35]

Health Status

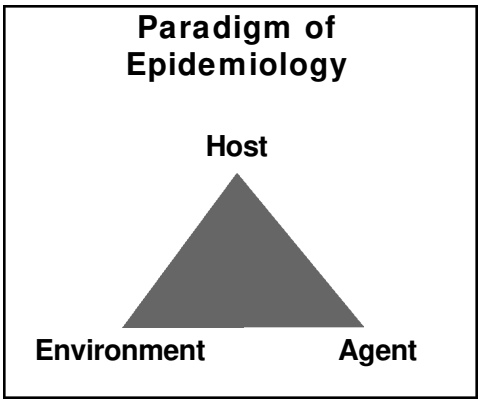
The health status of the United States is a description of the health of the total population, using information representative of most people living in this country. The ultimate measure of success in any health improvement effort is the health status of any defined population. For relatively small population groups, however, it may not be possible to draw accurate conclusions about their health using current data collection methods. The goal of eliminating health disparities will necessitate improved collection and use of standardized data to identify correctly disparities among select population groups.

General health status can be measured by birth and death rates, life expectancy, quality of life, morbidity from specific diseases, risk factors, use of ambulatory care and inpatient care, accessibility of health personnel and facilities, financing of health care, health insurance coverage, and many other factors. The information used to report health status comes from a variety of sources, including birth and death records, hospital discharge data, and health information collected from health care records, personal interviews, physical examinations, and telephone surveys. How a population is defined often determines the data collected.

Epidemiology is the study of the distribution and factors of health-related stress and events in a defined population.[36] Epidemiology is the major vehicle for evaluating health status, describing the natural history of diseases or disorders, identifying risk and protective factors, aiding in the process of clinical analysis and decisionmaking, and developing and evaluating the continuum of care.[37] The basic paradigm of epidemiology was developed in response to a need to measure the extent and characterize the occurrence of infectious diseases such as cholera and smallpox. That paradigm consists of agent, host, and environment.[38]

In infectious diseases, the focus of attention is the agent, without which the disease would not occur. Infectious diseases seem to result from a relatively straightforward cause-and-effect relationship, making epidemiological methods for describing the occurrence of disease apparently simple. In many cases, however, the mere presence of the agent in a host does not necessarily initiate the disease process. Thus, host susceptibility and environment are determinants of whether or not disease will occur. A natural result of decreasing infectious diseases was an increase in longevity of life. As a result of living longer, chronic diseases are more prevalent. And, although the rates of chronic disorders are highest among the elderly, one in four children younger than 18 years also has a chronic condition.[39, 40]

Etiological research, focusing on the causes and origins of diseases, reveals that chronic illnesses have multiple causes leading to a single effect. The metaphor of a "web of causation"[41] explains the complexity of chronic diseases. As for the classic paradigm of agent, host, and environment, Morris, in postulating a paradigm for chronic diseases, replaced the term agent with behavioral factors.[42] Etiologic research involving chronic diseases reveals the importance of behavioral risk factors. This perspective allows chronic diseases to be classified as diseases of lifestyle.[43] Research by Pentz suggests that host susceptibility is the most important factor in the paradigm, thereby lending credence to preventive interventions that support and increase resiliency.[44]



In a recent survey, 90 percent of participants agreed with this statement: My physical well-being is in my hands. In spite of this affirmation, 57 percent of respondents described themselves as overweight, 52 percent did not exercise, and 26 percent smoked cigarettes.[45] These paradoxical statements are further evidence of the need for a new model applicable to the complexity of the new millenium.

Epidemiology also has been seen as an important research method for identifying factors associated with a variety of social and health problems, such as violence, accidents, mental disorders, and addiction, and has assumed an important role in understanding these conditions and behaviors.[46] Although each of these conditions has unique characteristics, they all share a common trait involving the inability to cease a behavior, which has or could

have a deleterious effect on health or well-being. Similar to chronic disease, the focus of attention in the epidemiology of behavioral disorders is on environment and host susceptibility. Although basic research has demonstrated clear biochemical and neurophysiological changes that occur with some disorders, such as alcoholism and schizophrenia, a common element among the diseases appears to be a significant psychosocial dimension.[47] The conditions or precursors that lead to these disorders are generally more voluntary, and, to some extent, there is more knowledge of the consequences than with either infectious or chronic disease. The sensitive nature of the data associated with almost all of these disorders presents unique measurement problems. Traditional data sources fail to capture most of the afflicted population. Veracity of self-report also presents a challenging methodological problem. People with these problems or disorders generally avoid contact with facilities or systems through which their behavior can be identified, including health care systems.[48] Often, primary care providers are not cognizant of these problems or disorders as a potential cause of trauma and/or disease, and thus, important data may not be recorded.

Finally, the emergence of human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) as a major international health problem highlights the interrelationship among infectious, chronic, and behavioral diseases and the epidemiology used in their study. HIV, which causes the disease, is transmitted principally through behavioral factors, such as sexual activity or sharing of syringes among injection drug users. The AIDS issue (see HIV/AIDS focus area) is the most recent example of the importance of epidemiology in public health and chronicles the need for continually adapting effective methods of investigation to accommodate both changes in human behavior and changing conditions of life.[49]

The leading causes of death frequently are used to describe the health status of the Nation. Data for most Healthy People 2010 mortality objectives are based on the underlying cause of death.[50] The underlying cause of death is defined by the World Health Organization as the disease or injury that initiated the sequence of events leading directly to death or as the circumstances of the violence or accident that produced the fatal injury.[51] Tobacco and diet/activity patterns are the two most influential factors, outpacing all other causes by a tremendous magnitude.[52]

A very different picture emerges when the leading causes of death are viewed for various population groups. Unintentional injuries, mainly motor vehicle crashes, are the fifth leading cause of death for the total population, but they are the leading cause of death for people aged 1 to 44.[53] Similarly, HIV/AIDS is the 14th leading cause of death for the total population but the leading cause of death for African American men aged 25 to 44.[54]

Understanding and monitoring behaviors, environmental factors, and community health systems may prove more useful in monitoring the Nation's true health, and in driving health improvement activities, than the death rates that reflect the cumulative impact of these factors. This more complex approach has served as the basis for developing the Leading Health Indicators.

Leading Health Indicators

The Leading Health Indicators reflect the major public health concerns in the United States and were chosen based on their ability to motivate action, the availability of data to measure their progress, and their relevance as broad public health issues. The Leading Health Indicators illuminate individual behaviors, physical and social environmental factors, and important health system issues that greatly affect the health of individuals and communities. Underlying each of these indicators is the significant influence of income and education.

The process of selecting the Leading Health Indicators mirrored the collaborative and extensive efforts undertaken to develop Healthy People 2010. The process was led by an interagency work group within the U.S. Department of Health and Human Services. Individuals and organizations provided comments at national and regional meetings or via mail and the Internet. Additional developmental work was undertaken by the Institute of Medicine, National Academy of Sciences. The result—this small set of measures—will provide a snapshot of the health of the Nation. Tracking and communicating progress on the Leading Health Indicators through national- and State-level report cards will spotlight achievements and challenges in the next decade. The Leading Health Indicators serve as a link to the 467 objectives in Healthy People 2010 and can become the basic building blocks for community health initiatives.

A major challenge throughout the history of Healthy People has been to balance a comprehensive set of health objectives with a smaller set of health priorities.

The Leading Health Indicators are intended to help everyone more easily understand the importance of health promotion and disease prevention and to encourage wide participation in improving health in the next decade. Developing strategies and action plans to address one or more of these indicators can have a profound effect on increasing the quality of life and the years of healthy life and on eliminating health disparities—creating healthy people in healthy communities.

For each of the Leading Health Indicators, specific objectives derived from Healthy People 2010 will be used to track progress. Table 2 identifies the specific objectives and whether sexual orientation is in the data template. “DNC” in the template means that the data currently are not collected by the data system being used to track the objective.

At the time this Companion Document went to press, none of the 29 objectives with sexual orientation in the data template had data on sexual orientation. Until the surveys identified to track progress on the Leading Health Indicators collect data on sexual orientation, progress specifically for LGBT populations cannot be monitored. The addition of sexual orientation and gender identity measures to Federal surveys in general, and to those surveys that measure the Healthy People 2010 objectives and the Leading Health Indicators specifically is a recommendation that has been made consistently.

Some States have supplemented the Behavioral Risk Factor Surveillance System and the Youth Risk Behavior Surveillance System surveys to include questions of sexual

Table 2 Leading Health Indicators Healty People 2010 Objectives Short Text	Objective Number	
	General Population	Sexual Orientation in Data Tables?
Moderate physical activity in adults	22-2	
Vigorous physical activity in adolescents	22-7	
Obesity in adults	19-2	
Overweight and obesity in children and adolescents	19-3c	
Cigarette smoking by adults	27-1a	
Cigarette smoking by adolescents	27-2b	
Alcohol and illicit drug use by adolescents	26-10a	
Illicit drug use by adults	26-10c	
Binge drinking by adults	26-11c	
Responsible adolescent sexual behavior	25-11	
Condom use by adults	13-6	
Treatment for adults with recognized depression	18-9b	
Deaths from motor vehicle crashes	15-15a	
Homicides	15-32	
Ozone pollution exposure	8-1a	
Exposure to environmental tobacco smoke	27-10	
Fully immunized children aged 19 to 35 months	14-24	
Flu and pneumococcal vaccination in high-risk adults	14-29a,b	
Persons with health insurance	1-1	
Source of ongoing care	1-4a	
Early prenatal care	16-6a	

orientation. Perhaps more importantly, this Companion Document contains numerous examples of innovative programs and strategies that LGBT people have used to address the nature and magnitude of specific problems such as tobacco, AIDS, and cancer. Similarly, community-based organizations have built programs to promote the health of LGBT people from children to elders, based on local needs assessments and community consensus.

Although relatively few probability studies have been conducted with LGBT populations, these methods are increasingly feasible and can provide reliable data on which to develop programs, interventions, and educational strategies. Until sexual orientation and gender identity are measured by Federal health surveys, probability and, when appropriate, strong

nonprobability sampling techniques can strengthen the quality of surveys, prevention research, and program evaluation studies.

Healthy People 2010 Companion Document for LGBT Health

In 2000, the Gay and Lesbian Medical Association (GLMA) joined with Columbia University's Center for LGBT Health to coauthor the white paper, Lesbian, Gay, Bisexual, and Transgender Health: Findings and Concerns, a comprehensive overview of the state of LGBT health in the first federally funded paper on LGBT health concerns. This report discusses the health of LGBT individuals. The LGBT designation includes diverse and varied populations that often share little more than society's stigma and prejudice. Stigma, however, as well as a range of other social and cultural factors, are forces that impact both the health of LGBT people and the ability of health care providers to care for them in myriad ways. (The white paper can be downloaded from www.glma.org.)

The white paper helped Federal and other health professionals see LGBT people as distinct communities with a wide range of health issues and concerns. In addition to enlightening academics, health professionals, health care planners, community health planners, and consumers about the need for culturally competent health care for LGBT communities, the white paper:

- Identifies key health concerns for LGBT communities, including cancer, HIV/AIDS, mental health, suicide among youths, substance abuse, and access to quality care
- Presents the case for a national research agenda to determine the health needs of LGBT communities
- Identifies barriers that have thwarted prior research, including homophobia, ignorance, and fear
- Points out that these same barriers among many medical professionals have limited gay and lesbian access to health care or denied LGBT people culturally appropriate care

The imperative for building a more responsive health care system in the 21st century is clear in the pages of the white paper.

The white paper and Healthy People 2010 are the two key documents upon which the Healthy People 2010 Companion Document for LGBT Health was built. Federal funding was provided by the Health Resources and Services Administration to the Gay and Lesbian Medical Association (GLMA) to continue coordinating the process. As in the development of Healthy People 2010, an inclusive process has been used for writing the Companion Document, providing a catalyst for LGBT health care consumers, providers, researchers, educators, and advocates to join together in voicing the specific needs and concerns of this multicultural community. Eleven work groups included representatives from:

Academic and research institutions

National LGBT and health organizations

LGBT health clinics

LGBT community centers

Other community-based organizations

Professional associations

Federal, State, regional, and local governmental health agencies

A full list of participants in the Companion Document process may be found in Appendix E: Contributors.

From July to November 2000, the work groups met by conference call and shared documents through e-mail to develop the chapters. In October 2000, many of the participants met in Washington, D.C., for a working meeting. Existing work group members were joined by new participants to further expand and diversify the collaboration. In December 2000, a small editorial committee representing the work groups and the diversity of the LGBT communities spent two full days discussing a draft of the document, identifying gaps or inconsistencies, and suggesting improvements. The Healthy People 2010 Companion Document addresses 110 objectives in 12 topic areas. Where national data were lacking, local sources, program evaluations, small studies, and other research efforts have been used.

This Companion Document has been written for all possible audiences—Federal agencies administering publicly funded health and related services programs, State health departments, local health departments, health centers, health planners at all levels, policymakers, managed care plans developing benefits packages or options for purchasers of health care, other insurance companies, the business community, employers, health professionals in all settings, health professions students, the school system, and especially those who know little or nothing about LGBT people and their health needs.

With the exception of Public Health Infrastructure, which is broken into sections, each focus area or chapter is arranged with the same format:

Healthy People 2010 goal

Overview

Issues and trends

Disparities

Opportunities

Summary of LGBT research

Discussion of Healthy People 2010 Objectives

Recommendations

Terminology

References

The focus areas or chapters can be viewed in different ways. For example, each chapter can be an entity describing a particular subject, such as immunization or violence. Or chapters can be combined for a larger discourse, such as joining substance abuse, tobacco, and mental health to describe behavioral health.

LGBT People

In addition to the previously mentioned factors influencing health or well-being, culture is a significant factor in the context of personal and public health. Culture is not restricted to racial or ethnic identification or heritage; instead, culture is the customs, beliefs, values, knowledge, and skills that guide a people's behavior along shared paths.[55] In fact, culture even differently defines or broadens the concepts of health/wellness and disease/disorder. Culture is pervasively intertwined among the four factor influencing health: genetics, environment, health services, and habits. However, these factors need to be congruent with cultural and linguistic norms and morés.[56] This statement cannot be undervalued for LGBT culture, a construct that is not without debate,[57] because LGBT individuals are present in every community and subpopulation group within the United States. Thus, "gay" culture as it refers to the collective LGBT population is as diverse as all its members.

How many LGBT people are there? The actual number of people who identify themselves as LGBT is not known. Because of a lack of research focusing on the size of the population and the fear that many LGBT people, especially youth, have concerning revealing their sexual identity, reliable data are difficult to obtain.[58] Moreover, in the few surveys that do provide data, respondents are usually asked about sexual behavior, not orientation or identity.

The popular estimate that 10 percent of the male population and 5 to 6 percent of the female population are exclusively or predominately gay and lesbian is based on the Kinsey Institute data.[59, 60] Laumann and associates (1994), using the national probability Health and Social Life Survey combined with data collected in the General Social Survey, found that 2.8 percent of men and 1.4 percent of women identified as gay or lesbian, while 7.7 percent of men and 7.5 percent of women reported homosexual desire.[61] Michaels (1996) analyzed the limited available data and estimated that in the United States 9.8 percent of men and 5 percent of women report same-gender sexual behavior since puberty; 7.7 percent of men and 7.5 percent of women report same-gender desire; and 2.8 percent of men and 1.4 percent of women report homosexual or bisexual identity.[62] An analysis of U.S. census data has provided the most solid evidence of the presence and certain social characteristics of

lesbians and gays among the general population. In the 1990 census, gay and lesbian respondents could identify themselves as unmarried partners. Estimates from the 1990 census indicate that 1.63 percent of people aged 15 and older nationwide reported themselves as unmarried partners of the householder.[63]

Bisexual individuals are perhaps the most misunderstood population within the spectrum of LGBT populations. For some bisexual people, their bisexual identity is continuous and fixed across their life span. For others, sexual orientation may be more fluid and marked by changes from heterosexual to either lesbian or gay or vice versa.[64] It is not uncommon for gay men and lesbians in recalling their "coming out" process to remember self-identifying as bisexual. Although the stages of homosexual identity formation[65] denote that this is a very common experience, that does not negate the fact that bisexuality is a distinct sexual orientation. Nevertheless, mistaken beliefs about bisexuality are prevalent among lesbians and gays as well as the heterosexual population, and, unfortunately, may also be internalized by bisexual people. The following are some of the most persistent myths:

Bisexuals are confused about their identity.

Bisexuals are afraid to be lesbian or gay because of social stigma and oppression by the majority.

Bisexuals have become "stuck" in the coming-out process.

Bisexuals have knuckled under to the social pressure to "pass" as straight.

Bisexuals are hypersexual and will have sex with anyone.[66]

As health care providers may also embrace some of those myths and be inclined to view bisexual individuals as being psychologically or emotionally damaged, being developmentally immature, or having a personality disorder, Fox (1996), in reviewing the literature, asserts that "research has found no evidence of psychopathology or psychological maladjustment in bisexual men and women."[67]

Gender identity is even less understood. "Transgender" is an umbrella term that encompasses a variety of people including transsexuals, cross-dressers, drag kings and queens, as well as bigender and androgynous individuals.[68] "Transgender" came into common usage during the 1980s. Previously, people with mixed gender and sexual characteristics were described as transsexuals or transvestites, terms emanating from the psychiatric vocabulary. "Transgender" comes from the transgender community and is, therefore, the preferred term in working with transgender people.[69]

There are no probability studies of transgender people reported in the literature and no effort underway to develop measures for inclusion in Federal surveys. Some psychiatric literature estimates that 1 percent of the population may have had a transgender experience, but this

estimate is based only on transgender people who might have sought mental health services.[70] Approximately 25,000 U.S. citizens have undergone sex reassignment surgery. An estimated 60,000 consider themselves candidates for such surgery, and the doctors who perform such surgeries report long waiting lists.[71, 72] Transgender people exhibit the full range of sexual orientations, from homosexual to bisexual and heterosexual.[73]

LGBT people face many of the same issues all people face as they progress through life. As people, our commonality is linked by our experiences with the "problems of living"—those events, occurring during life, either expected or unexpected, which, in the absence of sufficient ability to cope, may lead to deleterious behaviors.[74] However, LGBT youth may have the most difficult life cycle issues. Most youth feel awkward and embarrassed by sexual conflicts. But, LGBT youth have an even more difficult time as such youth are not recognized as even existing within U.S. society, for sexual orientation is assumed heterosexual unless adults choose differently. Although "coming out" or sexual identity formation can occur in adulthood, the awareness of being different (i.e., not heterosexual) usually occurs during childhood. However, children who disclose to their family that they are LGBT risk rejection, ostracism, and possibly harm from the one societal unit always expected to give unconditional care, love, and support. The other traditional adolescent support systems—such as schools, faith organizations, and peer groups—may have similar negative reactions.

Homophobia is also viewed as a "family value" prejudice.[75] As adolescents struggle to reconcile societal myths and misconceptions about LGBT people, with a growing sense of dread that they, too, might be LGBT, these internalized feelings of stigma and self-hatred increase existing vulnerabilities, affect self-esteem, and, for many such youth, restrict life choices.[76] Some youth use alcohol, drugs, food, sex, or work as vehicles for dissociating from the painful realities of living in a homophobic society. Dissociation, by whatever manner it is manifested, enables survival.

Negotiating the "coming-out" process may be particularly challenging for racial and ethnic LGBT people, who must integrate their sexual orientation or gender identity with their racial or ethnic self when confronted with societal homophobia and racism.[77] Given that few surveys document or describe LGBT populations in the United States, there is little evidence as to the racial, ethnic, socioeconomic, and educational composite variables. The Voter News Service's lesbian, gay, and bisexual samples provide evidence that racial diversity is comparable to the Voter News Service's heterosexual samples.[78] Little research has been done on the interactions among racial/ethnic diversity and sexual orientation or gender identity. Some researchers, health care providers, advocates, and writers have discussed specific cultural variables within the context of being LGBT.[79, 80, 81, 82, 83] The multiple dimensions of culture can come into play as an LGBT individual may have a stronger connection to his or her racial or ethnic group than to the LGBT community, or the dominant allegiance may be to the LGBT community (sometimes referred to as "gay culture"), or there may be multiple permutations if the LGBT individual is partnered with someone of a different racial or ethnic group.

Gay culture is different in the degree to which it is submerged within other cultures as well as in the way that these cultures intersect. LGBT people's behavior is still stigmatized, and because there is usually no way to identify LGBT people apart from their own disclosure or identification with gay culture, gay culture is essentially hidden in the larger culture. The LGBT culture is one that is not developed, taught, or transmitted by people's legally defined families. Although history indicates homosexuality has existed throughout the ages and in many different cultures, gay culture as it is known today started in 1969, when the New York City police raided a popular gay bar, the Stonewall Inn. Although raiding gay bars was a common practice, that night in New York, the raid erupted into a violent protest as the crowd fought back. The protests that followed, known as the Stonewall Riots, gave birth to the gay rights movement and the celebration of being gay.[84]

Like all cultures, the gay culture or the world in which LGBT people live has its specific values, beliefs, traditions, language, nonverbal behavior, and learning styles.[85, 86, 87] In addition, these norms or morés are affected by race/ethnicity, age, geography, socioeconomic status, religion, and education. Neither the Introduction nor this Healthy People 2010 Companion Document can discuss in detail all nuances or facets of LGBT people. There are organizations and groups within the LGBT community that represent every conceivable segment of the community. (See Appendix D: Resources for a list of many of these organizations.)

Many of the developmental issues that LGBT adults face are the same as those faced by heterosexual adults: entering the workforce, finding a partner and developing a satisfying relationship, deciding where to live and buying a home, deciding whether to have children, becoming a parent, and negotiating the aging process. Many LGBT people consider becoming part of a couple an important part of life. Although there are no legal sanctions for such relationships, except the civil commitment available in Vermont, the majority of LGBT people are in relationships, and many are as committed as traditional heterosexual couples.[88] Deciding where to live is dependent upon many variables, such as job availability, cost of living, and quality of life. Using the 1990 census, Black and associates (2000) provide the first systematic evidence of the distribution of same-sex partners in large U.S. urban areas.[89] From their research, 50 cities with a population of at least 700,000 people were ranked. The top five cities for gay couples were San Francisco, District of Columbia, Austin, San Diego, and Seattle. The top five cities for lesbian couples were San Francisco, Austin, Sacramento, Seattle, and Minneapolis-St. Paul.

Despite the perception, not all LGBT people live in urban areas. In fact, for some LGBT people, living in rural areas is their preference. (For more information, see www.ruralgay.com.) Despite the fondness that some LGBT people have for rustic, bucolic locales, safety is a ubiquitous concern.[90]

Deciding whether or not to have children is an important and sometimes difficult decision for all women, whether lesbian, bisexual, or heterosexual. However, LGBT parents must cope with the very real fear that they will lose their children in custody battles or other legal situations.[91] Lesbians and gay men are often denied custody of and visitation with their biological children and denied the opportunity to adopt or become foster parents.[92, 93]

Lesbians and other unmarried women are still sometimes refused donor insemination services.[94]

An important LGBT subgroup to consider within the developmental life span is LGBT elders. For all the same reasons as the previous groups, the exact number of LGBT elders is unavailable.[95] According to Herdt and associates (1997), there are several generational cohorts identified for gay elders:[96]

Pre- and post-World War II

McCarthy witch-hunt era, arrests, and blackmail

Pre- and post-Stonewall generations

Pre- and post-advent of AIDS

Sexual and lifestyle development and sexual orientation-related identity formation in older LGBT individuals are the two major issues of importance. As Kimmel (1993) points out in his research, there is a large continuum of behaviors with many people falling somewhere within the gradient.[97] Six social-sexual patterns that many gay people experience during their lifetime are identified. These social-sexual patterns, through which many gay people migrate at varying lengths of time, include the following:

Heterosexual marriage with or without periodic homosexual relations, following or followed by a gay lifestyle

Celibacy with a homosexual affectionate orientation

Raising children, including adopted children

Long-term gay friend/lover relationship(s)

Gay lifestyle with no long-term sexual relationships

Bisexual lifestyle without marriage

Friend (1989) developed a model of lesbian and gay identity formation, which is used in many research studies in an attempt to explain the intense diversity in the lives of many older LGBT individuals.[98] Heterosexism is defined as the belief that every individual should be heterosexual and that homosexuality is negative and threatening to society. Older LGBT people are divided into three groups.

Stereotypic older LGBT people are identified as people who conform to many of the heterosexist assumptions of what it means to be older and gay (e.g., loneliness, depression, and isolation). Many of the people who fit into this category experience extreme internalized homophobia.

Passing older LGBT individuals fall within the midrange of this model's continuum. These individuals typically suffer some internalized homophobia and do not challenge the heterosexist belief system. They place intense effort and energy into passing as heterosexual. Passing individuals accept some "aspects of homosexuality while still believing that heterosexuality is inherently better or superior to homosexuality."

Affirmative older LGBT people are the individuals who are most likely to participate in research studies. They tend to be psychologically well adjusted, aging well, and active in many social settings. Many affirming individuals attempt to destruct heterosexual assumptions and views and have a great acceptance of their homosexuality. They exhibit positive values and beliefs that affirm homosexuality.

The elder LGBT community, similar to the general elderly U.S. population, depends heavily upon Government programs such as Social Security, Medicare, and Medicaid. Currently, many persons living with HIV/AIDS receive health care benefits via Medicaid. This program will certainly experience an unbearable strain as new, effective AIDS medications increase a person's life span, thereby increasing the number of elderly.[99]

Conclusion of the Companion Document for LGBT Health

The limited nature of research about LGBT populations makes it difficult to document and prioritize their health needs. Although numerous studies have been conducted with certain health conditions, notably for HIV in gay men and breast cancer in lesbians, in most other areas data are seriously lacking and, as noted previously for transgender individuals, very few studies have been attempted.

Although LGBT people in general have the same basic health needs as do all other people, they also have health needs associated with being LGBT. For example, all individuals should receive recommended early childhood immunizations, but young adult and adult LGBT individuals, due to an identified higher risk, also should be routinely immunized for hepatitis A, hepatitis B, and influenza. Older LGBT persons at high risk should be immunized for pneumonia. Each focus area highlights the health needs associated with LGBT people or infers from the literature, especially literature applicable to racial and ethnic minorities, that being both LGBT and non-White increases the probability of health disparities.

The Healthy People 2010 Companion Document for LGBT Health is designed to provide a context for educating all possible readers and for addressing the personal and systemic challenges that must be overcome if persons defined by sexual orientation or gender identity are to be fully understood and their needs met within the health care system. People in health care represent different disciplines, different occupations, and different institutional affiliations. All are interested in people and health, but unless there is an understanding of who people are, then the collective interest can easily be dissipated by individual differences. An operational context must be developed for that which encompasses our differences, integrates them, and permits us to realize that the power of a group or a

community to impact health is greater than the sum of its parts. This Companion Document can serve as the operational context.

Healthy People 2010 has provided a framework for national, State, and local health agencies and nongovernmental organizations to assess health status, health behaviors, and services and to plan and evaluate health promotion programs.[100, 101] The national Healthy People initiatives have served as a "menu" for identifying State and local priorities as well as selecting objectives that are most relevant to specific States, communities, specific settings (e.g., schools, the worksite), and health care delivery systems.[102, 103] By using the national Healthy People initiative as a common point of departure, agencies and organizations have tailored programs targeted toward their customers, yet retained a common basis for evaluating performance in relation to the Nation, other States, or populations.[104]

This focus on performance has prompted State and local health agencies to shift from their emphasis of primarily providing services to one that conducts needs assessment and quality assurance.[105, 106] This shift has required increased collection and analysis of data. Health care delivery organizations also have experienced this shift and have increased efforts to collect standardized data on patients, services, and outcomes.[107] The increased emphasis on data collection and analysis for purposes of assessment and evaluation has increased the need to address the associated issues of data availability, validity/reliability, comparability, and utilization.

The Healthy People "menu" provides a useful way for States and localities to focus on serious health issues, but many agencies, organizations, and communities have tailored the objectives to better focus on specific concerns of their constituents. To leverage resources, LGBT organizations are encouraged to seek out partnering or collaborative efforts with other health-focused organizations. Community coalitions or partnerships, particularly when they reach out to nontraditional partners, can be among the most effective tools for improving health in communities. They may be even more effective for populations in disparity in the receipt of needed services. LGBT people also can use a community-driven process to develop benchmarks and monitor the progress of this Companion Document.

A three-tiered health surveillance system—local, State, and national—can be established for LGBT health. The purpose of this surveillance system at the community, State, and Federal levels would be to ascertain whether the disparities of LGBT people are being reduced and the health of LGBT people is improving. One model for such a surveillance system has been in continuous operation since 1976 under the auspices of the National Institute on Drug Abuse (NIDA). Although this particular surveillance system focuses only on substance abuse, the model may be replicable for all focus areas covered in this document. The NIDA surveillance system, known as the Community Epidemiology Work Group, meets semiannually throughout the country to review current and emerging substance abuse patterns, as well as HIV/AIDS data, that are collected by community and State representatives. This information is distributed to prevention, treatment, public health officials, researchers, and policymakers. There are comparable meetings in some States.

For example, the Texas Epidemiology Work Group has also met on a semiannual basis for almost two decades, sharing its information to all interested parties in that State. The prototype for the third tier, the community level, is Miami, where representatives from diverse different community agencies meet on the same semiannual basis.

For Additional Information About the Companion Document

To obtain more information about this Companion Document, visit the Web sites of the Gay and Lesbian Medical Association (www.glma.org) and the National Coalition for LGBT Health (www.lgbthealth.net). The document is available in an Adobe® Portable Document Format (PDF) for electronic distribution worldwide.

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Access to Quality Health Services

Healthy People 2010 Goal

Improve access to comprehensive, high-quality health care services.

Overview

Access to quality health care and related services is important in order to eliminate health disparities and increase the quality and years of healthy life for all persons in the United States. This chapter focuses on eliminating barriers and increasing access to appropriate, needed health care for lesbian, gay, bisexual, and transgender (LGBT) populations. For example, a significant barrier to LGBT people accessing needed care is the lack of provider LGBT competency and the discrimination toward people of other sexual orientation or gender identity that frequently is encountered in the health care system. These and other adverse barriers may lead to delays in seeking care or an avoidance of preventive and treatment services. As LGBT people also represent diversity relative to race, ethnicity, socioeconomic status, disability, and other characteristics, their barriers may be compounded by the barriers experienced by people who are members of those other underserved populations with health disparities.

To better understand access to services and the factors that impact access, four care components of the American health care system—clinical preventive care, primary care, emergency services, and long-term and rehabilitative care are highlighted. In addition, the structural, personal, and provider barriers that LGBT populations experience in different health care settings are discussed along with current studies and research.

Issues and Trends

Major changes taking place in the U.S. health care system, including the increasing influence of market forces, changes in payment and delivery systems, and welfare reform, have significant implications for vulnerable and at-risk populations. As system changes negatively affect the numbers of the health work force and the availability of needed services, Federal, State, and local public health agencies must increase their efforts to identify and eliminate barriers to care, encourage more individuals of minority populations to enter health professions careers, strengthen the existing infrastructure of services at the

community level, and actively target reducing disparities for vulnerable, unserved and underserved populations. It is increasingly important that unbiased health care communication and the appropriate, needed primary care and preventive services be provided to all people in a culturally sensitive and linguistically accessible manner.

Managed care has recharged consumerism and is making the health care delivery system increasingly aware that it must provide access to quality health and related services to a multicultural enrollee population. Access to high-quality health care in each of the health care settings in the continuum of care must be improved in order to realize the full potential of preventive health care.

Managed care, the prevailing approach to managing costs and the delivery of services in the American health care system, is influenced by many variables, including social and cultural factors. However, with few exceptions, the culture of LGBT individuals is unknown to the majority of health professionals who work in managed care settings. Few LGBT health care consumers or organizations have openly voiced the specific needs and concerns of this multicultural group. Much of this silence is a reaction to prevailing or residual homophobic behavior. For example, how is an African American lesbian, who is quadriplegic and in a monogamous long-term relationship of over 25 years, categorized in the health care arena? Frequently, race and ethnic categorization is made by the provider through visual assessment, and assumed responses are filed on intake forms: African American and quadriplegic. The dangers of assumption are well documented and, in this case, would eliminate two critical facets of this woman's identity—her sexual orientation and her commitment or relational status.

LGBT individuals, especially non-white, are "hidden." They lose the critical potential for empowerment and an ability to participate in the design of services and policies that may improve their access to appropriate health care. There exists no national survey that provides accurate figures documenting the size of the sexually diverse population. With sanctions against same-sex activity in 20 States and widespread discrimination directed at people who have revealed their identity, many sexually diverse individuals feel that "coming out" is dangerous—even coming out to health care providers.

LGBT consumers, clients or patients, as well as health care advocates, are breaking their silence. The prevalence of behavioral problems within the gay community is too devastating to maintain silence. The gay community needs to avoid adversarial relationships with managed care plans and providers working in managed care settings, and build bridges so that the continuum of care is available within the private as well as the public sector.

It is almost impossible for LGBT and questioning youth not to experience feelings of self-hatred, depression, and anxiety as a result of being raised in a society with a significant number of people who continue to condemn and reject homosexuality. Children who admit their homosexuality to their family risk ostracism and non-existence from the one, basic societal unit expected to give unconditional care, love, and support. Many gay youth use alcohol, drugs, food, sex, and/or work as vehicles for dissociating from the painful realities

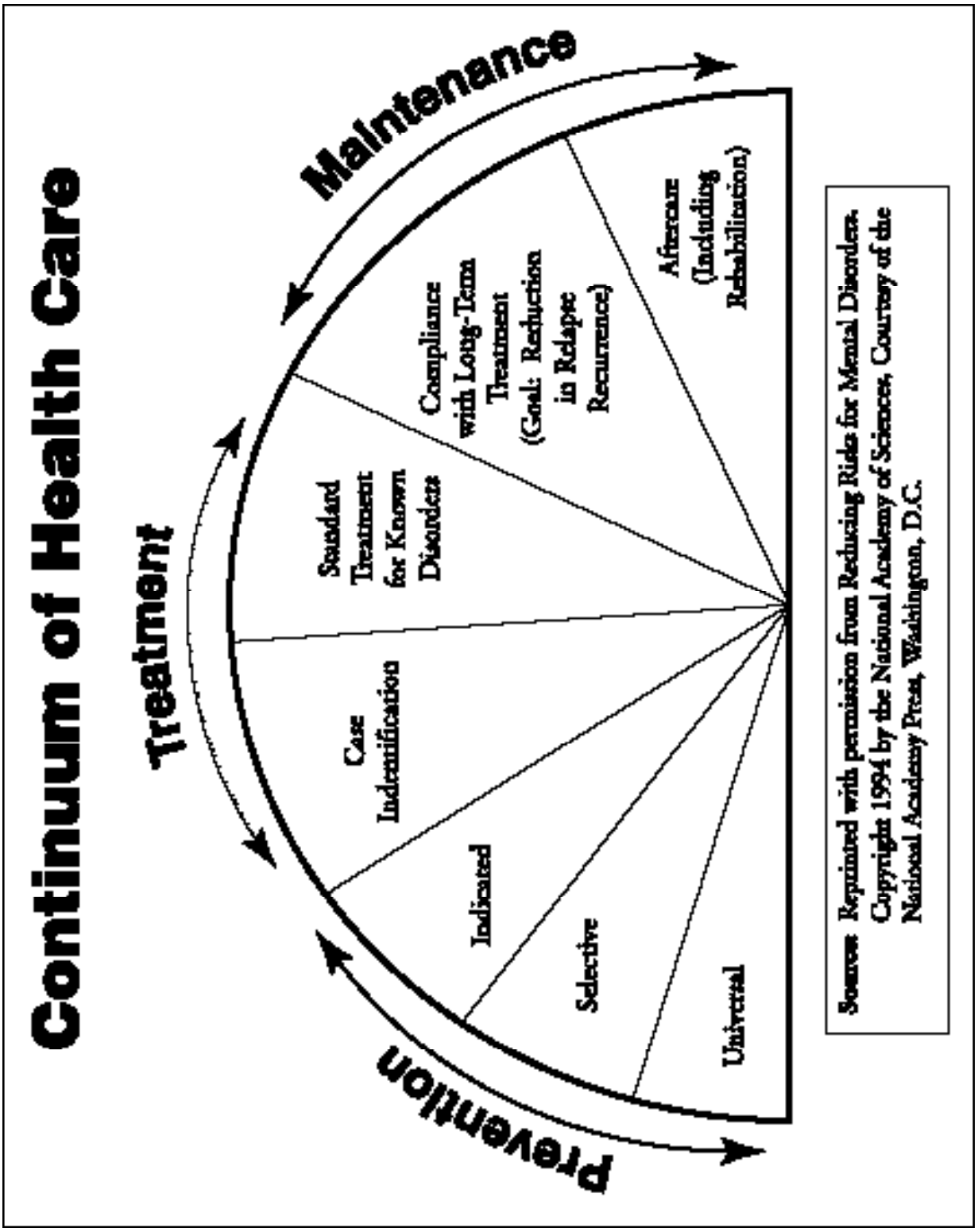
of living in a society with a strong homophobic element. The unfortunate consequences of homophobic attitudes and actions can result in devastating outcomes, including human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS), addictive disease, stress-related disorders, depression, and suicide. Thus, being served by a continuum of care ranging from preventive services to identification of risk conditions or disease, treatment, referral or rehabilitation or maintenance is essential for a group that has an increased probability of risk for developing chronic and costly conditions.

In addition to the possibility of reducing costs associated with many preventable conditions, managed care organizations derive another benefit. Professional guidelines, consumer report cards, and accrediting organizations are mechanisms in place to ensure access to culturally competent health care services. Attention or inattention to cultural issues impact both service delivery and service utilization which, in turn, affect not just access but also quality, utilization, and costs.

Clinical preventive care. Clinical preventive services have a substantial impact on many of the leading causes of disease and death. People must have access to clinical preventive services that are effective in preventing disease or in detecting asymptomatic disease or risk factors at early, treatable stages. The National Health Interview Survey (NHIS) reports that 69 percent of children aged 5 to 16 years had a physical examination once at ages 5 and 6 and once every 2 years from ages 7 to 16. The percentage was lower for children with family incomes below the poverty level (62 percent) but higher for children with Medicaid (83 percent).[1] Improving access to appropriate preventive care requires addressing many barriers, including those that involve the patient, the provider, and the system of care.[2, 3]

Use of preventive health services is a critical problem among school-aged children in families living below the poverty level.[4] In Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program, States are required to provide or arrange for "comprehensive, periodic assessments of the physical and mental health and followup services for Medicaid-eligible children under age 21 and to diagnose and treat any problems discovered as part of the screening process." Pediatricians and primary care providers (PCPs) are often the first health care professionals to be consulted or present when physical, behavioral and/or emotional problems are manifested.

Understanding the semantics of service delivery models is critical in overcoming barriers to accessing preventive health services. As frequently as the public health model is expounded (See Public Health Infrastructure focus area), misunderstanding of the model continues. A model that would be applicable for both the business orientation of the health care system and also the altruism of providers working to improve health and empower people is needed. The model that may enable such a system is the framework proposed by the Institute of Medicines (IOM).[5] It is referred to as either "the IOM model" or the "continuum of care model." (See Figure 1.) Prevention, treatment, and maintenance activities are clearly delineated as a continuum, with all parts interconnected. The relationship among prevention, treatment, and maintenance is displayed visually to better define and understand the semantics. With the continuum of care model, prevention,


Continuum of Health Care
Treatment
Maintenance
Prevention
Case Identification
Standard Treatment for Known Disorders
Compliance with Long-Term Treatment (Goal: Reduction in Relapse Recurrence)
Aftercare (Including Rehabilitation)
Indicated
Selective
Universal
Source: Reprinted with permission from Reducing Risks for Mental Disorders. Copyright 1994 by the National Academy of Sciences. Courtesy of the National Academy Press, Washington, D.C.

including clinical preventive services, has three components that more finitely describe the interventions appropriate for designated populations, such as LGBT people, and/or individuals.

Universal prevention. Not dissimilar to what is called primary prevention in the public health model, targets either the entire population or a designated segment of the population, such as adolescents, women, or LGBT people. In terms of probability (not as a negative label), everyone in the designated population shares the same general risks of disease occurrence, although the magnitude of risk may vary among individual members of the population. Universal prevention is not new, it provides a means by which to increase health and wellness by providing basic health promotion information and the skills necessary to avoid behaviors that may be deleterious. For example, all LGBT people can benefit from learning about the dangers of tobacco.

Selective preventive interventions. Used for specific subgroups of the general population whose risk or probability of a disorder, disease, or behavioral occurrence is significantly higher than average, either approaching (because of an expected life event) or over a lifetime (because of some biological or environmental factor). In keeping with the public health orientation, and in contrast to the medical model, the entire subgroup of individuals receives the selective preventive intervention. As the entire subgroup receives the intervention, it is not necessary to assess or identify a specific individual's magnitude of risk. Belonging to the subgroup presumes each person in that subgroup has the same risk of particular diseases, disorders, or problematic behaviors.

The purpose of selective preventive interventions is to deter the onset of a diagnosable disorder either by reducing those risk factors amenable to change and/or strengthening those protective or resiliency factors to cope with risk factors not amenable to change. Tapping resiliency can "ignite innate potential for full and healthy development." [6] An example of a selective preventive intervention is having adolescents, whose parents are substance abusers, attend a *Family Strengthening* program.[7]

Indicated preventive strategies. Services that involve high-risk individuals who have minimal or detectable signs or symptoms foreshadowing a diagnosable disease or disorder. Although indicated preventive interventions are appropriate for all high-risk individuals regardless of age, gender, or other variables, infancy, childhood, and adolescence are critical periods for intervention.[8] Adolescence is the time when the inevitable trajectory of socioeconomic status, probability the most consistent predictor of morbidity and mortality, can be most modified because of school attendance and other intervening factors.[9] Youth questioning their sexual orientation or gender identity may require an indicated preventive strategy so as to avoid deleterious manifestations that might result in serious consequences.

Primary care. The provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.[10] According to an IOM report on access, the definition used for access is "the

timely receipt of appropriate care." [11] Access to primary care across the Nation depends in part on ensuring that people have a usual source of appropriate care. Having a primary care provider as the usual source of care is especially important because of the known benefits of primary care.[12, 13, 14] These benefits include the provision of most of the prevention and treatment services within the continuum of care selected for the Access to Quality Health Services focus area of Healthy People 2010.

Primary care providers commonly are the gatekeepers in the managed care system; that is to say, primary care services should meet the health needs of most people and the primary care provider is the entry point into the medical care system through referral for other or specialized care. PCPs include physicians, nurse practitioners, physician assistants, and several other professional groups recognized by accrediting organizations.[15] Secondary medical care services require a certain degree of sophistication, additional, or focused training, and are considered specialized resources. As this is a three-tiered model, the degree of sophistication is greater than primary but less than tertiary. Secondary care usually takes place after a diagnosis is made and the patient's illness or disorder requires the services of a specialist or other specialized care. Tertiary medical care services are services that, due to the degree of sophistication of the resources to provide them and because of the low frequency with which they are needed, should be centralized and grouped within units emphasizing efficiency, effectiveness, and continuity. One of the best examples of tertiary medical care services is a shock trauma unit.

Consumers and their families are the primary caregivers in chronic illness.[16, 17, 18] Because of the nature of chronic disorders or illnesses that predominate within the United States, traditional medical interventions are not sufficient. Managed care may be an opportunity yet to be realized. Health care providers can be effective change agents because of the importance of behavioral factors in the development of chronic disorders and/or the building of collaborative community relationships to maintain or improve health or well-being. This is especially important for LGBT people, many of whom identify with an LGBT community. Behavioral problems commonly have their roots in the community; likewise, the community is the repository of solutions.[19]

A vital function of health care providers, especially physicians, is to teach individuals when and how to use self-care. The Latin word for *doctor* translates as "teacher." [20] However, few physicians demonstrate the ability to teach disease prevention and health promotion.[21] This limitation of physicians (or imposed on physicians) diminishes hope that consumers can control their environments.[22] Considering that 25 percent of physician office visits are for problems that consumers could treat themselves,[23] managed care organizations need to urge their physicians and professional staff to teach self-care. In addition to reducing inappropriate utilization of the medical care system, the result of appropriate health education is an increase in the individual's self-confidence and self-empowerment.

Emergency services. Prehospital emergency medical services (EMS), poison control centers (PCCs), and hospital-based emergency departments (EDs) are the most commonly sought sources of emergency care. Each year, they provide prompt first-contact care for millions of

people regardless of their socioeconomic status, age, or special needs. For many severely ill and injured persons, these settings are a crucial link in the chain of survival between the onset of symptoms and treatment in a hospital. For persons whose health problems are less pressing, but who believe they need urgent medical attention, emergency services are a gateway to additional health care. Some patients identify the emergency department as their regular source of care,[24] but this cannot be considered primary care, and as a regular source of care it may not be appropriate to their needs.[25]

Emergency medical personnel and other health care professionals in the emergency room also are an important contact point for addressing other medical, mental health, behavioral problems, and needed social interventions. For example, in dealing with victims of domestic violence, and timely identification and intervention on the part of the emergency medical personnel can save lives. Overall, upwards of 35 percent of all emergency room visits by women are the result of domestic violence, whether due to acute injury, problems during pregnancy, or stress-related complaints.[26] Unfortunately, domestic abuse frequently is not disclosed voluntarily by the patient, and may go overlooked by the attending provider.

A recent 1999 study examined the health problems and utilization patterns of homeless individuals seeking medical services in a small, southern community.[27] Results showed that the medical problems for which the homeless sought treatment were often (73 percent) a reoccurring problem for which treatment had been previously received. The most prevalent medical problem was upper respiratory infection (47 percent), likely exacerbated by the high rate (73 percent) of cigarette smoking found among the sample. More than half (51 percent) of the participants had used other medical services in the past month. Despite these high rates of utilization, the homeless may be underutilizing appropriate preventive medical services, waiting until the medical problem becomes serious before seeking treatment, and, thereby, overutilizing emergency rooms for non-emergency care.

In addition to emergency room services, there are other components of emergency services. Since 1953, poison centers have been making a positive contribution to public health in the United States. The goal of poison centers is to reduce morbidity and mortality due to poisoning. Poison center personnel include medical toxicologists, clinical toxicologists, and specialists in poison information. Services include:

- Emergency telephone treatment recommendations for all types of poisonings, chemical exposures, and drug overdoses
- Telephone followup for hospitalized and nonhospitalized patients to assess progress and recommend additional treatment as necessary
- Research and surveillance of human poison exposures
- Community education in poison prevention
- Education in the recognition and management of poisonings for health care providers
- Training of future toxicologists

In 1998, the American Association of Poison Control Centers (AAPCC) reported more than 2.3 million human poison exposures. The AAPCC Web site (www.aapcc.org) lists the certified poison control centers in each State. The primary goal of the voluntary certification process is to ensure that all residents of a given geographic area have access to the highest quality of certified poison center services. It has been shown that poison centers reduce health care expenditures. Despite the fact that poison centers save lives and decrease health care costs, poison center services throughout the United States appear to be eroding due to inadequate funding. Funding cutbacks have resulted in reduction or elimination of community poison prevention education, reduced areas of service, reduced areas of service, reduced toll-free access, delayed acquisition of current references, and reduced training programs for future toxicologists. In some areas of the country, poison control center funding has been totally eliminated. Data show that, by the end of 1993, only 54 percent of the U.S. population had access to a certified regional poison control center.

The National Association of Emergency Medical Technicians (NAEMT), founded in 1975 with support from the National Registry of EMTs and numerous leaders in emergency medicine, serves as the national voice for prehospital emergency health care professionals. The NAEMT's prime mission is to promote the professional status of the EMT, paramedic, EMS educator, and EMS administrator. NAEMT also encourages the development of national standards and accreditation of EMS education, develops continuing education programs for members and non-members, supports legislative initiatives, and produces career information for the public and EMS community. NAEMT has developed ongoing liaison relationships with close to 30 federal agencies and professional organizations serving the emergency/trauma medicine and public safety community, including the American College of Emergency Physicians, National Registry of EMTs, Commission on Accreditation of ambulance Services, Emergency Nurse's Association, and the Federal Emergency Management Agency. More information on NAEMT can be found online at www.naemt.org.

The National Association of State Emergency Medical Services Directors (NASEMSD) was formed in 1980 as the lead national organization for EMS. The goals of NASEMSD are:

To promote the orderly development of coordinated EMS systems across the nation

To promote uniformly high quality care of acutely ill and injured patients

To provide a forum for the exchange of information and the discussion of common concerns among State EMS directors

To facilitate interstate cooperation in such areas as patient transfer, communications and reciprocity of EMS personnel

To disseminate pertinent information to our membership and others

To maintain ongoing and effective liaison with State and national governments, professional organizations, and other appropriate public and private entities

To improve the quality and efficiency of State EMS program administration

To enhance the professional knowledge, skill and abilities of State EMS directors and staff

To encourage research and evaluation in all areas of EMS

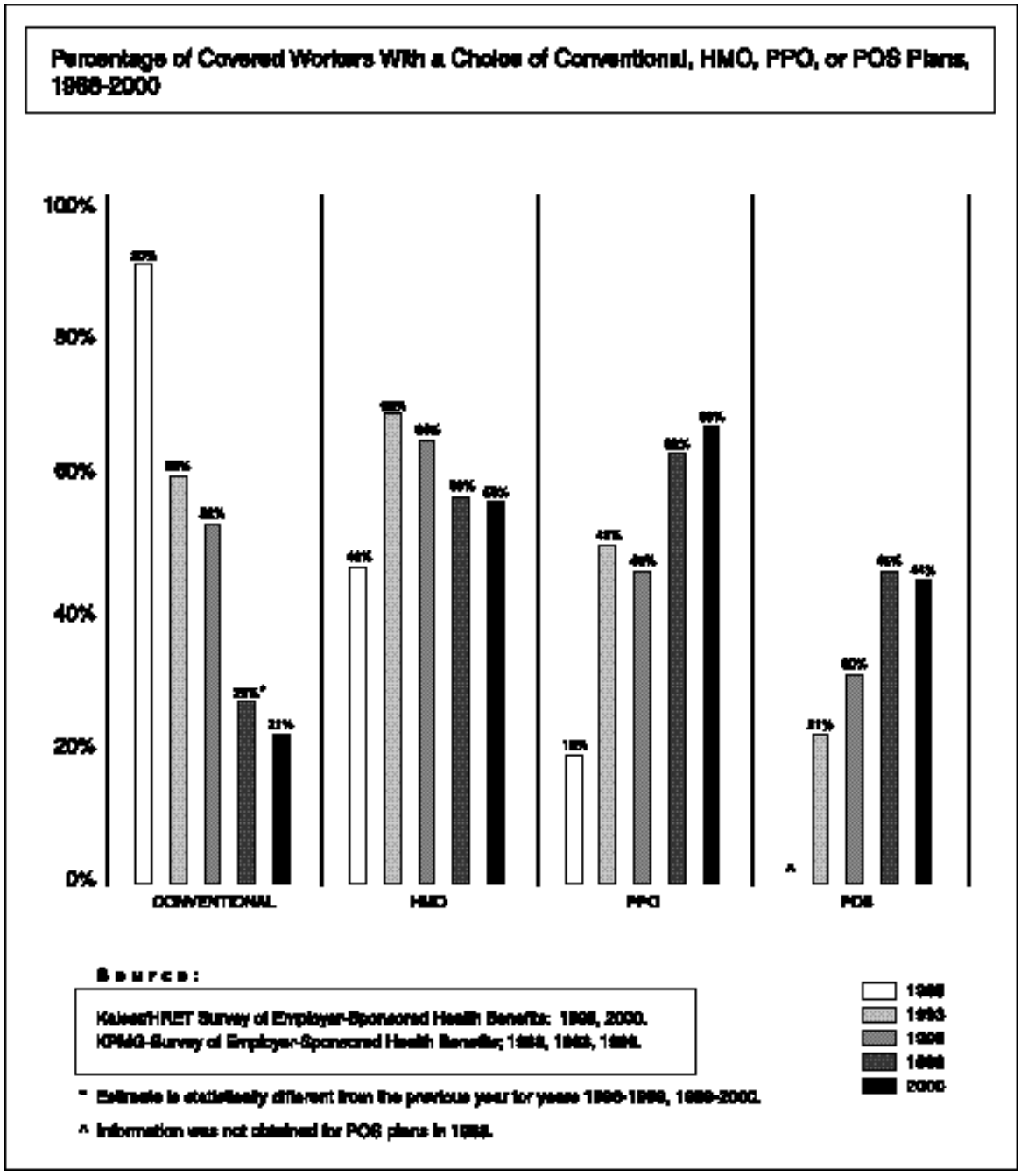
To serve as a permanent national advocacy group for EMS

The NASEMSD has posted an October 14, 2000 draft of a National EMS Information System on its Web site (www.nasemsd.org). The document states that "There is no central database, at a national level for example, that relates to the current practice of EMS. The data required to completely describe an EMS event exists in separate disparate locations. These include EMS agencies, emergency departments, hospital medical records, other public safety agencies and vital statistics offices. In most cases, meaningful linkages between such sites are non-existent." The plans for establishing a National database are well articulated within the document posted.

Long-term care and rehabilitative services. People with physical or mental conditions that limit their capacity for self-care need long-term care and rehabilitative services. (See Figure 1 for the maintenance components of the continuum of care.) This population includes people of all ages, from those who were born with physical or mental limitations or who developed such limitations later on in life, including those injured at any age, to those with diminishing functioning at older ages.[28] About 40 percent of the people in this population are under age 65 years.[29] The long-term care population includes individuals who need help or supervision to perform activities of daily living or instrumental activities of daily living. The goals of long-term care services are to improve functioning, maintain existing functioning, or slow the deterioration in functioning while delivering care in the least restrictive environment. Rehabilitative services, a critical component of long-term care, strive to return individuals to their optimal level of functioning.

The importance of long-term care is growing as the number of elderly, especially the very old, increases. Providing the long-term care services needed, now and in the future, presents difficult issues and challenges for coordinating care, for long term care extends well beyond the provision of personal health services to encompass issues of housing, nutrition, assistance in the activities of daily living, social services, transportation, and the roles of voluntary caregivers.[30] As with many preventive screening services and interventions, rehabilitation and long-term care are encumbered by a lack of policies ensuring reimbursement for such services. The role of primary care in the provision of long-term services is similarly impacted by the same issues. Nearly all persons who receive long-term care services are high utilizers of medical services, including primary care. Thus, access to appropriate caregivers is a critical issue. Family, friends, and community-based organizations work to fill the gap and provide many long-term care services.

Some avenues for improvement and some care models show a promise of better integration of services. Demonstration programs such as the Social Health Maintenance Organizations



(S/HMO), the program for the All-Inclusive Care of the Elderly (PACE program), and others, pool Medicare, Medicaid, and private funding sources to provide a coordinated approach to care that includes medical services.[31] Opportunities for coordination seem more likely in integrated health care systems that encompass community-oriented primary care.

Health insurance. Another significant measure of access is the proportion of people who have health insurance. Although most people assume that health insurance is an automatic benefit associated with employment, the beginning of financing health care costs originated in 1929 with the establishment of the forerunner of the Blue Cross Insurance Company.[32] In 1943, approximately 19 percent of the civilian population had protection for hospitalization.[33] In 1999, for the first time since at least 1987, the percentage of U.S. citizens with health insurance increased, and 82.5 percent of persons under age 65 were covered by some form of health insurance.[34] Significant numbers of privately insured persons, however, lack a usual source of care or report delays or difficulties in accessing needed care due to affordability or insurance problems.[35] These individuals are considered to be "underinsured" and frequently qualify for publicly-funded programs providing health care and related services.

Managed care, in multiple forms, has replaced fee-for-service (FFS) as the dominant form of health insurance for the privately insured, largely as a cost management tool. The following table demonstrates the saturation of managed within the private sector.

While those who were employed or could afford the out-of-pocket expense have fared well with the rise in medical coverage, the poor continued to fall mostly outside the insurance safety net. After lengthy national debate, Congress passed legislation in 1965 establishing the Medicare and Medicaid programs as Title XVIII and Title XIX, respectively, of the Social Security Act. Medicare was established as a health insurance program in response to the specific medical care needs of the elderly, while Medicaid was established in response to the widely perceived inadequacy of welfare medical care under public assistance. Together, Medicare and Medicaid financed $387 billion in health care services in 1998—about one-third of the country's total health care bill and almost three-fourths of all public spending on health care.[36]

Responsibility for administering Medicare and Medicare rests with the Health Care Financing Administration (HCFA) within the U.S. Department of Health and Human Services (DHHS). The Medicare program provides reimbursement for health care services for 95 percent of the aged population in the United States. As Medicare costs have risen, federal policymakers have turned to managed care techniques as a means of controlling and managing those cost increases. Until implementation of the Balanced Budget Act of 1997, health maintenance organizations continued to be the only managed care option available to Medicare beneficiaries. By the end of 1997, 13.5 percent of Medicare beneficiaries were enrolled in risk HMOs.[37]

Medicaid is the source of reimbursement for health care services provided for more than 1 in 7 U.S. citizens, accounts for 15 percent of our Nation's spending on health care, and is the major source of financial assistance to the States, accounting for 40 percent of all Federal grant-in-aid payments to States.[38] From its roots as a program to help States cover their welfare populations, Medicaid has developed into a program that addresses the needs of uninsured low income families, the elderly (who meet the eligibility requirements), and those with chronic, disabling health conditions.[39] Currently, Medicaid is the source of

coverage for one in five non-elderly persons with a specific, chronic disability who live in the community, and is the single largest source of public financing for HIV/AIDS-related care.[40, 41]

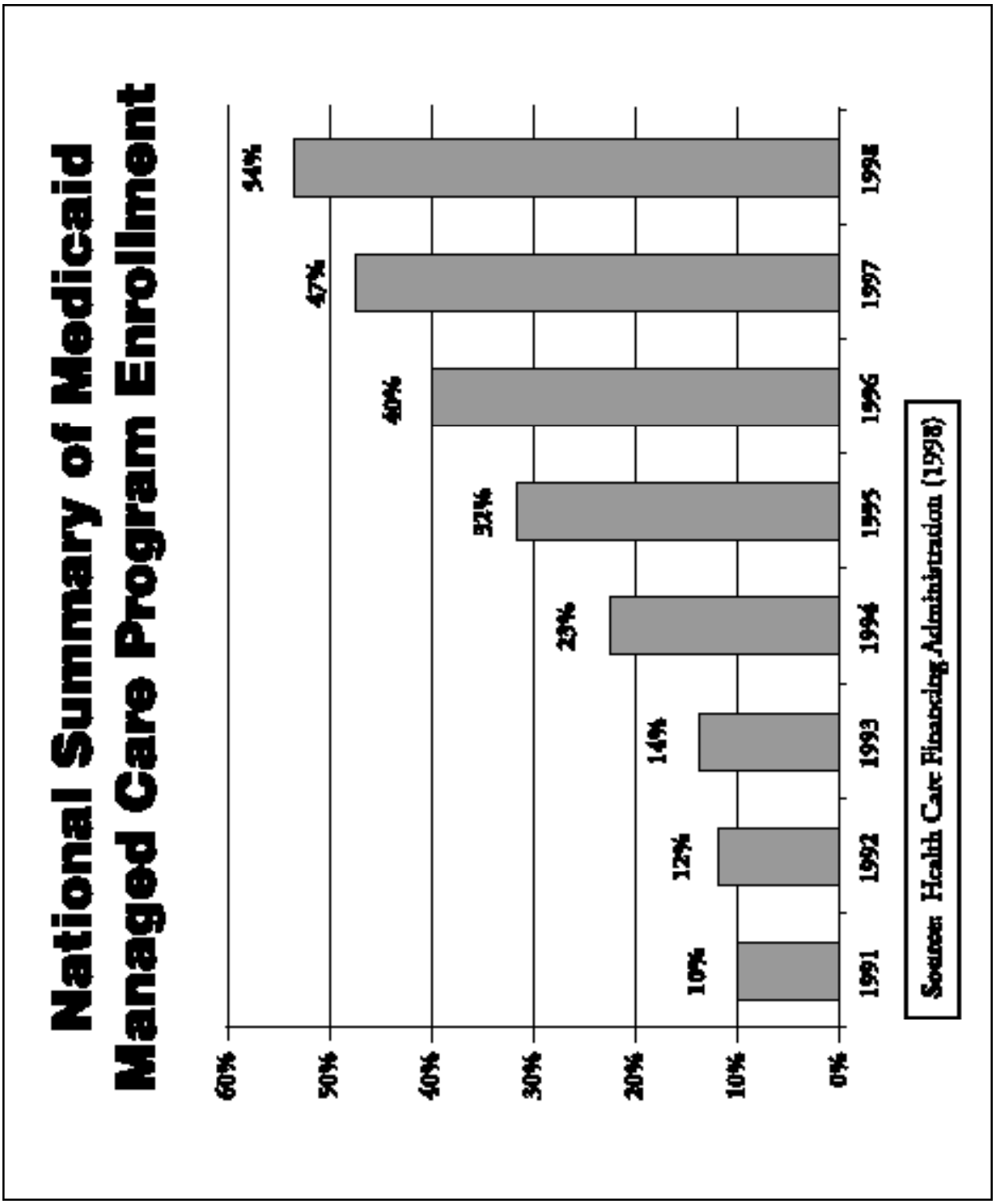
Faced with increases in the number of recipients and the costs of their care, State and federal Medicaid officials have increasingly turned to managed care (over the past decade largely through State Medicaid waivers), to control costs, estimating a 2 to 10 percent savings over FFS.[42] Figure 3 illustrates the increase in Medicaid managed care.

Medicaid also is part of the publicly funded financing system for the Nation's safety net of clinics and hospitals that serve low income and uninsured populations. In addition to its rules that guarantee payment of clinic providers, Medicaid, through its disproportionate share hospital program, makes supplemental payments available to institutions that serve a large portion of low income and uninsured patients.[43] Medicaid's financing is crucial to ensuring the solvency of many of these providers, making up 41 percent of revenues for safety-net hospitals and 34 percent of revenues for community health centers.[44, 45] Medicaid also is a key third-party resource to supplement funding for State public health efforts, such as tuberculosis control and family planning programs, as well as such Federal programs as the Ryan White Care Act.[46]

In 1997, Congress enacted the State Children's Health Insurance Program (SCHIP) legislation of Title XXI of the Social Security Act. This legislation further expanded Medicaid to serve as a health insurance program distinct from welfare, providing funds for States to expand coverage to children in families whose income is up to at least 200 percent of the Federal poverty level.[47] As of December 1999, nearly 2 million previously uninsured children were covered under SCHIP in addition to the 21 million children with Medicaid coverage.[48] In providing States with the option of covering all children in families with incomes up to 200 percent of the poverty level (in many States, this limit is even higher), Medicaid in combination with SCHIP could extend health insurance to all low income children—an expansion that would cover 19 percent of the total uninsured population in the United States today.[49]

Although Medicaid and SCHIP have been instrumental in providing health insurance coverage, especially to low income children, and hold the promise of extending coverage in the future, the ability of the programs to reach their full potential is undermined by barriers in outreach and enrollment.[50] Nearly one-half of uninsured children are eligible for Medicaid or SCHIP, but are not enrolled.[51]

The implementation of welfare reform has created another set of issues in regard to States' ability to broaden their Medicaid eligibility guidelines to cover more of the unserved, low income population. The welfare reform legislation of 1996 severed the automatic link between Medicaid and welfare eligibility, and has contributed to the apparent loss of Medicaid coverage for many low income adults and some of their children.[52] Low income families moving from welfare to the workplace are still eligible for Medicaid, but many appear to lose their Medicaid benefits in the transition. Studies show that one year after


National Summary of Medicaid Managed Care Program Enrollment
60%
50%
40%
30%
20%
10%
0%
10%
12%
14%
23%
32%
40%
47%
54%
1991
1992
1993
1994
1995
1996
1997
1998
Source: Health Care Financing Administration (1998)

leaving welfare, 49 percent of females and 29 percent of children formerly covered by Medicaid were uninsured, largely as a result of confusion over eligibility rules and systems errors.[53] This confusion has contributed to the recent declines in Medicaid enrollment and helped increase the number of uninsured U.S. citizens, despite what appears to be a robust economy.

Among the 44 million uninsured people (18 percent of the population under age 65), more than one-half have incomes below 200 percent of the Federal poverty level, and nearly two-thirds of the low income uninsured are children and their parents.[54] Eight in 10 of the uninsured are workers or their dependents.[55] Predictably, the uninsured are more likely than the insured to lack a regular primary care provider and to postpone or forego needed care. They are less likely to receive preventive services—screens such as Pap tests, or counseling interventions such as smoking cessation. According to the Agency for Healthcare Research and Quality, the top uninsured principal diagnoses in U.S. hospitals are infants born in the hospital, pneumonia, alcohol-related mental disorders, depression, and substance-related mental disorders.[56]

Medicaid's ability to reach and cover the uninsured is one of its persistent challenges. If Medicaid is to meet the challenge for which it was created, to provide needed health care services for an increasingly diverse population, there must be assurance that the health needs of the population it serves are met.[57] Even in the public sector, Medicaid coverage for mental health and substance abuse treatment tends to be limited, thereby affecting access.[58, 59]

Measuring access to care is an extremely important area of concern for health care consumers, providers, planners, policymakers, and purchasers, both in the private and public sectors. No one technology exists to measure access as it is a multi-faceted or compound construct. It may be assessed in a variety of ways: access to providers, to initial and followup appointments, to providers of choice, at time of day of choice, satisfaction with services, and other circumstances.[60] The Healthy People 2010 Access to Quality Health Services focus area objectives measure access from several sentinel perspectives, but there are subtle areas which are, as yet, not well defined. Different population groups have different health problem profiles, may be differentially represented, and have different health care needs and issues related to access. Thus, access issues for LGBT people, as well as other underserved populations, may be different than those for heterosexual people.

Quality improvement. Since the 1990s, increased attention has been paid at all levels of government and by the private sector to improving and measuring health care quality. Measurement of the quality of health care services is driven by different forces in the private and public sectors. In the private sector, quality measurement is a reflection of the requirements of the accreditation process and, increasingly, is also a response to the demands of employers and other purchasers through contracting, report cards, and other means.[61] In the public sector, performance measure is the primary tool of accountability for spending public funds on health care.[62, 63]

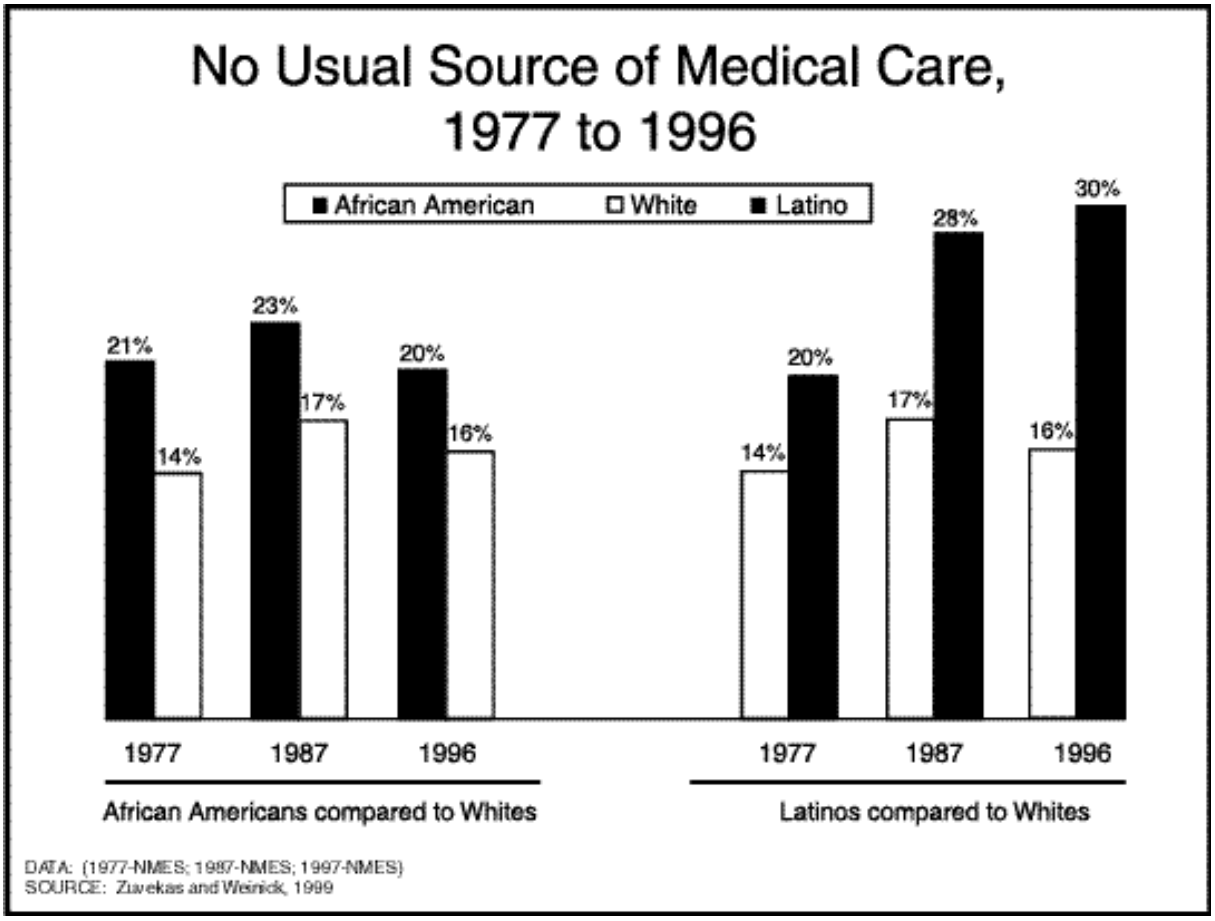
The Foundation for Accountability (FACCT), representing a broad coalition of public and private purchasers and others, has begun to develop and test tools that will allow documentation of population-specific functioning, quality of life, satisfaction with services, and risk reduction for several medical conditions commonly seen in health plans, such as diabetes, asthma, coronary artery disease, breast cancer, low back pain, and depression.[64] FACCT and its partners is currently identifying a "master set" of quality measures for children's health care.[65] This effort by FACCT follows the continuum of care—staying healthy, getting better, and living with illness.

There has been a proliferation and growth of accreditation organizations to match the changing organization and financing of the health care system. The following are the major accreditation organizations:

The National Committee for Quality Assurance (NCQA). NCQA was formed in 1979 by two managed care associations, the Group Health Association of America and the American Managed Care and Review Association [now merged and renamed the American Association of Health Care Plans (AAHP)]. NCQA developed a set of health performance measures known as the Health Plan Employer Data and Information Set (HEDIS), a widely used tool for evaluating health plan performance.[66] In 1996, NCQA released the Medicaid HEDIS, and today has multiple Medicare and Medicaid-focused projects such as the National HEDIS Medicaid database, Accreditation 1999 Medicaid Benchmarks (More information may be found online at www.ncqa.org). Although HEDIS data collection is not required for NCQA accreditation, managed care organizations (MCOs) regularly institute HEDIS measures.

The Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) is the oldest and largest of the accreditation organizations. Having started in 1951 as the Joint Commission on Accreditation of Hospitals, the named was changed in 1987 to JCAHO to reflect accrediting non-hospital health care organizations including managed care organizations.[67] JCAHO's performance system is known as ORYX™.[68] Currently, the hospital, long-term care, network, laboratory, home care, and behavioral health care accreditation programs have performance measurement requirements under the ORYX™ initiative with requirements yet to be developed for ambulatory care organizations and long-term care pharmacies.

The Council on Accreditation of Services for Families and Children (COA) was founded in 1977 as a joint effort of the Family Service America and the Child Welfare League of America (CWLA). (More information can be found online at www.coanet.org.) COA accredits or is in the process of accrediting more than 1,400 public and private organizations in the United States and Canada that provide child and family services, behavioral health care services, and financial management/debt counseling services. In contrast to the other accreditation organizations, the programs accredited by COA are largely community-based programs more closely related to a social services model than to a medical model of treatment.[69]



The Utilization Review Accreditation Commission (URAC), also known as the American Accreditation Healthcare/Commission, was founded in 1990 to establish standards for the managed care industry. (More information can be found online at www.urac.org.) URAC's broad-based membership includes representation from all the constituencies affected by managed care—employers, consumers, regulators, health care providers, and the workers' compensation and managed care industries. In contrast to some of the other accreditation organizations, URAC offers ten different accreditation programs for managed care organizations such as case management organization standards, health call center standards, and network practitioner credentialing standards. Since 1991, URAC has issued over 1,600 accreditation certificates to over 300 organizations doing business in all 50 States.

The Rehabilitation Accreditation Commission, formerly the Commission on Accreditation of Rehabilitation Facilities (CARF), was developed in 1966 through efforts of the American Rehabilitation Association and the Association of Sheltered Workshops. Each year, CARF produces separate Standards Manuals for Behavioral Health, Medical Rehabilitation and Employment and Community Services. A Standards

Manual for Adult Day Services was developed in 1999 and the Assisted Living Standards Manual was revised in 2001. (More information can be found online at www.carf.org.) The CARF standards emphasize communicating with consumers in a way that is understandable and making each consumer a key member on their own service team.[70] CARF currently accredits more than 11,000 programs in the United States and Canada, including alcohol and drug programs, mental health programs, and community-based rehabilitation programs.[71] CARF also requires that programs have a plan to reduce barriers to care, including cultural, architectural, attitudinal, and other barriers.[72]

New accreditation organizations and/or standards change in response to the fluidity of the current health care system. For example, URAC, NCQA and the Consumer Coalition for Quality Health Care are currently collaborating on performance assessment tools for preferred provider organizations, the largest and fastest growing sector of the health care industry.[73] Some organizations are unique, whereas others overlap in their accreditation domains, but have a slightly different focus.[74]

Historically, the public sector's involvement in quality assurance has been indirect. For example, the Federal government makes use of the information collected by JCAHO and relies on JCAHO's judgments regarding the quality of hospitals in setting eligilibity rules for reimbursement by Medicare.[75] In addition, 22 states recognize the COA accreditation process in lieu of Medicaid certification, state monitoring, or licensing.[76] Finally, TRICARE, formerly the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), uses both existing tools, such as the Consumer Assessment of Health Plans (CHAPS) as well as its own mechanisms including the Appointment Standardization Integrated Program Team (ASIPT). Another Federal initiative is OASIS (Outcome and Assessment Information Set), a data set developed for HCFA to certify Medicare home health agencies. (More information about OASIS is available online at www.hcfa.gov/medicaid/oasis/oasishmp.htm.)

In 1997, the Federal Advisory Commission on Consumer Protection and Quality in the Health Care Industry was established to study changes occurring in the health care system and recommend ways to ensure consumer protection and quality health care. The Commission's report[77] includes a "Consumer Bill of Rights and Responsibilities," which is designed to strengthen consumer confidence in the health care system while holding participants in the system accountable for improving quality.

Disparities

Limitations in access to care extend beyond such basic causes as a shortage of health care providers, the distribution of the existing health work force, or a lack of facilities. Individuals also may lack a usual source of care (See Figure 4) or face other barriers, such as financial barriers (having no health insurance or being underinsured), or personal barriers (sexual orientation, cultural differences, language differences, not knowing what to do, or environmental challenges for people with disabilities). Discrimination in a health care

setting can cross-cut these categories of barriers. People belonging to groups who experience the highest levels of discrimination (e.g., transgender people of color) face increased barriers. Patients with disabilities may face additional barriers arising from facilities that are not physically accessible or from clinician attitudes. Hispanics, young adults, and uninsured persons are least likely to have a usual source of care.[78] Hispanic persons or those with less than 12 years of education are least likely to have a usual primary care provider.[79] Certain people, such as those who are disabled, transgender, elderly, chronically ill, or HIV-positive, require access to health care providers who have the knowledge and skills to address their special needs.[80]

Substantial disparities in health insurance coverage remain for certain populations. Among adults under age 65, approximately 33 percent of Hispanic persons lacked coverage in 1998, a rate that is more than double the national average. Mexican Americans had one of the highest uninsured rates at 40 percent. For adults under age 65 years, 34 percent of those below the poverty level were uninsured. Similar disparities exist in access to a specific source of ongoing care. An average of 85 percent of adults identified a specific source of ongoing care in 1998, but the proportions dropped to 76 percent for Hispanics and 77 percent for those below the poverty level.[81]

Lesbians and gay men may be more likely to face barriers in access to care and preventive services.[82] The data do not exist that will allow for similar assessments for bisexual and transgender people although there is speculation that those groups also experience disparities in access to needed health care. Undoubtedly, the degree to which any LGBT individual feels comfortable disclosing his/her sexual orientation and/or gender identity appears to be related to health care access. There also is reason to expect that disparities in access to care for ethnic and minority populations also are experienced by LGBT people within those populations. Therefore, one would expect to find an increase in the lack of access to health care for LGBT people who are of minority racial or ethnic groups, or who lack health insurance, or whose income is below the poverty level, or who have a disabling condition/disorder.

Opportunities

Throughout the next decade, Healthy People 2010 and its partners will continue to promote community-wide efforts to provide clinical preventive services, using local leadership, insight, and experience to tailor and increase the accessibility of these services. Efforts will continue to promote the development of local prevention coalitions that include health departments, businesses, community institutions, and individuals in leadership roles from each community. Healthy People also will work to strengthen the capacity of States and localities to collect health data and conduct community health assessments for small geographic areas.

During the past several decades, the concept of “community” has become increasingly compelling in the design and implementation of health and social services programs. Many federally funded grants require that the grantee develop a community consortium that brings

LGBT Health Access Project
Community Standards of Practice

Standard 1:	The agency shall establish, promote, and effectively communicate an inclusive, nondiscriminatory work place environment for LGBT employees.
Standard 2:	The agency shall support and encourage visibility of LGBT employees.
Standard 3:	The agency shall work toward ensuring that LGBT employees of all ages are subject to the same terms of employment as all other employees.
Standard 4:	The agency shall ensure that comprehensive policies are implemented to prohibit discrimination in the delivery of services to LGBT and their families. The agency shall ensure that the staff will use inclusive language and forms with LGBT and their families. For the purposes of these standards, family shall be broadly construed, and shall include but not be limited to relatives by blood, adoption, marriage, or declaration of domestic partnership.
Standard 5:	The agency shall ensure that it has comprehensive and easily accessible procedures in place for clients to file and resolve complaints alleging violations of these policies.
Standard 6:	The agency shall develop and implement or revise existing intake and assessment procedures to ensure that they meet the needs of LGBT clients of all ages and their families.
Standard 7:	All agency staff shall have a basic familiarity with LGBT issues as they pertain to the services provided by the agency.
Standard 8:	All direct care staff shall routinely provide general care to LGBT clients. They shall be competent to identify and address, within the scope of their expertise, specific health problems and treatment issues for LGBT clients and their families and to provide treatment accordingly, including necessary referrals.
Standard 9:	All case managers and treatment plans shall include and address sexual orientation and gender identity where it is a necessary and appropriate issue in client care.
Standard 10:	The agency shall ensure the confidentiality of client data, including information about sexual orientation and gender identity issues. LGBT clients shall be informed about data collection that includes reference to sexual orientation and/or gender identity, including in what circumstances such information may be disclosed, whether it may be disclosed as aggregate or individual information, whether personal identifiers may be disclosed, and how and by whom such information may be used.
Standard 11:	The agency shall provide appropriate, safe and confidential treatment to LGBT minors, unless the agency's services are inappropriate for all minors. All clients who are minors shall be informed of their legal rights, and advised of the possibility and possible consequences of any statutory or otherwise mandated reporting.
Standard 12:	The agency shall include LGBT and their families in outreach and health promotion efforts.
Standard 13:	The composition of the agency Board of Directors and other institutional bodies shall encourage representation from LGBT communities.
Standard 14:	Agency community benefits programs shall include LGBT in the community the agency serves.

all local stakeholders, concerned citizens, and consumers to the planning table. Ambitious strategies that have incorporated community strengths and engaged community members create significant opportunities.[83, 84] The Metro Denver AIDS Consortium has been

Removing the Barriers
Cultural Competency Training Components

Overview of LGBT barriers to care
Exercises demonstrating the adverse impact of these barriers (a 'heterosumption' exersize is used, where a straight person in a homosexual environment tries to get their healthcare needs met without disclosure of their sexual orientation).
Defining LGBT cultural competence in terms of health care
Take heterosexual-based questions off the intake forms (i.e., Married? Yes or No?)
Do not presume heterosexuality
Use nonbiased behavior towards patient
Do not assess using labels/identity, use behavior
Conduct a competent sexual-risk screening
Demonstrate knowledge of LGBT-specific health risks
Review of language used in LGBT communities
Review of research on LGBT health risks
Personal contract for change

Removing the Barriers
Mautner Project for Lesbians with Cancer
and
The Centers for Disease Control and Prevention
(Excerpted with permission)

identified as one initiative whose changes in the health care system were attributed (at least in part) to the efforts of a community consortium or coalition.[85]

The Metro Denver AIDS Services Consortium was formed in response to concern about rising treatment costs and lack of alternatives in the community for home-based and hospice care. The consortium's goal was to establish a continuum of medical and psychosocial services for people with HIV/AIDS by planning and coordinating services, ensuring access to needed services, and marshalling public and private sector support. The initial membership included the health department, a State-wide AIDS services organization providing social work, and the Visiting Nurses Association. After an unsuccessful initial attempt to secure Ryan White CARE Act funding, the consortium made an effort to include more community-based organizations and expand the heavily medical model to that resembling the continuum of care model. Between 1986 and 1989, the average length of stay for inpatient care dropped from 11.3 days to 8.2 days, and the average inpatient and outpatient charges per patient dropped 55.9 percent.[86]

The Health Resources and Services Administration (HRSA) within DHHS has a new Community Access Program to assist communities in building partnerships among health care providers, to deliver more and better care to their neediest residents. Grantees in 23 States were awarded monies in Fiscal Year 2000 to build integrated health care systems among local partner organizations, all of which are committed to expanding health services to the uninsured. HRSA is dedicated as the "Access Agency" to helping communities find their own ways to improve access to health care and to eliminate health disparities. State health departments play a key role in mobilizing necessary partnerships to improve access and reduce disparities.[87]

The Gay, Lesbian, Bisexual and Transgender Health Access Project is a collaborative community-based program funded by the Massachusetts Department of Public Health (MDPH). The project's mission is to foster the development and implementation of comprehensive, culturally appropriate, quality health promotion policies and health care services for LGBT people and their families (see Figure 5).[88] The standards are designed to assist providers in the development and delivery of comprehensive, culturally competent services. Consumers can use these standards to guide them to quality providers in their community. Sanlo (2000) took the Community Standards of Practice for Provision of Quality Health Care Services for Gay, Lesbian, Bisexual and Transgender Clients and adapted them for college and university health care settings.[89] Several examples of standards of care or practice also exist for transgender people. Resources include the Harry Benjamin Standards of Care for transgender people[90] and the Tom Waddell Health Center's "Protocols for Hormonal Reassignment of Gender."[91]

Even when knowledgeable providers are available, the existing Standards of Care (SOC) for gender identity disorders, announced by the Harry Benjamin International Gender Dysphoria Association (HBIGDA), can create additional barriers to care for persons seeking cross-gender hormone therapy. The SOC, to which most well informed providers usually adhere, require an extensive psychological evaluation before hormones can be prescribed.[92] Many transgender persons are unable to afford such an evaluation, and many also are unable to afford the services of a prescribing physician. Under these circumstances, it is not surprising that use of unsupervised "black market" hormones is widespread among urban transgender persons. The prevalence of black market hormone use has been reported to range from 29 percent to 63 percent within urban groups of male to female (MTF) transgenders.[93, 94, 95, 96]

> ". . . Unrecognized homosexuality by the physician or the patients' reluctance to report his or her sexual orientation can lead to failure to screen, diagnose, or treat important medical problems. . ."
>
> —American Medical Association[147]

Recently some progressive clinics, such as the Tom Waddell Health Center in San Francisco, have begun offering supervised hormone therapy to persons who would otherwise use black market hormones, without requiring a preliminary psychological evaluation.[97] This "harm reduction" model of transgender hormone prescription is expected to receive at least a qualified endorsement in

the forthcoming revision of the HBIGDA Standards of Care (Version Six), due to be released in early 2001.

In addition to standards of care, providers must be culturally sensitive so as to build a therapeutic alliance and maintain an ongoing relationship with a primary care provider. LGBT people have barriers to accessing health care.[98] Certainly, one of the most critical barriers involves the relationship, or lack thereof, between providers and consumers.[99] The LGBT consumer's avoidance of existing but inappropriate or non-LGBT-competent health care services will diminish as provider cultural competency training brings about attitudinal changes, and the health care system demonstrates increased access to equal quality of care for all. In a review of comprehensive care for LGBT patients and families, Harrison and Silenzio (1996) summarize four steps physicians (and other health care professionals) can take to offer appropriate care.[100]

Step 1: Maintain a nonhomophobic attitude.

Step 2: Distinguish sexual behavior from identity.

Step 3: Communicate clearly and sensitively using gender-neutral terms.

Step 4: Be aware of how their own attitudes affect clinical judgments.

Throughout their careers, health care providers should be expected to participate in continuing education opportunities that offer cultural competency training. Allied health professions educational institutions should incorporate LGBT cultural competency training in their curriculum with the other core competencies. (See discussion under Objective 1-7 in this chapter. Also see Educational and Community-Based Programs focus area and Public Health Infrastructure focus area for a more comprehensive discussion of this issue.) Continuing medical education (CME) credit must be available to reinforce initial training and for the health care work force in the field. CDC has developed cultural competency-based training focusing on women who partner with women (WPW). Its basic approach, shown in Figure 6 can be modified for use in a number of contexts. The Mautner Project for Lesbians with Cancer successfully uses this training approach.

Bisexual people may have the least amount of information relative to standards of conduct and to training curricula. After a groundbreaking conference on bisexuality and HIV prevention was held in June 1999, Miller and Solot (2000) wrote *Tips for Health Care Providers when Working with Bisexually-Identified and Behaviorally-Bisexual Clients*.[101] BiHealth is the first and only program of its kind in Massachusetts, and one of the only of its kind in the country. BiHealth provides prevention and education about HIV and sexually transmitted diseases (STDs), and addresses health concerns in a holistic way, whether one identifies as bisexual, bi-curious, bi-questioning, pansexual, heterosexual, gay, lesbian, transgender, or no label at all. BiHealth is located at the Fenway Health Center in Boston.

A core function of public health agencies is to promote a statewide assessment of current health status and access barriers to help prioritize interventions and set baselines upon which to measure progress. The Association of State and Territorial Health Officers

(ASTHO) in partnership with HRSA has started a resource compendium that supports a State or community in assessing where they are on the range towards 100-percent access and 0 health disparities. The online version at www.astho.org/access/documents.html will include links to many of the innovative, online State and local data sources.

All of the accreditation organizations have provider and consumer occasions that solicit input to ensure that the needs of all enrollees are being met. For example, JCAHO requires organizations requesting the accreditation process to notify the community, patients, their families, patient advocates and others of the opportunity of a public information interview (PII) with the survey team.[102] LGBT consumers and providers should contact both the accreditation organizations as well as the local health care programs that have received accreditation and inquire as to the opportunities that exist. Perhaps the next version of NCQA's HEDIS instrument or JCAHO's ORYX ™ could include information specific to the health care needs and concerns of LGBT consumers.

Summary of Research

LGBT persons face documented structural, financial, personal, and cultural barriers when attempting to access health care services.[103, 104, 105, 106, 107, 108, 109, 110] These barriers tend to alter the individual's behavior and attitudes toward health care services, if available, and probably adversely affect health outcomes.

Personal and cultural barriers to health have been well researched for LGBT populations. The results from multiple studies document provider bias as to LGBT people or patients.[111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126] Findings also show that, perhaps in an effort to avoid this bias or because of internalized homophobia, LGBT patients frequently withhold personal information about their sexual orientation, gender identity, practices, and behavioral risks from their health care providers.[127, 128, 129, 130, 131, 132] In addition, many health care providers may be uncomfortable, reluctant, and under-trained to take sexual histories.[133 , 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144] These barriers are of concern for LGBT individuals and providers of health care, as barriers could result in LGBT people not seeking needed preventive screening tests and preventive interventions, or delaying seeking treatment for acute health conditions or exacerbation of chronic conditions.[145, 146]

Despite known biases against LGBT populations, little training is provided to medical professionals on how to overcome biases or gain cultural competency-based skills in treating LGBT populations.[148] Provider bias against LGBT populations or the non-prioritization of these populations also may lead the provider to de-prioritize the need for training to overcome these biases.[149]

LGBT populations face several financial barriers to health care. Some community surveys show that LGBT individuals often experience lower socioeconomic status than the general population, as well as being uninsured or underinsured.[150, 151, 152] Gay men and lesbians in committed relationships are at a disadvantage in obtaining insurance compared to married

heterosexual couples since many insurance companies and employers do not provide domestic partner benefits.[153, 154]

The full impact of financial barriers is difficult to measure because of a lack of scientific data. The best available data on population disparities in insurance is an analysis of approximately 96,000 older women enrolled in the Women's Health Initiative.[155] In this study, despite the fact that lesbian and bisexual women were most likely to have attended graduate school and work in managerial professions, they were significantly more likely to be uninsured (6.8 percent for heterosexuals, 9.7 to 10.4 percent for lesbians, and 12 percent for bisexuals). Other surveys yielded similar findings. The National Lesbian Health Care Survey (NLHCS) highlighted groups of lesbians particularly likely to lack insurance, such as those who were younger, unemployed, in school, poor, and/or African American. Sixteen percent of respondents reported that they did not obtain health care because they could not afford it.[156] Those who were uninsured had a greater preponderance of certain illnesses—such as anxiety, suicide ideation, physical or sexual abuse, ulcers, substance use, and eating disorders.[157] A 1997 Los Angeles County survey of almost 5,000 women found that lesbians and bisexual women were less likely than heterosexual women to have health insurance. Seventy percent of the heterosexual women were insured compared to 63 percent of lesbians and 42 percent of bisexual women.[158]

The Michigan Lesbian Health Survey yielded similar findings whereby 12.3 percent of lesbians sampled indicated that they did not have health insurance compared to 9.7 percent of Michigan women in general.[159] And while middle-aged lesbians report that they are in good to excellent health, 27 percent stated that they did not have health insurance.[160]

Little is known about the percentages of insured or uninsured status for gay males. The Urban Men's Health Study provides some insight as it is based on a random household sample of men in census tracks with high proportions of gay men in San Francisco, New York, Los Angeles, and Chicago.[161] Key findings from the study suggest that about 16 percent of men who have sex with men in America's largest cities do not have any form of health insurance, and about 13 percent do not have a health care provider. In addition, economic privilege seems to predict having health insurance or a health care provider.

Uninsured levels are highest among transgender people. A 1997 survey in San Francisco found that 52 percent of the almost 400 transgender individuals surveyed lacked health insurance,[162] while the Washington Transgender Needs Assessment Survey, conducted between 1998 and 2000, found that 47 percent of respondents lacked health insurance.[163] A December 1999 survey by the New York City Department of Health found that 21 percent of transgender respondents reported having no health insurance of any kind.[164] Within these transgender communities, people of color are likely to be disproportionately uninsured—a finding that mirrors statistics on people of color throughout the Nation.[165, 166]

Unlike married heterosexual couples, partnered LGBT couples are unlikely to be eligible for the benefits of family health insurance coverage. LGBT families, therefore, pay more for

the same level of coverage for all family members, and are less likely to enjoy the benefits of family-focused care under the same set of doctors.

Structural barriers that have been linked to LGBT health include the health care system's unfamiliarity with LGBT populations[167] and the lack of legal recognition of partners.[168] As our predominant form of health care organization and financing is managed care or managing care in some form, LGBT persons within most types of managed care arrangements such as HMOs or PPOs may not be aware of LGBT-friendly providers or health professionals who have demonstrated their cultural competence with these population groups. Or, the LGBT person may be more concerned about breach of confidentiality in managed care settings because of the level of detail often required to approve benefits.[169]

The lack of structure for recognizing an LGBT family goes beyond the insurance concerns expressed to an additional set of structural barriers that may affect the individual's health care options. There is a "systemic bias in favor of heterosexuals" in a number of Federally administered social benefit programs, particularly around survivor benefits and joint assets.[170] Many Federal health care programs for women are focused on reproductive care. Since this is not as relevant to most lesbians, they have less access to the concomitant care bundled in with the reproductive services. Without legal acknowledgement of the LGBT family unit, LGBT persons whose partners become medically incapacitated can be left out of medical decisionmaking, denied information on their partner's condition, or even barred from seeing their partner. Since social and family support has been shown to have a positive effect on health outcomes, denying that support is not in the best interests of the patient and creates a hardship for the partner.[171]

Access to culturally competent health care is a particular issue for intersex individuals—those born with characteristics of both male and female anatomy. Around the late 1950s, it became widespread practice to perform surgery and start hormone treatments on intersex children so that the child would be viewed as clearly male or clearly female. Many people believe most of these interventions were and are not medically necessary. Beginning in the mid-1990s, a growing number of adults who had been subjected to these treatments as children began to speak out, criticizing the interventions as causing emotional trauma and physical damage to sexual function. Psychologists and ethicists soon joined these critics.[172, 173, 174] By 2000, many clinicians had acknowledged that the model of treatment introduced in the 1950s, which was based on secrecy and early genital plastic surgery, was scientifically unsound.[175, 176] Some even called for a moratorium on early surgeries.[177, 178, 179, 180]

Access to care is especially limited for adolescents. They are the most uninsured and underinsured of all age groups. Access is especially complicated for LGBT youth who may fear loss of confidentiality, ridicule, or discrimination in seeking care, and who are at risk for a range of health and mental health concerns associated with stigma, a lack of accurate health prevention and promotion information, and a lack of adequately trained providers. At the same time that this population is experiencing extraordinary barriers to care, they are also at increased risk for suicide, violence, and substance abuse.[181] A report from the

DHHS's Task Force on Youth Suicide found that gay men are up to six times more likely to attempt suicide than their heterosexual counterparts, and lesbians are up to twice as likely to attempt suicide than heterosexual women.[182] Later research on suicide shows the rates of suicide attempts among LGBT youth are consistently between 20 and 42 percent.[183, 184, 185, 186, 187, 188, 189, 190, 191, 192]

In a 1993 study across 13 cities, 80 percent of LGBT youth had experienced verbal abuse, 44 percent had been threatened with attack, and 17 percent had experienced a physical assault.[193] The particularly vulnerable position of LGBT youth may intensify the deleterious effect of anti-LGBT bias on their health care. In a 1998 survey, "two-thirds of youth had never discussed their sexual orientation with their provider but reported a desire to do so. Fewer than one-half of subjects remembered being informed about their right to medical confidentiality."[194] Another study found that less than half of doctors were screening adolescents for sexual health risks.[195]

What limited information there is about transgender youth demonstrates the increased risks of being members of multiple underserved populations, and its negative impact on health status and health risk behavior.[196] The issues of stigma and discrimination that affect health care for LGBT youth pervade the range of social services this at-risk population might need. Not only will LGBT youth be challenged to find appropriate medical care, but they also will be challenged to find an accepting homeless shelter, or nondiscriminatory treatment if they are in the foster care system. The combination of provider aversion to conducting a sexual risk screening, provider lack of training to do so for LGBT populations, the understandable fear LGBT youth have of disclosure, and the research showing higher risk behaviors for this group may be a deadly combination.

The cross-cutting issue of discrimination in health care affects LGBT people through their full lifespan. As LGBT people age, the cumulative impact of years of health care delay, avoidance, or mismanagement can be expected to have a greater impact on their health status. In addition, not all lesbian and gay people "come out" or declare their gender identity during adolescence. Among age cohorts, many lesbian and gay people have been married to someone of the opposite sex.[197] For example, in Adams and Kimmel's study (1997) of older Black gay men in New York, six out of 20 had been married to a woman.[198] At least four, and as many as six of the 20, reported having fathered children, and 16 of 20 reported at least one heterosexual experience.[199]

Herdt et al.'s study (1997) of 160 older gay men, lesbians and bisexuals in Chicago found over 40 percent of the sample had been married to a person of the opposite sex, for an average of 14 years. Some 40 percent of the women had children, as did 24 percent of the men.[200]

Little is known about the health care needs of older LGBT people, especially transgender people.[201] However, LGBT elderly share many common health care challenges with all other elderly persons. For example, one of the shortcomings of Medicare is that, unless enrolled in a Medicare HMO, prescriptions medications are not reimbursed or the reimbursement is minimal.[202]

There is some evidence from the limited research that LGBT seniors are more likely to live alone. A 1999 study conducted for Senior Action in a Gay Environment (SAGE) found that 65 percent of 253 gay and lesbian seniors surveyed in New York City reported living alone. This was nearly twice the rate of all people 65 years or older in New York City, where 36 percent lived alone.[203] Another more representative study found that 75 percent of gay and lesbian seniors in Los Angeles lived alone.[204]

San Francisco: Setting an Example

In 1997, the city of San Francisco implemented a law requiring every company that does business with the city to provide the same benefits to its employees' domestic partners as it does to its employees' spouses. Within 3 years, over 2,700 companies changed their benefits policies to include domestic partners. Given that no other single law has ever made such a profound impact on domestic partner benefits, this form of government action clearly has the potential to make a dramatic difference in the availability of health insurance to LGBT people.

Since passage of the San Francisco law, Broward County, Florida, and Seattle, Washington, have adopted similar ordinances, and several other cities have considered them.

Few agencies exist to specifically meet the social service needs of LGBT seniors.[205] A 1994 study of 24 Area Agencies on Aging (AAA) and 121 lesbian and gay elders (aged 60 and older) who lived in those regions found that 96 percent of the AAAs did not offer any services specifically for them and did not have outreach efforts to lesbian and gay seniors.[206] While this lack of social support can have a deleterious effect on health itself, when it is combined with the discrimination within the health care system, LGBT seniors are at serious, increased risk. This discrimination can be particularly malicious when a person is wholly dependent upon their health care providers for basic life needs and the staff refuses to touch "the lesbian," as documented in one study.[207]

Very little of the information cited here looks at the differences among LGBT populations that are also members of other underserved populations (such as racial and ethnic groups, rural populations, people whose primary language is not English, immigrants, people with disabilities, and children of LGBT people). For example, minor children of LGBT couples or parents are also negatively affected by Social Security's failure to recognize LGBT families. In States that do not recognize second-parent adoptions, in the death of the primary parent, children are deprived of minors' survivor benefits.[208]

In recognition of the earlier mentioned health barriers to access, LGBT communities, especially in urban areas, have expended a significant level of energy and resources in building service delivery systems designed to be more responsive to their unique health care needs. (See Appendix D: Resources for a national listing of the Gay and Lesbian Centers throughout the United States, most of whom also offer services for bisexual and transgender people.) The top 10 largest clinics serve a combined 45,000 LGBT clients.[209] However, not all LGBT individuals have access to such systems; in addition, many LGBT individuals in

these larger cities choose, for many different reasons, to pursue their health care through different routes. Regardless of where or when LGBT people present for care, they should be assured of equal access to culturally competent systems of care that are devoid of bias and responsive to the health concerns of LGBT people.

Discussion of Healthy People 2010 Objectives

Clinical Preventive Care

Healthy People 2010 Objective

1-1: Increase the proportion of persons with health insurance.

Access to health services often depends on whether a person has health insurance.[210, 211, 212] Even without the optimal level of research on this issue, exploratory studies suggest that LGBT people may be more likely than heterosexual people to be uninsured or underinsured. In addition, some insured LGBT people with private insurance or who are self-insured may be reluctant to have claims for health services submitted to the plan out of fear that their employer will have access to their medical record and personal information about their sexual orientation.[213]

Within the diversity grouping of LGBT people, transgender individuals are likely to have the highest rates of being uninsured. Virtually all of the services related to hormone and endocrinology therapy and surgical procedures are not covered by standard health insurance policies on the grounds that the treatments are either cosmetic or experimental.[214] Transgender people also may have the most difficult task in overcoming some of the obstacles and barriers to needed services as relevant procedures and/or treatments specifically may be excluded in health care plans or insurance policies. For example, one insurance policy excludes any "procedure or treatment designed to alter the physical characteristics of a member's biological sex to those of the opposite sex, regardless of any diagnosis of gender role or psychosexual orientation.[215] This is not the only health plan stipulating such an exclusion,[216] and most private insurance specifies that medical services related to sex-reassignment are excluded from coverage.[217]

There have been cases in which insurance coverage denials were overturned. For example, in May 2000, a Massachusetts court ordered the Massachusetts Division of Medical Assistance (DMA) to pay for breast reconstruction surgery for a transsexual woman. The woman, Germaine Beger, a 50-year-old Medicaid recipient whose sex-assignment surgery in 1975 included breast implants, sought treatment in 1999 for a possible cyst in her right breast. The Massachusetts DMA approval the removal but denied the followup breast reconstruction surgery citing a State regulation that excludes Medicaid coverage for sex-assignment surgery. The Court decision directed DMA to authorize payment for the procedure stating that the decision was arbitrary and based on an incorrect interpretation of the agency's regulations.[218] A similar Medicaid case was successfully won in Iowa in

1980.[219] Another successful case was won in 1979 against Aetna Life and Casualty Insurance Company.[220]

An additional reason for the lack of adequate insurance coverage relates to the lack of family health insurance for domestic partners and their children. Unlike heterosexual families, such coverage frequently is not available when one member of a LGBT couple is unable to work, due to illness, caring for a child or an elderly relative, or for any number of other reasons.[221, 222]

To increase the level of LGBT people covered by health insurance, the inability of LGBT people to have access to family insurance plans routinely offered to married employees should be addressed. A report on domestic partner insurance benefits by the Institute for Gay and Lesbian Strategic Studies (IGLSS) showed a distinct increase in the number of private companies to extend this benefit to their LGBT employees.[223] In 1990, no Fortune 500 companies offered domestic partnership insurance. By 2000, more than 20 percent offered this benefit. The trend is not limited to large companies. About 18 percent of all employers—numbering more than 3,500—offer domestic partner benefits. Most make the benefits available to both same-sex and different-sex unmarried couples.[224] This inclusive definition of domestic partners recognizes that some bisexual and transgender people have different-sex partners, and acknowledges the increasing family diversity of the workplace. The IGLSS report also assessed the financial impact of this benefit on companies and found it to be much smaller than previously assumed, usually a cost increase of 1 to 2 percent.

Even when employers offer domestic partner or family recognition benefits, other barriers may prevent some LGBT employees from taking advantage of them. Some employees are afraid that enrolling an eligible same-sex partner will "out" them or make their other sexual orientation known in a homophobic workplace, exposing them to harassment or possibly loss of their job. Others are deterred when domestic partner health benefits are taxed as part of the employee's salary, when spousal benefits are not taxable.

Across the United States, 13 communities form the building blocks of a national effort to improve the health care system. The national effort is called Community Voices: Health Care for the Underserved, and is a 5-year W. K. Kellogg Initiative.[225] The following are the cities in which the 13 communities are located: Oakland, CA; Sacramento, CA; Denver, CO; Washington, DC: Miaimi, FL; Baltimore, MD; Detroit, MI; Lansing, MI; Albuquerque, NM; New York, NY: Pinehurst, NC; El Paso, TX; and Charleston, WV. Each community is investigating a model of addressing the problem of access, inclusive of, but not restricted to health insurance. One strategy that a number of States are using is "community benefit" legislation which can assist vulnerable populations to gain access to health care by imposing certain requirements on nonprofit providers if they want to retain their tax-exempt status.[226] Some States, such as California, have required health plans converting from nonprofit to for-profit status to set aside a certain amount of conversion funds to be used to promote better access to care for vulnerable populations.

1-2: (Developmental) Increase the proportion of insured persons with coverage for clinical preventive services.

Insurance coverage for clinical preventive services improved substantially during the 1990s, but significant variations remain in the services covered, depending on the plan and type of insurance. A 1997 national survey of over 3000 employers found that 88 percent of employer-sponsored plans covered well-baby care, 89 percent covered adult physical examinations, 92 percent covered gynecologic examinations, 89 percent covered Pap tests, and 91 percent covered mammograms. Coverage was highest in health maintenance organizations (HMOs) and lowest in indemnity or fee-for-service (FFS) insurance plans.[227] Including effective clinical preventive services among those routinely covered by insurance is an effective way to emphasize the importance of clinical preventive services as an integral part of health care.[228] The Balanced Budget Act of 1997 (Public Law 105-33) added colorectal cancer screening among other new preventive benefits covered by Medicare, and expanded Medicare coverage of mammography and cervical cancer screening.

The proposed data source for Access objective 1-2 is the Medical Expenditure Panel Survey (MEPS), which is administered by the Agency for Healthcare Research and Quality (AHRQ). The 1996 MEPS data are currently being analyzed and are expected to provide baseline data on the percentage of persons with coverage for selected preventive services (well-child visits, immunizations, cervical cancer screening, and adult physicals). The current demographic data for the MEPS includes age, race, ethnicity, region, occupation, employment status, and household composition.

The numerator will be the number of people who have coverage for clinical preventive services as part of their health insurance. The denominator will be the number of insured persons. These data are based on an abstract of the respondents' insurance policies, rather than household reports. Data will be collected periodically, with as much as a 3-year lag time in reporting these data. Data that are collected periodically from policy booklets obtained from MEPS household respondents could be modified to collect information on a broader set of preventive interventions such as recommended cancer screening and smoking cessation.

1-3: Increase the proportion of persons appropriately counseled about health behaviors.

1-3a. (Developmental) Counseling about physical activity or exercise for adults

1-3b. (Developmental) Counseling about diet and nutrition for adults

1-3c. (Developmental) Counseling about smoking cessation for adults

1-3d. (Developmental) Counseling about reducing excessive alcohol consumption by adults

1-3e. (Developmental) Counseling about childhood injury prevention: vehicle restraints and bicycle helmets

1-3f. Counseling about unintended pregnancy (females aged 15 to 44 years)

1-3g. (Developmental) Counseling about sexually transmitted diseases (males aged 15 to 49 years; females aged 15 to 44 years)

1-3h. (Developmental) Counseling about management of menopause (females aged 46 to 56 years)

The notation "development" indicates subobjectives for which data are missing. This objective, however, is one of the HP2010 objectives in which sexual orientation is in the data table as DNC (Data are Not Collected). DNC indicates that the data source or sources listed for the objective do not collect data on the specific subpopulation or demographic characteristic at this time. A different or new data source may be needed or added in order to measure progress on this objective for persons of other sexual orientation or gender identity.[229]

Selective clinical preventive services have a positive influence on personal health, and many are cost-effective in comparison with the treatment of disease.[230, 231, 232] Insurance coverage, especially, is problematic for counseling services, in part, because of the difficulty in demonstrating the efficacy or proving the benefits of the interventions. For example, only 22 percent of employer-sponsored plans cover medications or counseling for smoking cessation.[233] The effectiveness of smoking cessation counseling, however, is supported by strong evidence, with more intensive interventions having the greatest impact and most favorable cost-effectiveness ratios.[234]

Unhealthy diets, smoking, physical inactivity, and alcohol use account for a majority of preventable deaths in the United States.[235] Data indicate that risk assessment and counseling interventions are delivered less frequently than other interventions (for example, cancer screenings).[236] That is understandable, given that nearly all of a physician's training is devoted to acquiring technical skills associated with medicine. Such technical intervention may reverse or palliate biologic illnesses, but have little effect on the factors influencing health/wellness or disease/disorder.[237] The type and number of preventive counseling interventions offered also may be affected by whether the provider will be reimbursed for certain preventive counseling or screening services, i.e., whether the counseling or screening service is covered by the patient's health insurance. In many care settings, other health staff (physician's assistants, nurses, nurse practitioners) provide preliminary counseling screens. Thus, the appropriate or necessary counselor may not always be the physician.

Time is an important constraint in the primary care setting. However, brief clinician counseling is effective in having consumers stop smoking and reduce problem drinking.[238, 239] In addition, brief counseling interventions aimed at high-risk individuals can increase condom use and prevent the spread of sexually transmitted diseases.[240] (See Sexually Transmitted Diseases (Infections) and HIV/AIDS focus areas.)

Cultural Competency. . .

"The framework which allows us to design research and provide services uniquely tailored to each community or individual by integrating and being responsive to factors that influence attitudes, behavior and experience."

—E. J. Rankow

Applying principles of cultural competency to lesbian health, *Journal of the Gay and Lesbian Medical Association,* 2(3), 1998

Provider counseling should be tailored to the individual risk factors, needs, preferences, and abilities of each health care consumer.[241] Rather than medical interventions or verbal admonitions to change lifestyles by adopting behaviors that either never existed or are culturally disharmonius, what is necessary are preventive interventions delivered by appropriate messengers. The subsequent measures of success may become quality of life in lieu of "cures." [242]

The likelihood of LGBT people having appropriate messengers and/or messages is rare within traditional settings, given societal assumptions and the fact that most health professionals are poorly informed about the health care risks of LGBT patients.[243, 244, 245, 246, 247] A 1998 survey of all U.S. medical schools found an average of only 2.5 hours devoted to this topic in the 4-year program.[248] The amount of time that other providers, such as physician assistants, nurse practitioners, nurses, social workers, employee assistant professionals and health educators who may engage in counseling with LGBT consumers is not known.

While it is known that more research is needed to better quantify some risks for the LGBT community, preliminary research does show some disparities.[249] The Women's Health Initiative is a longitudinal research project that collects health risk information for older women. It is also one of the first large-scale health studies to include a measure of sexual orientation, so the data can be analyzed for lesbian and bisexual (although not transgender) subpopulations. Of a sample of 96,000 of the participants, lesbians and bisexuals were significantly more likely than heterosexuals to be heavy drinkers, current or previous smokers, obese, and nulliparous (never having born children). They were also significantly less likely than heterosexuals to have never had a mammogram, have waited longer since their last PAP test, and to eat fewer fruits and vegetables daily.[250] Another study shows similar results. A total of 1,362 women were surveyed in California, and it was found that lesbians and bisexuals were significantly more likely than heterosexuals to have recently used illicit drugs and to have been tested for HIV; they also were less likely to have had an appropriate cholesterol screening or mammography.[251, 252]

Both gay men and lesbians show a higher rate of smoking than the general population.[253] (See Tobacco focus area.) A number of community-based studies on transgender populations report them to be at high risk for HIV or STDs, suicide, becoming victims of violence, and having substance abuse issues.[254, 255, 256, 257, 258, 259] Gay and lesbian youth are at disproportionate risk for suicide, victimization, sexual risk behaviors, and multiple substance use than their heterosexual counterparts.[260] [See all other relevant focus areas, especially Mental Health, HIV/AIDS, and Sexually Transmitted Diseases (Infections).]

Increasing preventive screening and counseling for LGBT health risks is dependent upon better scientific identification of the factors found to accompany elevated risk—including sexual orientation and gender identification. Studies have clearly identified the reluctance of many LGBT individuals to self-identify for such reasons as a lack of provider cultural competency, and fear of discrimination and breach of confidentiality.[261, 262] Therefore, to increase the proportion of LGBT persons appropriately counseled, cultural competency training should be a standard component of the health professions training curriculum and made available to the public health workforce in the field, additional research and data collection on health status and disparities must take place, and the LGBT community must become informed about what clinical preventive services they should be receiving from their health care providers.

Health promotion and disease prevention marketing campaigns are designed to build prevention awareness, promote healthy behaviors, and better enable individuals to access available health care services. The most successful campaigns target populations with culturally appropriate messages. To increase the number of LGBT persons who are appropriately counseled about health behaviors, health educators and planners developing health promotion/disease prevention campaigns should include representation from the LGBT community to create community-specific messages.

With the exception of subobjectives 1-3f and 1-3g, the sources of data for the other subobjectives are the National Health Interview Survey (NHIS), CDC, NCHS, each State's Behavioral Risk Factor Surveillance System (BRFSS), CDC, and NCCDPHP. Subobjective 1-3f is the only subobjective that has baseline data and is not developmental. The baseline data for unintended pregnancy is the 1995 National Survey on Family Growth (NSFG), which is administered periodically by CDC's National Center for Health Statistics. This survey is to be the source for 1-3g. NSFG is being conducted this year (2001) and also scheduled for 2004 and 2007. The primary survey content contains data on factors affecting birth and pregnancy rates, adoption, and maternal and infant health. The current demographic data associated with NSFG are age, race, Hispanic ethnicity, family income, and educational attainment.[263]

Primary Care

1-4: Increase the proportion of persons who have a specific source of ongoing care.

Access to care depends in part on access to an ongoing source of health care services. People with a usual source of health care are more likely than those without a usual source of care to receive preventive health care services.[264, 265] An estimated 15 percent of adults in the United States lack a usual source of care.[266] The National Health Interview Survey does not count emergency departments as a usual source of care. Thus, more than 40 million persons have no particular doctor's office, clinic, or health center.

An estimated 93 percent of children aged 17 years and under have a specific source of ongoing care. The Children Health Insurance Program, implemented in 1999, provides a mechanism for increasing the proportion of children with an ongoing source of care and generates new opportunities through school-based health centers and other types of facilities.[267, 268] For example, the Adolescent Health Network affiliated with the St. Paul-Ramsey County Department of Public Health, in St. Paul, Minnesota, and other collaborators is planning an educational forum on the health care needs of LGBT youth.[269]

To increase the proportion of LGBT people who have a specific source of ongoing health care, a number of barriers need to be addressed, including those for LGBT people living in rural areas or where there are no LGBT-competent providers, as well as a general lack of LGBT-friendly or LGBT-informed health professionals. The Gay and Lesbian Medical Association (www.glma.org), the Association of Gay and Lesbian Psychiatrists (www.aglp.org), the Renaissance Transgender Association (www.ren.org), Whitman Walker Clinic (www.wwc.org) and GayHealth.com (www.gayhealth.com) have online services that identify LGBT providers. The Lesbian and Gay Community Services Center of New York offers a guide to community centers serving the lesbian, gay, bisexual, and transgender communities across the country (www.gaycenter.org). (Appendix D: Resources contains a listing of each center by State.)

Although not currently inclusive of LGBT populations, a new Web site with expanded coverage of health care and healthy policy issues, especially access, has been launched at www.comumunityvoices.org. A project of the W. K. Kellogg's Community Voices Initiative, the site contains the latest information about national health policy as well as the efforts of local communities to improve health care access and quality. The Web site will be updated weekly and will cover health care issues related to the millions of people in the United States who are uninsured or underinsured.

1-5: Increase the proportion of persons with a usual primary care provider.

Primary care providers (PCPs) are the gatekeepers of our current health care system, most commonly characterized as some form of managed care, managed costs, or coordinated care. As the entry people, PCPs are to meet the medical, and if well trained and educated,

the health care needs of most people.[270] PCPs can include physicians, nurse practitioners (NPs), physician assistants (PAs), and several other professional groups, usually with certification and/or licensure, who are recognized by accrediting organizations.

A usual source of primary care helps people clarify the nature of their health problems and usually directs them to the appropriate health services, including specialty care.[271] Primary care also emphasizes continuity, which implies that individuals use their source of primary care over time. More afterhours care, shorter travel time to the site of care, and shorter waiting times for care have been associated with health care consumers' initiation with a usual PCP. Greater continuity has been observed for individuals with shorter appointment waits, insurance, and access to more afterhours care.[272] Evidence suggests that first contact care provided by an individual's PCP leads to less costly medical care.[273]

Members of the LGBT community often share information regarding which providers are LGBT-friendly, culturally competent, and accepting. Transgender people are more likely to go to doctors who have been recommended by other transgender people because of their need for expertise related to any issues of hormones or surgery.[274]

No study or organized body of literature exists discussing the relationship between PCPs and LGBT people. A few examples of the availability of primary care do exist.

More than 14 MCOs have formed contractual relationships for primary physical health care services with the new Lambda Medical group in Los Angeles. The Los Angeles Lambda Medical group is a medical center connected to the L.A. Gay and Lesbian Community Center that provides primary health care by physicians and other health care providers who specialize in the health care needs of lesbians and gay men.[275]

The Lesbian Health Wellness Network, based in Washington, D.C., is a 150-member provider network with many PCPs who are affiliated with different PPOs. In addition to a provider manual and a referral system, the network is also actively involved in providing LGBT-competency training for mainstream providers.[276]

Since 1971, the Fenway Community Health Center in Boston, Massachusetts has provided comprehensive, high-quality health and medical care to LGBT people. Every medical client at Fenway works with a primary care team, which includes a PCP and a registered nurse. Fenway accepts all major insurance plans, private and public. (More information can be obtained online at www.fenwayhealth.org.)

Howard Brown Health Center in Chicago, Illinois, offers every client a continuum of care that is broad in scope. Founded in 1974 by a small group of medical students and other concerned volunteers, Howard Brown's original focus was on the provision of low cost, confidential testing and treatment of sexually transmitted diseases. Over the course of two decades, the Center has dramatically expanded its role in the community, responding to the most pressing needs of the LGBT community. The Center accepts private insurance and public aid claims as well as sliding fee scales. (More information can be obtained online at www.howardbrown.org.)

Michael Callen-Audre Lorde Community Health Center is New York's only health facility devoted primarily to the LGBT communities. Throughout its 15-year history, more than 27,000 people have been served by Callen-Lorde. The center delivers a comprehensive health service model which provides on-going health maintenance and preventive care, as well as screening and treatment for STDs, hepatitis B prevention and immunization, walk-in services for acute and episodic medical care, dermatological care, and other medical and specialty services. Primary care is provided by paid practitioners, and episodic (walk-in) care is provided by a combination of paid and volunteer staff. (More information can be obtained online at www.callen-lorde.org.)

In November 1973, the Gay Men's VD Clinic, part of the Washington Free Clinic, began operating in the basement of the Georgetown Lutheran Church in Washington, D.C. As the forerunner of Whitman-Walker Clinic (WWC), the renamed STD Clinic is the longest running program. The professional staff and 270 medical and clinical volunteers provide the effective delivery of HIV/AIDS-related, culturally sensitive health care. The HIV Clinic provides comprehensive medical evaluations, ongoing primary medical care, and treatments for HIV disease and related illnesses. In order to become a client and receive HIV/AIDS services at WWC, you must schedule a meeting with an access counselor. The counselors, not unlike PCP gatekeepers, provide information about services available through WWC and other organizations. WWC also provides many programs to lesbians, bisexual, and transgender members of the community. (More information can be obtained online at www.wwc.org.)

1-6: Reduce the proportion of families that experience difficulties or delays in obtaining health care or do not receive needed care for one or more family members.

In 1996, according to the Medical Expenditure Panel Survey (MEPS), 12.8 million families (11.6 percent) for a variety of reasons experienced difficulty or delay in obtaining care or did not receive health care services they thought they needed.[277] In addition to a lack of insurance or being underinsured, barriers include a lack of appropriate referrals, travel distance to the provider, lack of transportation, and unavailability of specialists. Families experience barriers to care for a variety of reasons: inability to afford health care (60 percent); insurance-related causes (20 percent) including the insurance company not approving, covering, or paying for care, preexisting conditions for which insurance coverage often is restricted, lack of access to required referrals, and clinicians refusing to accept the family's insurance plan; and other problems (21 percent), such as transportation, physical barriers, communication problems, child care limitations, lack of time or information, or refusal of services.[278]

An additional source of information on obtaining services is the Robert Wood Johnson (RWJ) National Access to Care Survey. Results of the 1994 RWJ survey suggest that some studies have missed substantial components of unmet needs by failing to include specific questions about supplementary health care services, such as prescription drugs, eyeglasses, dental care, and mental health care or counseling.[279] When specific questions were added

about these services, the findings showed that 16.1 percent of respondents (approximately 41 million) were unable to obtain at least one service they believed they needed with dental care being the highest reported. This problem can be attributed partly to insufficient provider reimbursement, which discourages participation in plans even when the service is covered.[280]

The MEPS queries the head of household and does not include questions as to sexual orientation and gender identity. There may be opportunities to explore for LGBT data, however. While it is not possible to disaggregate the MEPS data, undoubtedly LGBT people were included in the MEPS survey and, if head of household, were asked questions regarding family members. Obviously, some men and women have had children in the context of heterosexual relationships that split up after one or both partners assumed lesbian or gay identities. (See Summary of LGBT Research.) A growing number of men and women have also had children after assuming lesbian or gay identities.[281]

Many organizations have developed or have changed to reflect the changing family structure. For example, the mission of the Family Pride Coalition is to advance the well-being of lesbian, gay, bisexual, and transgender parents and their families through mutual support, community collaboration, and public understanding. (More information about the Coalition and links to similar organizations is found online at www.familypride.org.) The alternative insemination program at Fenway Health Center has helped more than 200 families.[282] The diversity of different family systems is rapidly changing and should influence the design of survey instruments.

1-7: (Developmental) Increase the proportion of schools of medicine, schools of nursing, and other health professional training schools whose basic curriculum for health care providers includes the core competencies in health promotion and disease prevention.

Significant changes in the health care system and in the expectations of consumers are influencing the education of health care providers in the United States. For example, many medical schools are assessing the content of their predoctoral and postgraduate curricula.[283] Medical educators and medical schools are recognizing that physicians will need to be prepared to provide population-based preventive health care as well as high-quality medical care to their patients.[284] This challenge exists for other health professionals, including nurses, nurse practitioners, physician assistants, health educators, social workers, mental health and substance abuse providers, and other allied health personnel.

The most disturbing barriers that LGBT consumers and providers face in health care are the biases and discrimination in the health care system. In a 1999 study of second year medical students, 25 percent of them believed homosexuality to be "immoral and dangerous to the institution of the family."[285] Another survey of medical students found that 52 percent agreed that an openly homosexual candidate for residency programs was discriminated against.[286] A survey of physicians and medical students showed that 59 percent of respondents had suffered discrimination, harassment, or ostracism within the medical

profession because of their sexual orientation.[287] Another survey found that 32 percent of lesbian physicians experienced harassment on the job.[288]

Multicultural training is a common component in medical school curricula. One survey of family practice residencies found 86 percent of programs had some form of multi-cultural training.[289] Yet, multicultural training may not include sexual orientation or gender identity issues, even though there is evidence that health care students are much more uncomfortable with LGBT populations versus people of different races or ethnicities.[290] This discomfort or bias is likely to be further exacerbated when confronting a bisexual or transgender patient.[291] In a 1998 study of family medicine departments at medical schools, 50.6 percent offered no training on LGBT cultural competency or health issues in the full 4-year curriculum. Of those that did offer training, it averaged only 2.5 hours. Medical students themselves express a preference that cultural competency in this area be woven throughout the curricula.[292] A survey of LGBT medical students found that they are significantly more likely to "come out" or identify their sexual orientation when they have LGBT faculty, but people of color were less likely to know of supportive faculty, to "come out," or to know of support services.[293] Of all the students, 62 percent had been exposed to anti-LGBT comments.

National-level health professions societies have taken tentative steps to stand against discrimination in health care. Several have added organizational nondiscrimination statements in recent years, or encouraged providers to provide equal care to LGBT populations.[294, 295] In 1999, the American Medical Association adopted a resolution asking for one of the major medical school accreditation agencies to require nondiscrimination policies that include sexual orientation for all accredited schools. These national-level health professions societies need to be made aware that an antidiscrimination policy that does not include gender identity as well as sexual orientation will not protect the full LGBT population, and will likely leave unserved the group that experiences the highest level of discrimination.

While inroads are being made, the widespread tolerance of discrimination against LGBT people in general, and in the health care area in particular, serves to suppress opportunities for LGBT providers to "come out"—another major factor in the barriers to LGBT-competent care experienced by LGBT people.

Because the demand is high for nondiscriminatory and culturally competent health care, increasing the proportion of LGBT persons with a usual primary care provider can be accomplished by providing people with a cadre of health care providers trained in LGBT health needs. This can be accomplished through a multipronged approach:

Supporting current and developing LGBT health centers

Placing emphasis on educating and urging LGBT people to enter the health professions

Developing an advanced training program for health professionals interested in developing a specialty in LGBT health

Certifying current providers as competent in LGBT care (especially telemedicine health care providers)

A core set of competencies for medical students in health promotion and disease prevention was developed by a task force established by the Association of Teachers of Preventive Medicine (ATPM) and HRSA. The competencies, derived from the ATPM Inventory of Knowledge and Skills Relating to Health Promotion and Disease Prevention,[296] cover four categories—clinical prevention, quantitative skills, health services organization and delivery, and community dimensions of medical practice. This set of competencies will provide medical educators with measurable education outcomes in prevention education. The core competencies will be evaluated for potential adaptability to health provider education curricula in schools of nursing and other health professions schools. The core competencies also will be reviewed for potential expansion to cover emerging issues such as LGBT health concerns. Because health care providers will have to address new health issues, policies, technologies, and practice guidelines over their careers, continuing education programs also need to be updated periodically.

1-8: In the health professions, allied and associated health profession fields, and the nursing field, increase the proportion of all degrees awarded to members of underrepresented racial and ethnic groups.

Certain racial and ethnic groups and low income communities lag behind the overall U.S. population on virtually all health status indicators, including life expectancy and infant death. Furthermore, access to health care is a problem, and these groups often lack a specific source of care. Increasing the number of health professionals from certain racial and ethnic groups is viewed as an integral part of the solution to improving access to care.[297] This same strategy can apply to LGBT populations, as they, too, are minority populations, and, particularly, underrepresented racial and ethnic groups who are LGBT.

Members of underrepresented racial or ethnic groups make up about 25 percent of the U.S. population. Their representation among health professionals, however, is in the range of 10 percent. Several studies have shown that minority health professionals are more likely to serve areas with high proportions of underrepresented racial and ethnic groups and to practice in or near designated health care shortage areas.[298, 299]

Despite considerable efforts to increase the number of representatives of racial or ethnic groups in health profession schools (medicine, dentistry, nursing, pharmacy, and allied and associated health professions), the percentage of such entrants, enrollees, and graduates has not advanced significantly, and in some cases has not advanced at all since 1990. The targets set for the Healthy People 2000 objective for enrollment and graduation were not achieved across all population groups, and achieving the revised targets by 2010 presents a significant challenge. In addition to the federally-funded programs in place, additional attention is needed to such efforts as providing financial assistance for students from underrepresented racial and ethnic groups to pursue health care degrees, encouraging mentor relationships, promoting the early recruiting of students from racial and ethnic groups before they graduate from high school, and increasing the number of racial and ethnic group faculty and administrative staff members in schools that train health care professionals. Other suggested approaches to improving culturally appropriate care for

ethnic and minority populations include increasing cultural competency among all health workers and increasing the number of lay health workers from underrepresented racial and ethnic groups.[300]

Data sources for this objective as written in Healthy People 2010 are:

Survey of Predoctoral Dental Educational Institutions, American Dental Association

Profile of Pharmacy Students, American Association of Colleges of Pharmacy

AAMC Data Book: Statistical Information Related to Medical Schools and Teaching Hospitals, Association of American Medical Colleges

Annual Data Report, American Association of Schools of Public Health

Annual Survey of RN (Registered Nurse) Programs, National League for Nursing, Center for Research in Nursing Education and Community Health[301]

1-9: Reduce hospitalization rates for three ambulatory care sensitive conditions—pediatric asthma, uncontrolled diabetes, and immunization-preventable pneumonia and influenza in older adults.

The three indicators selected here represent common problems encountered in primary care and allow monitoring of hospitalization rates for children (asthma), working-age adults (diabetes), and elderly persons (pneumonia and influenza). If data on sexual orientation and gender identity were collected as part of the Healthcare and Utilization Project (HCUP) of AHRQ, then these indicators would serve as a measure of the utilization of primary care throughout the lifespan of LGBT people as well.

For each of these conditions, interventions can reduce hospitalization rates. Advances in the management of asthma have reduced its adverse health effects. Primary care can prevent both acute problems and long-term consequences of diabetes. Illness and death from preventable pneumonia and influenza among elderly persons can be avoided through the use of pneumococcal and influenza vaccines. These three conditions have been chosen because coordination of community preventive services, public health interventions, clinical preventive services, and primary care can reduce levels of these illnesses. To be effective, these services must be culturally competent and linguistically appropriate.[302]

This objective can be achieved by targeting high-risk populations. Because multiple factors besides access and quality contribute to the admission rates for ambulatory-care-sensitive conditions, each State will need to examine its rates and

In 1995, Tyra Hunter was injured in an automobile accident. When first-responding EMT personnel discovered she had male genitalia, they stopped treating her and stood back, making derogatory comments. She died later that night. Her mother later won a $1.75 million lawsuit against the District of Columbia Fire Department with provisions that they institute a diversity and sensitivity training program for all personnel.

interpret them in the context of its population, health system, and community characteristics and will need to implement corresponding strategies. The objective is to improve primary care and preventive services and thereby reduce the need for hospital admission and the extended illness and costs associated with hospitalization.[303, 304, 305, 306]

It should be noted that persons who are privately insured have admission rates that are half those of the national average, indicating what is potentially achievable. Because of data limitations and potential access barriers to hospital admission among the uninsured, the Medicaid rate is artificially high and the uninsured rate is artificially low. (See Tracking Healthy People 2010 for more information.) Data by race are not included because these data are reported at the State level. State-level hospital discharge databases can provide accurate estimates of racial and ethnic disparities in hospital admission rates at the State level. There are substantial disparities in hospital admission rates for pediatric asthma and uncontrolled diabetes by race and ethnicity. The magnitude of this disparity also fluctuates by State, suggesting that access to care and quality of services may play a role. Specifically, among seven States for which rates were determined, the age- and gender-adjusted relative risk of hospitalization for pediatric asthma ranged from 2.3 to 5.8 for African Americans and 1.3 to 2.6 for Hispanics compared to non-Hispanic Whites. For uncontrolled diabetes, the relative risk of hospitalization ranged from 3.0 to 4.4 for African Americans and 1.2 to 2.0 for Latinos compared to non-Hispanic Whites.[307] AHRQ is developing a "minority national inpatient sample" as part of HCUP that will provide national estimates of disparities in avoidable hospitalization rates by race and ethnicity.

HCUP is based on data collected by individual States and provided to AHRQ by the States. HCUP would not exist without State data collection projects. HCUP databases contain patient-level information compiled in a uniform format with privacy protections in place. The Nationwide Inpatient Sample (NIS) includes inpatient data from a national sample of over 1,000 hospitals. The State Inpatient Databases (SID) cover inpatient care in community hospitals in 22 States that represent more than half of all U.S. hospital discharges. The State Ambulatory Surgery Databases (SASD), the project's newest restricted access public release, contain data from ambulatory care encounters in nine States.

HCUP's objectives are to: (1) obtain data from statewide information sources; (2) design and develop multi-State health care databases for health services research and health policy analysis; and (3) make these data available to a broad set of public and private users. The uniform data in HCUP make possible comparative studies of health care services and the use and cost of these services, including:

The effects of market forces on hospitals and ambulatory care

The care provided

Variations in medical practice

The effectiveness of medical technology and treatments

More information on HCUP can be found online at www.ahrq.gov/data/hcup.

Emergency Services

1-10: (Developmental) Reduce the proportion of persons who delay or have difficulty in getting emergency medical care.

Emergency services are a vital part of access to health care in the United States. All population groups, regardless of their socioeconomic, health, or insurance status, want to know that emergency services will be available and will function quickly and effectively when needed.[308] This broadly shared social expectation was reinforced by landmark Federal legislation, the Emergency Medical Treatment and Active Labor Act (EMTALA) of 1986. EMTALA stipulates that anyone seeking care at a hospital ED must receive a medical screening examination for an emergency medical condition and appropriate stabilizing measures.[309]

For many people, however, a variety of barriers continue to block access to emergency departments when the need for emergency medical care arises.[310] Among these barriers are psychological and cultural factors that may keep some people, even if insured, from seeking care promptly; financial constraints that may inhibit some people, even if insured, from seeking care promptly; and shortcomings in the number, location, or capability of EDs in a specified geographic area.

A significant component of this objective is to reduce the proportion of people whose access to emergency services is blocked by their health insurance coverage or payment policies. These policies affect access to hospital emergency departments and, in some instances, use of prehospital emergency services.[311] Typically, these policies stipulate that unless an enrollee's condition is life threatening, the enrollee or the ED must obtain authorization before an ED visit, or risk that a claim for services will be denied if it is deemed by the insurance company that the services were medically unnecessary. The rationale for these coverage and payment policies is clear: to manage care and contain costs. These policies, however, discourage some enrollees from receiving emergency treatment when it is warranted.[312]

Concerns about access barriers have prompted Federal, State, and organizational groups to seek assurances that health coverage or payment policies will provide payment when people go to an ED with acute symptoms of sufficient severity—including severe pain—such that a prudent layperson could reasonably expect that the lack of medical attention could result in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

This objective includes emergency medical care received in the emergency department of a hospital as well as emergency medical care in the field. When people are severely injured or believe they are in need of emergency care, they become physically and psychologically vulnerable. LGBT people may delay or have difficulty in getting needed emergency medical care due to previous negative experiences with emergency medical personnel who may be biased against gays, lesbians, or transgender individuals. Reports of other LGBT people who have had negative experiences with emergency medical personnel affect the attitudes of the entire LGBT community. These negative experiences greatly diminish the probability that LGBT individuals, particularly transgender people, will seek out emergency medical care and risk putting themselves in the hands of one or more health professionals with biases. Emergency medical personnel routinely should receive training in cultural competency and LGBT health needs, and their training enhanced by updates providing the most current clinical information.

1-11: (Developmental) Increase the proportion of persons who have access to rapidly responding prehospital emergency medical services.

The outcome of many medical emergencies depends on the prompt availability of appropriately trained and properly equipped prehospital emergency medical care providers. In urban areas, this capability is defined by an interval of less than 5 minutes from the time an emergency call is placed to arrival on the scene for at least 90 percent of first-responder emergency medical services and less than 8 minutes for at least 90 percent of transporting EMS. In rural areas, this capability is defined as an interval of less than 10 minutes from the time an emergency call is placed to arrival on the scene for at least 80 percent of EMS responses.

Assuring a prompt response requires a well-coordinated system of care involving a variety of organizations and agencies, some of which are outside the traditional health care arena. The components include public awareness of how and whom to call for emergency assistance and public education concerning initial lifesaving emergency care procedures to be followed until the arrival of EMS providers. They also include access via a 911 or enhanced 911 system or, in rural areas, a uniform addressing system that allows emergency responders to locate the person requesting emergency assistance quickly; the availability of well-trained and appropriately certified response personnel, who are frequently from law enforcement or fire services; transportation (ground, air, or water ambulance); medical direction and oversight; and destination hospitals that are well-equipped and appropriately staffed.

Emergency medical services, as a profession, is now barely a generation old.[313] Effective components of quality EMS education have emerged during the last 30 years, including national standard EMS curricula, accreditation standards, and a national registration system. However, these parts developed independently, and currently there is no formal EMS education *system* in which the components are clearly defined, the interrelationships articulated, and the decisionmaking prcoess for changes and improvement established.[314] The National Highway Traffic and Safety Administration (NHTSA) of the Department of Transportation (DOT), in concert with HRSA and other Federal agencies, will continue to

be the Federal departments and agencies responsible for coordinating the EMS education system. The hope is that by 2010 the following components will exist:

National EMS Core Content

National EMS Scope of Practice Model

National EMS Education Standards

National EMS Education Program Accreditation

National EMS Certification

As this is an evolutionary process, it is hoped that the needs and concerns of LGBT people related to receiving appropriate care by EMS personnel can be addressed and LGBT EMS providers can be part of the work force.

In 1983, Sharon Kowalski was hit by a drunk driver. Her injuries left her a quadriplegic. After caring for Sharon as a quadriplegic for years, her lover, Karen Thompson, lost custody to Sharon's biological family and was barred from seeing Sharon for six years. Many LGBT couples still do not have the legal protections that would guard against this possibility.

1-12: Establish a single toll-free telephone number for access to poison control centers on a 24-hour basis throughout the United States.

Poison control centers (PCCs) are staffed on a 24-hour basis by toxicologists and specialists in poison information who respond to requests from the general public and to health care professionals for immediate information and treatment advice about poisonings and toxic exposures. Local or toll-free telephone calls to PCC hotline numbers provide primary access to these services. Each year more than 2 million callers seek telephone assistance from PCCs throughout the United States.[315] When a caller reports a poisoning or toxic exposure, a PCC toxicologist or specialist in poison information assesses the severity of the incident, advises the caller about treatment, and makes referrals for further medical attention when necessary. PCCs respond to inquiries in languages other than English by using language translation services, interpreters, or bilingual staff members. PCCs manage most incidents by providing telephone advice to a caregiver at home, avoiding the need for more costly care at a hospital emergency department or another health care facility.

Previously, there were hundreds of PCCs in the United States; currently, there are 70, accessed by 115 different emergency numbers, and 16 different TTY/TTD numbers.[316] In the past few years, at least three PCCS have closed due to a lack of funding, and in 2000, seven States received a total of $1.2 million in emergency funding to stabilize centers at risk of closing or severely disrupt services. This crisis in PCCs prompted the 106th Congress to pass the Poison Control Center Enhancement and Awareness Act (P. L. 106-174, February 25, 2000).

A total of $20 million was appropriated for Fiscal Year 2001 to support this legislation. The Act is intended to provide assistance for PCCs and establish a nationwide toll-free phone

number to access poison control centers. In addition, the law states that the Secretary of Health and Human Services shall:

> Establish a national media campaign to educate the public and health care providers about poision prevention and the availability of poison control resources in local communities, and conduct a media campaign promoting the nationwide toll-free number
>
> Establish a grant program to award grants to certified PCCs for the purposes of achieving financial stability of such centers, and for preventing and providing treatment recommendations for poisonings
>
> Expand education programs, develop standard patient management protocols for commonly encountered toxic exposures, improve the data collection systems, improve national toxic exposure surveillance, and expand physician/medical toxicologist supervision of PCCs.

Federal responsibility for the implementation of this legislation rests within the Injury/Emergency Medical Services Branch, Division of Child, Adolescent and Family Health, Maternal and Child Health Bureau (MCHB), HRSA.

Linking all PCCs in the United States through a single toll-free telephone number and consolidating several key PCC functions can make contacting PCCs easier and more cost-effective.[317, 318] When PCCs are linked through a common telephone number, callers can be routed automatically to the nearest PCC based on their area code, telephone exchange number, and ZIP Code. Educational efforts could focus on a single easy-to-remember emergency number that permits callers to access PCCs quickly. Incorporating all PCCs under the umbrella of a toll-free nationwide telephone number will help ensure access to poison control services when and where they are needed.

CDC's National Center for Injury Prevention and Control and HRSA have provided funding through a collaborative agreement with the American Association of Poison Control Centers (AAPCC) to establish a national toll-free poison control number. The new number, which will provide universal access to poison control services will link callers with their state and local poison control centers. The supporting telecommunications system will include contingency plans for disasters and network failures, and will expand call capacity and functionality over time. The AAPCC will develop, implement, and evaluate a national public-education campaign to raise awareness about the toll-free number and services provided by PCCs. The primary target audience for this campaign will be caregivers of children, including parents, grandparents, and childcare providers. Materials will also be developed to address the educational needs of potential teen and adult poisoning victims.

LGBT people are as vulnerable as non-LGBT individuals relative to poisonings. More than 90 percent of poisonings, as reported to PCCs, occur in the home with 53 percent of the poisoning victims being children younger than 6 years of age.[319] The expectation for this objective, as with most objectives, is that PCCs never be discriminatory in responding to

request for information and treatment advice from LGBT people and the targeted media campaigns be inclusive of LGBT populations and their diversity.

The data source for this objective is the AAPCC Survey, U.S. Poison Control Centers.

1-13: Increase the number of tribes, States, and the District of Columbia with trauma care systems that maximize survival and functional outcomes of trauma patients and help prevent injuries from occurring.

A trauma care system is an organized and coordinated effort in a defined geographic area to deliver the full spectrum of care to injured patients. The main goals of the system are to match the available trauma care resources in a community, region, or State with the needs of individual patients, and to ensure that patients have rapid access to the acute care facility and rehabilitation services they need. In a trauma care system, Prehospital, acute care, and rehabilitation services are integrated and administered by a public agency that provides leadership, coordinates service delivery, establishes minimum standards of care, designates trauma centers (which offer 24-hour specialized treatment for the most severely injured patients), and fosters ongoing system evaluation and quality improvement.

Trauma care systems traditionally have focused on preventing adverse outcomes in the event of injury. Many trauma care professionals and people in the public health field believe that trauma care systems also should contribute to the prevention of injuries.[320, 321] Trauma care professionals are in a good position to provide leadership in injury surveillance, clinical preventive services, and community-wide injury prevention programs. Recent Federal initiatives in trauma care have resulted in the design of a model system that incorporates public information, education, and prevention of injuries as key features.[322]

The Charles McC. Mathias, Jr., National Study Center for Trauma and Emergency Medical Systems was designated by the United States Congress in 1986 to serve as a focal point for research related to trauma, emergency medicine, and emergency medical systems. Based at the University of Maryland School of Medicine, Study Center faculty and staff collaborate with clinicians and policymakers who share the goal of reducing preventable deaths and disabilities caused by injury and illness. Research on the following facets of trauma and emergency care is currently under way at the National Study Center:

Biomechanics of car crashes

Substance use/abuse and injury

Prehospital emergency care

Trauma care systems and disaster management

Trauma/EMS informatics, including telemedicine

Injury prevention

Rehabilitation

The National Study Center's expertise includes study design, epidemiology, systems analysis, statistical analysis, and professional publication. The Study Center also sponsors educational forums for clinicians and other investigators. Faculty from the Program in Trauma and Emergency Medicine collaborate on many Study Center initiatives. (More information on the National Study Center can be found online at www.umm.edu/shocktrauma/trauma_nsc.html.)

CDC (65 FR 31001-31003) announced the availability of funds in Fiscal Year 2000 for a grant to develop a National Trauma Information and Exchange Program (TIEP). The purpose of TIEP is to make data and information on trauma care in the United States more accessible to a broad spectrum of individuals and organizations, including trauma care professionals and professional associations, trauma centers and other acute care hospitals, trauma care systems, emergency medical services systems, injury researchers and research organizations, public health agencies, health care payers, and the general public. In an ongoing funding initiative to support injury prevention goals supported by the Coalition for American Trauma Care and a broad cross section of acute care and public health groups in Healthy People 2010, CDC announced a series of grants for Fiscal Year 2001 in injury prevention and control which include evaluating the availability and effectiveness of trauma systems of care in the United States.

Results of a national survey conducted in 1993 indicated that only 5 States had complete trauma systems, but 19 other States and the District of Columbia had at least some trauma system components in place.[323] A survey of all 50 States and the District of Columbia in 1998 again indicated that only 5 States satisfied all trauma care system criteria.[324] However, results from this survey also showed that 37 other States and the District of Columbia had at least some trauma system components in place.

Being transported to a trauma care system is an ordeal not only for the victim but also for family and friends. Sometimes, the experience is much more disturbing for the family and friends as the victim is often unconscious or in shock. The thought of this experience is obviously of particular concern for many LGBT people because it is a time when they know they may have little control over the situation and be subjugated to the rules and policies of the trauma center and the staff. Time is of the essence and life or death decisions must be made without delay. Some institutional policies restrict decisionmaking to the biological or legally defined family, often to the detriment of an LGBT partner or parent. Some of these unfortunate situations might be rectified by couples having already prepared medical durable Powers of Attorney or Health Proxies. In addition, trauma care center staff need information about LGBT relationships and families. Trauma staff recognize that the physical presence of a significant other improves health outcomes; however, as for many mainstream providers, "significant other" needs to be identified.

The data sources for this objective are the State EMS Directors Survey, National Association of State EMS Directors and the Indian Health Service. (Tribal data are developmental.)

Long Term Care and Rehabilitative Services

1-15. (Developmental) Increase the proportion of persons with long-term care needs who have access to the continuum of long-term care services.

The long-term care population needs access to a range of services, including nursing home care, home health care, adult day care, assisted living, and hospice care.[325] Persons with long-term care needs require the help of other persons to perform activities of daily living (personal care activities) and instrumental activities of daily living (routine needs). Access problems are viewed as a need for specified long-term care services that were not received in the past 12 months.

In the context of objective 1-15, the continuum of care includes nursing home care, home health care, adult day care, assisted living, and hospice care. Long-term care needs are defined as needing the help of another person with personal care such as eating, bathing, dressing, and getting around in the home or needing the help of other persons with routine needs such as everyday chores, doing necessary business, shopping, or getting around for other purposes. Persons without access to the continuum of long-term care services are those with long-term care needs who report needing long-term care services but not receiving them in the past 12 months.

Long-term care also crosses the boundaries of different types of care—from health to social—and intensity of services—from periodic home health and homemaker visits to round-the-clock subacute care. Access to the full range of long-term care services continues to be a problem because of financial barriers and the limited availability of specific services.[326, 327] Although people in the long-term care population and their caregivers prefer long-term care to be delivered in the least restrictive environment, limited access and limited knowledge about care options can result in a long-term care population that is more dependent than necessary. The long-term care services selected cover key services in institutions, in the home, and in the community. Obtaining access to this range of services in rural areas is often difficult.

The Policy Institute of the National Gay and Lesbian Task Force Foundation (NGLTF) estimate that 1 to 3 million people in the United States over 65 are LGBT, based on a range of 3 to 8 percent of the population.[328] This is most probably an undercount as there are no national data available on transgender people who can exhibit the full range of sexual orientations, from homosexual to bisexual and heterosexual.[329] LGBT people are distributed along the income scale in the same proportions to heterosexuals.[330] Little is known about the racial and class diversity of the LGBT community but the Voter's News Service's gay, lesbian, and bisexual sample is racially representative of the larger population.[331] Like the

rest of the overall elder population, so, too, the LGBT elders will increase significantly in the next two decades.[332]

Most seniors turn to members of their families of origin for assistance and support in coping with the aging process. However, according to the limited data existing on gay and lesbian seniors, gay elders are more likely to live alone—75 percent in one study and 65 percent in another.[333, 334]

Aging LGBT people appear to lack access to a personal caregiver should they urgently need one. This was indicated in a 1999 survey conducted at a gay and lesbian health fair in New York City by Pride Senior Network. Some 64 percent of respondents aged 50 years and younger indicated that, if they needed a caregiver immediately, they would have someone upon whom to rely. By contrast, 68 percent of those aged 51 or older could not identify such a person.[335]

Nursing homes, assisted living centers, congregate housing, and home health care services need to take proactive steps to minimize the potential abuse and neglect of LGBT elders.[336] All providers of caregiving services and housing to elders and their staff need culturally competency training in issues of sexuality and gender identity. Nursing homes in particular should include detailed sexuality policies as part of residents' rights policies. Such policies validate the natural and healthy sexual needs of all seniors and remove devastating judgments regarding sexuality from individual staff.[337] Transgender individuals face particular concerns of sensitivity and safety in such living environments. Transgender people with gender-congruent bodies may be closeted, while transgender people with noncongruent bodies are at risk for psychological and physical abuse at the hands of caregivers or other residents.[338]

As long as homophobia and transphobia persist in health and aging services, providing more choices, particularly LGBT-competent choices, for elders is critical. Like their heterosexual counterparts, most LGBT elders would probably prefer to live in familiar surroundings. Thus, the passage of the Medicaid Community Attendant Services and Supports Act (MCASSA) would enable elders to either remain at home and receive home care services or move from institutional care to a home setting. It is essential that home care workers also must be culturally sensitive to the health care needs of LGBT elders.[339]

Proposed national data sources for objectives 1-15 are the National Long-Term Care Survey, Medicare Current Beneficiary Survey, HCFA; National Health Interview Survey (NHIS), CDC, NCHS; or the Medical Expenditure Panel Survey (MEPS), AHRQ (formerly AHCPR).

Services—RECOMMENDATIONS

Private and public sector health care systems should create receptive environments for LGBT health care consumers. For example, health care forms should be inclusive rather than exclusive.

The 1,200 school-based health care centers located in 45 States and the District of Columbia should offer targeted preventive interventions for LGBT and questioning youth.

The National Coalition of LGBT Health and other interested organizations can create a "Health Care Report Card for LGBT Consumers."

A national resource list of health plans, agencies, and professionals that are LGBT competent should be made available through the Internet.

DHHS, in partnership with the health sector should collaborate on a web site that addresses LGBT health issues, including such information as LGBT health consumer rights and responsibilities, self-care, promotion of culturally appropriate standards of care for LGBT people, and a compendium of LGBT health information for professionals.

DHHS, in partnership with professional organizations and other health care agencies already concerned with cultural competency in health care, should fund the expansion and evaluation of existing programs to promote sensitivity among health care providers to serve LGBT populations. The Gay, Lesbian, Bisexual and Transgender Health Access Training Project is ongoing in Massachusetts and the Removing the Barriers to Accessing Health Care for Lesbians was developed through funding from CDC's Division of Cancer Prevention and Control to the Mautner Project for Lesbians with Cancer in Washington, D.C.

Appropriate social service agencies should include LGBT-sensitive support for informal family caregivers, including same-sex partners and close friends.

Education and Training—RECOMMENDATIONS

Cultural competency training, specific to LGBT populations, should be a standard component of all health professional training curricula and made available to the health care workforce through continuing education institutes or other appropriate mechanisms.

Models for training health care providers in LGBT-sensitive care should be collected in a database applicable to key stakeholders.

Medical Boards and other groups that license or certify health care professionals should ensure that their examinations include questions on LGBT health care.

Academic departments of health should encourage, if not require, an internship or a rotation at a community center or health center that serves LGBT people.

Home care agencies should be trained to be culturally sensitive and respectful of the cultural differences among all elders, including LGBT.

Policy—RECOMMENDATIONS

All health care accreditation organizations should specifically include language within their policies regarding access to health care services for LGBT populations.

All Federal and other publicly funded health programs, including Medicare, should specifically have nondiscriminatory language related to sexual orientation and gender identity.

DHHS, in partnership with organizations such as the American Association of Health Care Plans, the American Medical Association, the National Assembly of School-based Health Care, the American Public Health Association, National Association of State Medicaid Directors, and the National Association of Community Health Centers, should convene a task force of experts to discuss health care access for LGBT populations and issue recommended standards of care for adoption by appropriate health care programs.

Confidentiality for LGBT people is critical and confidentiality guidelines and assurances must not only be communicated but also incorporated into all health care record keeping.

Hospitals, nursing homes, assisted living facilities and any other health care facility should adopt policies that ensure that the families of LGBT people are treated as are the family members of heterosexual patients and residents.

Medicaid spend-down protections, which provide income and asset protections to the husband or wife of a nursing home resident, should be expanded to cover the life partners of LGBT people who enter nursing homes.

Research—RECOMMENDATIONS

Government and/or private funding should be directed to determining the barriers to access for LGBT populations as a whole as well as its component parts, including crosscutting variables such as race, age, ethnicity, and disability.

Health care economists should be encouraged to develop an algorithm for determining the costs-benefits associated with sexual reassignment surgery and/or hormones so that health care insurers can make informed decisions.

Health care researchers should be encouraged by public and private funders to identify LGBT individuals, if appropriate, within all studies relating to health care access.

Government and/or private funding should be used to investigate the impact of domestic partnership policies on insurance coverage for LGBT populations.

Research is critical in determining not only the causes of but also the resolutions to homophobia within the health care system.

Data are needed to compare hospitalization rates for three ambulatory-care-sensitive conditions—pediatric asthma, uncontrolled diabetes and immunization-preventable pneumonia and influenza for LGBT adolescents, adults, and elders, respectively, with the total population.

Terminology

Access: According to the Institute of Medicine, "The timely use of personal health services to achieve the best possible health outcomes."[340] This definition includes both the use and effectiveness of health services. The concept of access also encompasses physical accessibility of facilities.

Activities of daily living (ADL): Personal care activities, such as bathing, dressing, eating, and getting around (with special equipment, if needed) inside the home.

Ambulatory care: Health care that does not require the patient to stay in a hospital or other facility, such as care provided on an outpatient basis.

Asymptomatic: Without symptoms. This term may apply either to healthy persons or to persons with preclinical (prior to clinical diagnosis) disease in whom symptoms are not yet apparent.

Clinical care: The provision of health care services to individual patients by trained health care professionals.

Clinical preventive services (CPS): Common screening tests, immunizations, risk assessment, counseling about health risk behaviors, and other preventive services routinely delivered in the clinical setting for the primary prevention of disease or for the early detection of disease in persons with no symptoms of illness.

Consumerism: The movement seeking to protect the rights of consumers by requiring such practices as honest packaging, labeling, and advertising, fair pricing, and improved safety standards.

Continuum of care: The array of health services and care settings that address health promotion, disease prevention, and the diagnosis, treatment, management, and rehabilitation of disease, injury, and disability. Included are primary care and specialized clinical services provided in community and primary care settings, hospitals, trauma centers, and rehabilitation and long-term care facilities.

Core competencies: A defined set of skills and knowledge considered necessary in the educational curricula for training health care providers. Examples of core competencies include skills in prevention education; skills in using sources of health data to identify what clinical preventive services should be delivered to the individual patient based on that

person's age, gender, and risk factor status; an understanding of the U.S. public health system (local and State health departments) and its role in monitoring and maintaining the health of the community; and skills to evaluate and translate medical and scientific research reports into clinical practice.

Emergency services: Health care services that are or appear to be needed immediately because of injury or sudden illness that threatens serious impairment of any bodily function or serious dysfunction of any bodily part or organ.[341]

Health insurance: Any type of third party payment, reimbursement, or financial coverage for an agreed-upon set of health care services. Includes private insurance obtained through employment or purchased directly by the consumer, or health insurance provided through publicly funded programs, including Medicare, Medicaid, CHAMPUS/CHAMPVA, or other public hospital or physician programs.

Health outcomes: The results or consequences of a process of care. Health outcomes may include satisfaction with care as well as the use of health care resources. Included are clinical outcomes, such as changes in health status and changes in the length and quality of life as a result of detecting or treating disease.

Instrumental activities for daily living: Routine activities, such as everyday household chores, shopping, or getting around for other purposes, that enable a person to live independently in the community.

Intervention: Any measure taken to improve or promote health or to prevent, diagnose, treat, or manage disease, injury, or disability.

Long-term care (LTC): A broad range of health and social services delivered in institutions, in the community, and at home. Long-term care services include institutional services, such as those delivered in nursing homes, rehabilitation hospitals, subacute care facilities, hospice facilities, and assisted living facilities; services delivered in the home, such as home health and personal care, hospice, homemaker, and meals; and community-based services, such as adult day care, social services, congregate meals, transportation and escort services, legal protective services, and counseling for clients as well as their caregivers.[342]

Managed care: According to the Institute of Medicine, "a set of techniques used by or on behalf of purchasers of health care benefits to manage health care costs by influencing patient care decisionmaking through case-by-case assessments of the appropriateness of care prior to its provision." [343]

Patient barriers: Any mental, physical, or psychosocial condition that prevents an individual from accessing needed health care. Examples include attitudes or biases, mental disorders or illnesses, behavioral disorders, physical limitations, cultural or linguistic factors, sexual orientation, and financial constraints.

Persons with long-term care needs: Persons who need the help of other persons to perform activities of daily living (personal care activities) and instrumental activities of daily living (routine needs).

Primary care: According to the Institute of Medicine, "The provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community."[344]

Primary care provider: A physician who specializes in general and family practice, general internal medicine, or general pediatrics, or a nonphysician health care provider, such as a nurse practitioner, physician assistant, or certified nurse midwife.

Primary prevention: Health care services, medical tests, counseling, and health education and other actions designed to prevent the onset of a targeted condition. Routine immunization of healthy individuals is an example of primary prevention.[345]

Provider barriers: Any mental, physical, psychosocial, or environmental condition that prevents or discourages health care providers from offering preventive services. Examples of provider barriers include a poor practice environment, lack of knowledge, and lack of efficacy studies.

Quality: According to the Institute of Medicine, "The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."[346] Simply stated, it is doing the right thing, for the right patient, at the right time, with the right outcome.

Rehabilitative services: Services to restore specific skills, including overall physical mobility and functional abilities.

Secondary prevention: Measures such as health care services designed to identify or treat individuals who have a disease or risk factors for a disease but who are not yet experiencing symptoms of the disease. Pap tests and high blood pressure screening are examples of secondary prevention.[347]

System barriers: Conditions within a health care system that prevent people from accessing needed services or prevent health care providers from delivering those services. System barriers include physical, cultural, linguistic, and financial barriers as well as the availability of health care facilities or providers with special skills, such as eye, ear, nose, and throat specialists.

Tertiary prevention: Preventive health care measures or services that are part of the treatment and management of persons with clinical illnesses. Examples of tertiary prevention include cholesterol reduction in patients with coronary heart disease and insulin therapy to prevent complications of diabetes.[348]

Usual source of care: A particular doctor's office, clinic, health center, or other health care facility to which an individual usually would go to obtain health care services. Having a usual source of care is associated with improved access to preventive services and followup care.

Vulnerable and at-risk populations: High-risk groups of people who have multiple health and social needs. Examples include pregnant women, people with human immunodeficiency virus infection, substance abusers, migrant farm workers, homeless people, poor people, infants and children, elderly people, people with disabilities, people with mental illness or mental health problems or disorders, and people from certain ethnic or racial groups who do not have the same access to quality health care services as other populations.

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Cancer

Healthy People 2010 Goal

Reduce the number of new cancer cases as well as the illness, disability, and death caused by cancer.

Overview

Cancer is a serious health issue for many people, including lesbian, gay, bisexual, and transgender (LGBT) persons. Research suggests that LGBT people may be disproportionately affected by some types of cancers, including breast cancer, cancers related to acquired immunodeficiency syndrome (AIDS), lung cancer, and cancers caused by human papillomavirus (HPV). Data are needed on rates of these cancers in LGBT populations, with participants identified by sexual orientation and gender identity in population-based research efforts and data surveillance systems. Risk factors for these cancers are likely to vary by sexual orientation and gender identity status, and they need research attention. Heterosexism and homophobia in the health care system may make LGBT people less likely to receive needed prevention information and treatment. Therefore, research is needed to determine culturally appropriate methods of prevention- and treatment-oriented interventions for LGBT populations, so that targeted health education, care services, and planning policies can be implemented.

Issues and Trends

Cancer is the second leading cause of death in the United States. During the year 2000, an estimated 1,220,100 persons in the United States were expected to be diagnosed with cancer, and 552,200 persons were expected to die from cancer.[1] These estimates did not include most skin cancers, and new cases of skin cancer are estimated to exceed 1 million per year. One-half of new cases of cancer occur in people aged 65 and older.[2]

About 491,400 persons who get cancer in a given year, or 4 in 10 patients, are expected to be alive 5 years after diagnosis. When adjusted for normal life expectancy (accounting for factors such as dying of heart disease, injuries, and diseases of old age), a relative 5-year survival rate of 60 percent is seen for all cancers.[3] This rate means that the chance of a

person recently diagnosed with cancer being alive in 5 years is 60 percent of the chance of someone not diagnosed with cancer. Five-year relative survival rates commonly are used to monitor progress in the early detection and treatment of cancer and include persons who are living 5 years after diagnosis, whether in remission, disease-free, or under treatment. In addition to the human toll of cancer, the financial costs of cancer are substantial.[4]

Cancer prevention activities could reduce the burden of cancer if applied to the whole population and if health education and culturally competent prevention efforts are targeted toward subpopulations with an increased risk for certain types of cancers. Increasing evidence for screening and primary prevention efforts indicates several possibilities for prevention of breast, cervical, lung, and colorectal cancers.

Disparities

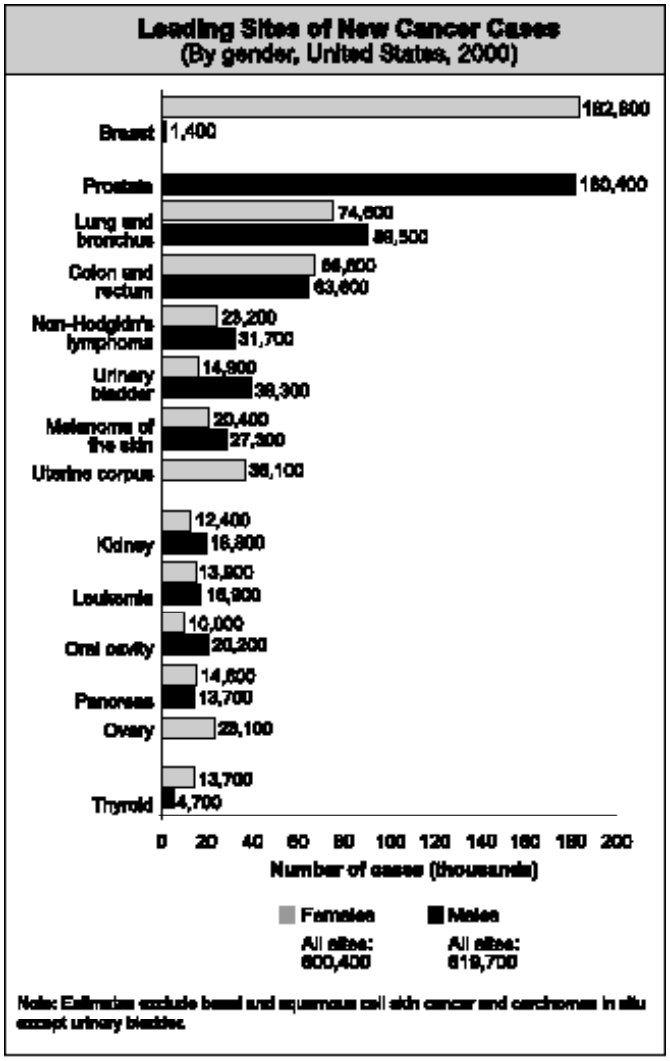
Cancer death rates vary by gender, race, and ethnicity.[5] The most relevant changes have been in lung cancer rates. Among males, lung cancer death rates have declined since 1990. In contrast, lung cancer death rates have continued to increase among females. Since 1987, more females have died from lung cancer than breast cancer.

African Americans are about 34 percent more likely to die of cancer than are whites and more than two times more likely to die of cancer than are Asians and Pacific Islanders, American Indians, and Hispanics.[6] African American women are more likely to die of breast and colon cancers than are women of any other racial and ethnic group. The recent decrease in deaths from breast cancer in White females is attributed to greater use of breast cancer screening in regular medical care. However, deaths due to breast cancer in African American females continue to increase, in part, because breast cancer is diagnosed at later stages in African American females.

African American men have the highest death rates of colon and rectal, lung, and prostate cancers. Age-adjusted lung cancer death rates are approximately 40 percent higher among African American males than White males. Little difference in age-adjusted lung cancer death rates has been observed between African American females and White females. Hispanics have higher rates of cervical, esophageal, gallbladder, and stomach cancers. New cases of female breast and lung cancers are increasing among Hispanics, who are diagnosed at later stages and have lower survival rates than Whites. Similarly, some specific forms of cancer affect other ethnic groups at rates higher than the national average (e.g., stomach and liver cancers among Asian American populations, colorectal cancer among Alaska Natives). Certain racial and ethnic groups have lower survival rates than Whites for most cancers.[7] These differences in cancers and risks among racial and ethnic groups represent both a challenge to understand the reasons and an opportunity to reduce illness and death so to improve survival rates.

Data on colorectal cancer show a decline in new cases and death rates in White males and females, stable new case rates in African Americans, and a continued rise in death rates in African American males. Five-year survival rates for the 1989–94 period are 64 percent in

Whites and 52 percent in African Americans.[8] Early detection and treatment play a key role in these survival rates.



Source: American Cancer Society. *Surveillance Research*, 2000.

Less is known about potential disparities in cancer rates among individuals of diverse sexual orientations, due primarily to the lack of collection of appropriate data in national registries and databases. Little is known about differential rates of cancer among women of diverse sexual orientations. Possible disparities regarding the health status of lesbians and possible barriers to access to health services by lesbians have been identified by the Institute of Medicine as a research priority.[9] The January 2001 newsletter of the Mary-Helen Mautner Project for Lesbians with Cancer points out that "each year 23,000 women are diagnosed with ovarian cancer, and 14,000 die from the disease, making it the deadliest of the gynecologic cancers and the fifth leading cause of cancer death among women."[10] Although there are common risk factors for ovarian cancer among all women (e.g., personal or family history of ovarian, breast, and colon cancer; increasing age), additional factors are suspected to increase the risk of ovarian cancer for lesbians. Among these are not bearing children, not using oral contraceptives, barriers to access of health care or lower utilization of the health care system, and, possibly, use of fertility drugs.[11] Because of the research on human immunodeficiency virus (HIV) and AIDS, much is known about rates of certain cancers (i.e., Kaposi's sarcoma, anal cancer, lymphoma) in gay men. Relevant data are summarized later.

Opportunities

Evidence suggests that several types of cancer can be prevented and that the prospects for surviving cancer continue to improve. The ability to reduce cancer death rates depends, in part, on the existence and application of various types of resources. First, the means to

provide culturally and linguistically appropriate information to the public and to health care providers on prevention, preventive clinical screens, early detection, and referral for treatment is essential. Second, mechanisms or systems must exist for providing people with access to state-of-the-art risk assessment, preventive services, and treatment. Where suitable, application for participation in clinical trials also should be encouraged. Third, a mechanism for maintaining continued research programs and for fostering new research is essential. Emerging information on genetic markers or environmental linkages that can be used to improve disease prevention strategies and healthy behavior counseling is emerging for many cancers and may provide the foundation for improved effectiveness in clinical care and preventive counseling services.

There is a continuing and vital need to foster new partnerships and innovative research on both the causes of cancer (including genetic and environmental causes) and on methods to translate biologic and epidemiologic findings into effective prevention and control programs for use by publicly funded programs and community organizations. This will provide new opportunities for cancer prevention and control in the future and further reduce many burdens associated with cancer. This need can be met, in part, with the network of cancer control resources now in place. This network has the organizational and personnel capacity for various cancer interventions. Despite the extent of these resources, they alone are insufficient to reduce deaths from cancer. Gaps exist in information dissemination, information on optimal practice patterns and clinical guidelines, research capabilities, and research underway in other countries. These gaps must be recognized and filled to meet cancer prevention and control needs.

It is estimated that 50 percent or more of cancer can be prevented through smoking cessation and improved dietary habits, such as reducing fat consumption and increasing fruit and vegetable consumption.[12, 13] Physical activity and weight control also can contribute to cancer prevention.[14, 15] These are all relevant to the LGBT community, due to potential differences in risk factor rates in this population as well as some behavioral characteristics of populations within the community (e.g., lesbians who tend to have a higher body mass than the general population of women, groups of men who have sex with men who glorify higher body weight and are known as “bears”).

Scientific data from randomized trials of cancer screening together with expert opinions indicate that adherence to screening recommendations for cancers of the breast, cervix, and colon/rectum reduces deaths from these cancers. To reduce breast cancer deaths in the United States, a high percentage of females aged 40 and older need to comply with screening recommendations. A reduction in breast cancer deaths could be expected to occur after a delay of roughly 7 years.[16] To reduce cervical cancer deaths, a high percentage of females in the United States aged 18 and older need to comply with screening recommendations. Evidence from randomized preventive trials is unavailable, but expert opinion suggests that a beneficial impact on cervical cancer death rates would be expected to occur after a delay of a few years.

Evidence shows that a reduction in colorectal cancer deaths can be achieved through detection and removal of precancerous polyps and treatment in the earliest stages of the disease. The findings from randomized, controlled trials indicate that biennial screening with fecal occult blood tests can reduce deaths from colorectal cancer by 15 to 21 percent in people aged 45 to 80.[17, 18, 19, 20, 21] The efficacy of sigmoidoscopy has been supported by three case-control studies that showed reductions of 59 to 79 percent in colorectal cancer deaths from cancers within reach of the sigmoidoscope in persons aged 45 and older.[22, 23, 24] In the past year, however, a preference appears to be emerging among some gastroenterologists for colonoscopy screening over sigmoidoscopy for screening individuals at higher risk for colorectal cancer and for preventive, baseline purposes among the unscreened total population over aged 50.

Prostate cancer prevention strategies are not available at this time. Race and age are the only clearly identified risk factors for prostate cancer. African Americans and older men are at higher risk. There is no scientific agreement on the benefits of screening for prostate cancer, and screening is not recommended in the general population or in high-risk groups because it is unclear, in certain cases, if screening and treatment do more harm than good.[25] Clinical trials currently are underway to assess the benefits and risks of screening and treatments, and additional research is needed to identify modifiable risk factors for prostate cancer.

Melanoma and other skin cancers were expected to claim the lives of nearly 9,600 persons in the year 2000.[26] Evidence is still being weighed on whether routine skin examinations (by self or physician) decrease deaths from melanoma or other skin cancers. However, many of the skin cancers diagnosed each year could be prevented by limiting exposure to the sun, wearing protective clothing, and using sunscreen.

For all cancers, treatments proven to increase survival are needed along with improved access to state-of-the-art screening and post-detection care. In addition to measurements of survival, indices of quality of life for both the short term and long term are important considerations.

Summary of LGBT Research

Preliminary data lend credence to the suggestion that gay men and lesbians are at increased risk for certain cancers, and that more research is needed to understand the natural history of the disease in lesbian, gay, bisexual, transgender, and transsexual (through gender surgical reassignment) populations.

Innovative studies in psychoneuroimmunology further suggest a direct association between psychological phenomena, reduced immunity, and tumor growth. Thus, gay men and lesbians who do not disclose their sexual orientation may be at increased risk for melanoma or other cancers due to psychogenic suppression of the immune response.[27]

Several investigators have hypothesized that lesbians are at higher risk for breast cancer than heterosexual women due to higher rates of risk factors, such as obesity, alcohol

consumption, nulliparity, and lower rates of breast cancer screening.[28, 29] Although definitive studies in this area have yet to be completed, data on prevalence of each of the risk factors confirm the plausibility of this hypothesis.[30, 31] Lesbians also receive less frequent gynecologic care than heterosexual women [32] and therefore might be at greater risk for mortality and morbidity from gynecological cancers, especially ovarian cancer. Both of these risks are likely compounded by the difficulties many lesbians experience in communicating with or receiving standard clinical care from physicians and health care systems. Little is known about prevalence and incidence of other cancers among lesbians, but more research is needed. Even less is known about cancer in transsexual persons, and research is needed to determine rates, risk factors, and screening needs.[33, 34]

Among gay men, high rates of Kaposi's sarcoma (KS) were some of the first described indicators of AIDS.[35] Estimated risk for KS among gay and bisexual men was thousands of times higher than in the general population prior to approval of highly active antiretroviral therapies.[36] This was a byproduct both of HIV's weakening of the immune system and of the sexually transmitted nature of the herpes virus now thought to cause the cancer.[37] The risk for AIDS-related non-Hodgkin's lymphoma is also elevated among gay men, although at lower magnitudes.[38] Between 1973 and 1987, non-Hodgkin's lymphoma incidence increased tenfold, and KS incidence increased more than five-thousandfold in single men aged 20 to 49 in San Francisco.[39] Although highly active antiretroviral therapies have significantly reduced KS rates,[40] non-Hodgkin's lymphoma remains among the AIDS-related malignancies that continue to occur at sharply higher rates among HIV-positive individuals. An increase in the incidence of Hodgkin's disease has also been observed, but its association with HIV/AIDS is equivocal, and the disease is not included in the AIDS case definition.[41]

A cohort design, using studies of records in New York and California cancer registries and the National Death Index, found gay and bisexual men to be at excess risk for anal cancer, non-Hodgkin's lymphoma, and Hodgkin's disease. These accounted for an increased risk for all cancers in this population. The authors found no difference in the incidence of cancers in any other site, including lip, oral cavity, and pharynx; digestive system and peritoneum; respiratory system; bone and connective tissues; skin; genital and urinary organs; bone marrow (multiple myeloma); blood and tissues (leukemia); or other and unspecified sites. Although the authors determined that the increase in risk for both non-Hodgkin's lymphoma and Hodgkin's disease was related to increased incidence of HIV/AIDS among gay men, they found the increased risk for anal cancer to be unrelated to HIV/AIDS.[42]

Research suggests that risk factors for the excess incidence of anal cancer among men who have sex with men includes an increase in human papillomavirus (HPV) and anal squamous intraepithelial lesions—both of which are putative anal cancer precursors.[43, 44, 45, 46] HPV has been found in both HIV-positive and HIV-negative men, but prevalence of infection is higher among HIV-positive men, with highest prevalence associated with the latest stages of HIV disease.[47, 48] In a study of HIV-positive and HIV-negative gay and bisexual men, a high prevalence of HPV was observed (93 percent and 61 percent, respectively)—most of the

HPV-16 subtype. Infection with multiple HPV types was found in 73 percent of HIV-positive and 23 percent of HIV-negative men.[49] Higher risk for HPV has been related to a history of receptive anal intercourse, rectal administration of recreational drugs,[50] and a higher number of lifetime sexual partners.[51] In addition to sexual behavior, smoking prevalence—which is sharply higher among gay men—increases the risk of anal cancer.[52]

Survival time among gay men with cancer may also be lower than the general population. One study found 5-year survival rates for non-Hodgkin's lymphoma (9.8 percent) and Hodgkin's disease (32.8 percent) was much shorter than the expected national rates (50.2 percent and 75.7 percent, respectively).[53] The shorter-than-expected survival rate is probably related to HIV/AIDS comorbidity. Additional reasons for the lower survival rate may include delay in detection and treatment, possibly related to barriers in accessing care or communication with health care providers. The disparity in survival rate "highlights the need for rapid identification of such patients, and more effective approaches to detection and treatment of malignancies."[54] The use of rectal Pap tests for detection of HPV infections has been suggested as one such intervention,[55] although further research needs to assess the association of HPV subtypes and anal cancer, and the efficacy of Pap tests in detection.

Difficulty in assessing sexual orientation in the general population may lead to bias in studies of any existing studies on LGBT participants and their risk for various cancers. Available studies typically use study respondents who live in urban areas and are highly sexually active—usually of midlife age. It is not known to what extent the results are applicable to less sexually active, older, or younger LGBT populations.

There are other negative impacts of homophobia and heterosexism. Because of the many barriers to health access outlined in this document, LGBT people may not receive adequate or optimally useful prevention information about cancer. For example, a health care provider may not be comfortable discussing sexuality with a patient, or the patient may fear disclosing information about sexual practices. In this situation, a gay man may not receive prevention education from his health care provider about the risk of anal cancer from HPV.

Discussion of Healthy People 2010 Objectives

Although the Cancer focus area objectives of Healthy People 2010 are for all people, the following section of this chapter identifies those Healthy People 2010 objectives seen as being of direct relevance to LGBT populations. The discussion of objectives 3-1, 3-2, 3-3, 3-4, 3-5, 3-7, and 3-8 has been collapsed into a single section.

3-1: Reduce the overall cancer death rate.

3-2: Reduce the lung cancer death rate.

3-3: Reduce the breast cancer death rate.

3-4: Reduce the death rate from cancer of the uterine cervix.

3-5: Reduce the colorectal cancer death rate.

3-7: Reduce the prostate cancer death rate.

3-8: Reduce the rate of melanoma cancer deaths.

Currently, no national-level, Federal health surveys incorporate sexual orientation or gender identity as a demographic or population variable in relevant data collection. It is commonly accepted that data collection on the health characteristics and health status of all smaller populations within the total population, particularly those with identified higher risk factors, could generate a wealth of new knowledge about additional health risks and health behaviors of racial, ethnic, and other populations. At this time, no national cancer registries collect data based on sexual orientation or gender identity, even though there is a need for data on the incidence and prevalence of various forms of cancer among LGBT individuals in the United States. Inclusion of sexual orientation measures in registries and large national surveys could answer many of the basic questions about potential disparities and point toward new research opportunities in addressing disparities in access to or the receipt of care or efficacy of preventive services. Likewise, to date, there has been no reporting or monitoring of non-AIDS cancer deaths among sexual minorities via national registries or large-scale epidemiological studies.

As has been discussed, there is sufficient evidence to suggest that gay, lesbian, and bisexual individuals may be at increased risk for various forms of cancer. AIDS-related cancer deaths appear to be higher in gay men, although recent reports indicate a reduction in such deaths due to current AIDS therapy.[56, 57] Rates of anal cancer are higher among gay men.[58] One study has found higher rates of breast cancer among lesbians,but because the cohort was small and the research methodology was not population-based, the reliability of these findings have been questioned. [59] Several recent studies have found higher risk of breast cancer among lesbians, using reasonable samples, but none have been truly population-based.[60] Some data exist on possible higher risk factors among lesbians for other cancers (e.g., tobacco use, weight status, low screening rates), but there are only limited population-based data. There is discussion that lesbians may be at increased risk for ovarian cancer as well.[61]

There has been very little research concerning cancer among transgender persons. One population-based study from the Netherlands suggests that overall cancer morbidity and mortality rates among transsexuals are comparable to those of the general population.[62] Nevertheless, transsexuals' exposure to hormone therapy over an extended period of time might be expected to increase the risk of certain hormone-related cancers. For example, estrogen is a risk factor for cancer of the breast, and there have been four case reports of breast cancer in male-to-female transsexuals treated with estrogens.[63, 64, 65] There have also been two case reports of ovarian cancer in female-to-male (FTM) transsexuals, and it has been suggested that testosterone therapy may be a risk factor for such cancers in FTM transsexuals.[66]

3-10: Increase the proportion of physicians and dentists who counsel their at-risk patients about tobacco use cessation, physical activity, and cancer screening.

There are no national data on the degree to which physicians and dentists recommend preventive measures or deliver clinical preventive screens for cancer among LGBT patients. However, there is a significant amount of data, cited in this document, to suggest that LGBT individuals have limited access to appropriate care, including culturally appropriate health education materials, cancer screening, and prevention counseling. There is also evidence that health care providers from a variety of disciplines are uncomfortable providing care to LGBT persons and therefore may not address LGBT-specific needs as well as general prevention strategies.

3-11: Increase the proportion of women who receive a Pap test.

There are no national data on Pap test rates among women of other sexual orientation or gender identity. Recent survey data suggest lower Pap test rates among sexual minority women.[67] However, little or no population-based data on lesbians, bisexual women, or male-to-female (MTF) transgender people are obtained through national-level surveys or studies.

Data indicate that sexual behaviors between women can result in HPV transmission.[68, 69] And there is some indication that lesbians and their providers may not perceive women who have sex with women as an at-risk group, contributing to a lack of Pap tests among sexual minority women. Cancer has been related to HPV infection. However, gay men, who are at higher risk for anal cancer, often do not receive preventive care, including Pap tests.

For MTF transgender individuals, the belief among many providers that they are still biologically male may interfere with preventive gynecological care. Also, tissue remaining after sex reassignment may still produce cancer cells. FTM transgender people who have cervixes remain at risk for cervical cancer and require regular Pap tests. However, there are no existing data on actual risk. Specific guidelines for recommended prevention efforts have not been developed, but the Harry Benjamin International Gender Dysphoria Association recommends that transgender persons be screened for malignancies "as are all other persons."[70] MTF transsexuals who have undergone vaginoplasty also may not be perceived as being at risk. However, persons who have undergone penile-inversion vaginoplasty with the penile gland retained as a neocervix should be offered neocervical Pap tests because of the risk of penile cancer in this group.[71]

3-12: Increase the proportion of adults who receive a colorectal cancer screening examination.

There are no national data on colorectal cancer screening rates among LGBT persons. Additional studies are needed to identify specific barriers that may inhibit early and appropriate screening among these groups.

3-13: Increase the proportion of women aged 40 and older who have received a mammogram within the preceding 2 years.

Although there are no national data on rates of mammography among lesbian and bisexual women and transgender populations, existing data indicate that a possible disparity by sexual minority status may exist. Access barriers may inhibit appropriate mammography screening, and specific interventions should be designed for both providers and patients. Breast and cervical health programs funded by the Centers for Disease Control and Prevention may serve as a potential model for replication in sexual minority communities, but no evaluation data on these programs have been published.

3-14: Increase the number of States that have a statewide population-based cancer registry that captures case information on at least 95 percent of the expected number of reportable cancers.

No statewide registries currently collect data using sexual orientation or gender identity as demographic variables. Such variables would generate a wealth of new knowledge on LGBT populations, and would lay the foundation for future LGBT-specific prevention subobjectives.

3-15: Increase the proportion of cancer survivors who are living 5 years or longer after diagnosis.

Although there are no data on long-term followup of sexual minority cancer survivors, it is reasonable to suggest that several barriers may affect the survivorship of LGBT populations. For example, a lack of community support, health care access barriers, and barriers in provider-patient communication may jeopardize the long-term survival of LGBT individuals diagnosed with cancer. Additional research is needed to verify that these are barriers for LGBT individuals and to design appropriate solutions that may increase longevity.

There are currently a wide variety of demonstration projects that provide services to lesbians in large urban areas living with cancer. These cancer projects provide services for survivors of cancer and other chronic diseases. There is no available research on the efficacy of these projects, but their continued wide use and availability speaks to the role that they fill in communities.

Services—RECOMMENDATIONS

- All public health clinics and providers should participate in cultural competence training about sexual minority status and its effect on health and the provision of health care and related services. Federal funding for other types of provider situations should be contingent on the completion of cultural competency training.
- LGBT-friendly and, where necessary, LGBT-specific services should be provided in all areas of cancer care, including prevention and health behavior change.

- Existing lesbian cancer projects should be reviewed for their appropriateness as models for care for all sexual minority people.

Education and Training—RECOMMENDATIONS

- Health professions organizations should address sexual orientation and gender identity concerns in continuing medical education courses, clinical guidelines, risk assessment, and screening policies.
- Culturally appropriate interventions specific to LGBT health needs should be developed and made available to LGBT health centers, to other providers, and within the community itself.
- Preventive services screening programs, both current and future, should explicitly promote access for people of other sexual orientation or gender identity.

Research—RECOMMENDATIONS

- Additional research is needed to better understand disparities in cancer rates among LGBT populations and the degree to which potential disparities are associated with the lack of culturally appropriate prevention information and barriers to effective provider-patient communication.
- Population-based studies are needed to increase knowledge of breast and other forms of cancer among lesbians and to confirm hypotheses that obesity, alcohol consumption, nulliparity, and lower rates of breast cancer screening are risk factors for lesbians.
- Research is needed on how to target and market health education and health promotion programs successfully to diverse segments of the LGBT community.

Terminology

Cancer: A term for diseases in which abnormal cells divide without control. Cancer cells can invade nearby tissue and can spread through the bloodstream and lymphatic system to other parts of the body.

Cancer screening: Checking for changes in tissue, cells, or fluids that may indicate the possibility of cancer when there are no symptoms.

Clinical trials: Research studies that evaluate the effectiveness of new treatment or disease prevention methods on patients.

Fecal occult blood test: A test to check for small amounts of hidden blood in stool.

Invasive cervical cancer: Cancer that has spread from the surface of the cervix to tissue deeper in the cervix or to other parts of the body.

Malignant (malignancies): Cancerous.

Mammogram: An x ray of the breast.

Melanoma: Cancer of the cells that produce pigment in the skin.

Pap (Papanicolaou) test: Microscopic examination of cells collected from the cervix. The Pap test is used to detect cancer, changes in the cervix that may lead to cancer, and noncancerous conditions, such as infection or inflammation.

Risk factor: Something that increases a person's chance of developing a disease.

Sigmoidoscopy: A procedure in which the physician or health care provider looks inside the rectum and the lower part of the colon (sigmoid colon) through a flexible lighted tube. During the procedure, the physician or health care provider may collect samples of tissues or cells for closer examination.

Stage: The size and extent of a cancer, including whether the disease has spread from the original site into surrounding tissue and other parts of the body.

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Educational and Community-Based Programs

Healthy People 2010 Goal

Increase the quality, availability, and effectiveness of educational and community-based programs designed to prevent disease and improve health and quality of life.

Overview

Educational and community-based programs have an important role in improving the health of the community and, particularly, in reaching people outside traditional health settings. Educational and community-based programs present exemplary opportunities for health promotion, health education, fostering health behaviors, and improving quality of life. Healthy People 2010 focuses on health promotion and health education programs in four basic settings: the school, the worksite, the health services setting, and the community overall. The Healthy People 2010 Educational and Community-Based Programs objectives focus on creating and seizing opportunities within the different settings to improve the health of the community and the quality of life for all residents.

Within all living, learning, and working environments, people experience conflict and stress throughout their lives. A certain amount of conflict and stress is viewed as normal and is a natural part of the learning, growth, and maturation processes. There are types of conflict and stress, however, that are highly unpleasant experiences with lasting, negative effects. Conflict may arise between people for many different reasons, but often is due to different beliefs, values, and needs. So, too, people have different responses to negative conflict and stress, such as avoidance, internalization, and confrontation. Unfortunately, our schools and communities have become potential sites for confrontational violence. Lesbian, gay, bisexual, and transgender (LGBT) students, children of LGBT individuals, and students who are perceived as not being heterosexual often are targets of verbal harassment and, sometimes, physical confrontation. One thing on which all community leadership, students, parents, guardians, and school personnel agree is that schools and other educational facilities must be safe. To this end, communities and school settings have an important role in educating people,

especially children, about conflict and stress and about similarities and differences between people. And that understanding the nature of conflict can be a positive learning experience.

The health and quality of life for LGBT people, like other people, is enriched by educational and community-based programs—not simply a well-functioning health and medical care system. Positive attitudinal and health status changes most often occur within all communities when partnerships are formed between a variety of organizations with shared interests. Whereas schools are natural settings for reaching children and youth, worksites reach most adults. Unfortunately, although the workplace is a convenient setting for health promotion activities, it also can be a source of stress and conflict, especially for LGBT people. Antigay bias can affect the entire workforce and harm both individual and corporate productivity.[1]

Representatives and expertise from across communities need to be involved with the organizations conducting health-related research, to ensure that the content of the health promotion and health education efforts developed is tailored to meet the needs of their communities and the populations served. Communities also need to be involved to enhance the appropriateness and sustainability of science-based interventions and prevention programs and to ensure that the lessons of research are transferred back to the community.

Issues and Trends

Communities experiencing the most success in addressing health and quality of life issues have involved many, if not most, components of their community: public health, health care, business, local government, schools, civic organizations, voluntary health organizations, faith organizations, park and recreation departments, and other interested groups and private citizens. Communities eager to improve the health of specific at-risk groups have found that they are more likely to be successful if they work collaboratively within their communities and if the social and physical environments are conducive to supporting healthy changes.

Because many health problems relate to more than one behavioral risk factor as well as to social and environmental factors, communities with effective programs also work to improve health by addressing the multiple determinants of a health problem. Among the more effective community health promotion programs are those that implement comprehensive intervention plans with multiple intervention strategies (e.g., educational, policy, environmental) within various settings (e.g., the community overall, health care facilities, schools [including colleges and universities], worksites).[2, 3, 4, 5]

Four basic settings—schools, worksites, health care facilities, and the community—serve as locations in which to reach desired audiences and to apply strategies or intervention across populations. Each of the settings has multiple components, increasing the venues for interventions. These settings also provide major social structures for intervening at the policy level to facilitate healthful choices.[6] For example, the school library is an integral part of education that permeates the continuum of education from the elementary level to the doctoral level.

The school setting. The school setting, ranging from preschool to university, is an important avenue to reach the entire population and specifically to educate children and youth. Schools have more influence on the lives of young people than any other social institution, except the family, and provide a setting in which friendship networks develop, socialization occurs, and norms that govern behavior are developed and reinforced. In 1997, the Institute of Medicine advised that students should receive the health-related education and services necessary for them to derive maximum benefit from their education and enable them to become healthy, productive adults.[7]

To ensure that all students receive the maximum benefits from federally conducted educational programs, on June 23, 2000, President William Clinton issued Executive Order 13160, which prohibits sexual orientation-based discrimination in federally conducted education and training programs.[8] Executive Order 13160 also prevents discrimination based on status as a parent. The order, however, applies only to programs run by the Federal Government. It does not apply to State and locally operated educational systems that only receive Federal funding. However, some States (such as California, Connecticut, Massachusetts, and Wisconsin) and local school districts have enacted their own antidiscrimination laws.

The Gay and Lesbian Parent Teacher Student Association (GLPTSA) of Greater Puget Sound in Washington State was founded by a parent who acted because of the treatment she observed her gay son experiencing within the Seattle school district. GLPTSA, numbering 251 parent and staff members, is involved in such standard PTA activities as playground cleanups and school carnivals. GLPTSA is an organizational member of the Safe Schools Coalition of Washington State. This is a public-private partnership of agencies and individuals. Its mission is to help make Washington State schools safe places in which every family can belong, every educator can teach, and every child can learn, regardless of gender identity or sexual orientation. More information is available online at www.safeschools-wa.org/safe.html.

The Commonwealth of Massachusetts provides funding and legislation for a safe-schools teacher-training program.[9] Massachusetts also contracts with several organizations, including the Gay, Lesbian, and Straight Education Network (GLSEN), to teach adult training on violence prevention, suicide prevention, and LGBT issues. Educating teachers contributes to a safer, more informed environment for all students, but especially for students perceived or known to be LGBT or for children of LGBT parents. GLSEN also offers training and education to students. Through its chapters in 40 States, GLSEN tailors the training according to the needs of schools and communities. Information on this program can be found online at www.glsen.org.

Each school day, about 48 million youth in the United States attend almost 110,000 elementary and secondary schools for about 6 hours of classroom time. More than 95 percent of all youth aged 5 to 17 are enrolled in school. Schools are second only to homes among the primary places that children spend their time and thus are one of the significant places where children may be exposed to potentially harmful environmental conditions. Violence has motivated some schools to address the issue of school safety, especially the

overt and covert acts of violence directed at LGBT students, children of LGBT individuals, and students who are perceived as not being heterosexual—all of whom are often targets of verbal harassment or physical confrontation.

During high school, national dropout rates average 12 percent. Prior to high school, dropouts are nearly nonexistent.[10, 11, 12] Because healthy children learn better than children with health problems, schools also have an interest in addressing the health needs of students. Although schools alone cannot be expected to address the health and social problems of youth, they can provide, through their climate and curriculum, a focal point for efforts to reduce health-risk behaviors and improve the health status of youth.[13]

The Commonwealth of Massachusetts provides funding and legislation for a safe-schools teacher-training program. Massachusetts also contracts with several organizations, including the Gay, Lesbian, and Straight Education Network (GLSEN), to teach adult training on violence prevention, suicide prevention, and LGBT issues. Educating teachers contributes to a safer, more informed environment for all students, but especially for students perceived or known to be LGBT or for children of LGBT parents. GLSEN also offers training and education to students. Through its chapters in 40 States, GLSEN tailors the training according to the needs of schools and communities. Information on this program can be found online at www.glsen.org.

More than 12 million students currently are enrolled in the Nation's 3,600 colleges and universities.[14] Thus, colleges and universities are important settings for reducing health-risk behaviors among many young adults. Health clinics at the postsecondary level can help empower students to take responsibility for their own health through education, prevention, early detection, and treatment.

The worksite setting. The growing cost of health care, combined with the increase of preventable acute and chronic illnesses, drives the continuing need for comprehensive worksite health promotion programs. The worksite setting provides an opportunity to implement educational programs, policies, and environmental actions that support health, which benefits managers, employees, and the community as a whole. These programs have become an integral part of corporate plans to reduce health care costs, improve worker morale, decrease absenteeism, and improve behaviors associated with increased worker productivity.[15] Although reductions in health risks have been achieved through many worksite health promotion programs, risk reduction for hourly and part-time workers and companies with fewer than 50 employees has lagged.[16]

Much of the debate about LGBT people in the workplace centers around discrimination, stigma, and concomitant health problems. Nondiscrimination bills have been considered in recent years in more than 18 States and in the U.S. Congress.[17] The need for systematic research is tantamount. But even without such research, companies need harmonious workplaces to maintain productivity and profit. When diversity is valued, the workplace is a site of health, wellness, and vitality.

The health care setting. In health care facilities—such as hospitals, medical and dental clinics, and offices—health care providers often see their patients at a teachable moment. Individualized education and counseling by health care providers at such moments in these settings have been shown to have positive and clinically significant effects on behavior in persons with chronic and acute conditions.[18] (See Access to Quality Health Services.) Providers must be cognizant of these opportunities and prepared to provide appropriate patient education. Institutions that employ providers also must allow sufficient time and training for patient education and counseling to occur.

The health care setting is critical to the delivery of health education and health promotion because of the dramatic change it has undergone since 1990. In 1989, 18 percent of the population reported they were covered by some form of managed care; [19] in 1996, that number had risen to 29 percent, an increase of 57 percent. As of June 1999, the number had jumped to 70 percent. As of January 1, 1997, more than 4.9 million Medicare beneficiaries were enrolled in managed care plans, accounting for 13 percent of the total Medicare program and representing a 108-percent increase in managed care enrollment since 1993. As of June 30, 1998, more than 16 million—or 54 percent—of Medicaid beneficiaries were enrolled in managed care programs.

The community setting. Whereas health promotion in schools, health care centers, and worksites provides targeted interventions for specific population groups, community-based programs can reach the entire population. Broad public concern and support are vital to the functioning of a healthy community and to ensure the conditions in which people can be healthy.[20] Included in the community setting are public facilities, local government and agencies, and social service, faith, and civic organizations that provide channels to reach people where they live, work, and play. These venues can be strong advocates for educational, policy, and environmental changes throughout the community. Places of worship may be a particularly important setting for health promotion initiatives, and they may effectively reach some underserved populations. Approaches to prevention must account for the character of the community and ensure community participation in the process.[21] Valuable and effective health benefits of community-based approaches have been demonstrated by community interventions that have served a variety of ethnic, racial, and socioeconomic population groups.[22, 23, 24] Community-based approaches in conjunction with targeted approaches in schools, health care settings, and worksites increase the likelihood for success to improve personal and community health.

Disparities

The U.S. population is composed of many diverse groups. Evidence indicates a persistent disparity in the health status of racially and culturally diverse populations, as well as other unserved or underserved groups, as compared with the overall health status of the Nation. Over the next decade, the demographic composition of the United States will become more racially and ethnically diverse, thereby increasing the need for effective prevention programs tailored to specific community needs. Poverty, inadequate access to quality health services, and the lack of culturally competent and linguistically accessible health and

preventive services also are underlying factors that must be addressed. (See Access to Quality Health Services.) Given these disparities, the need for appropriate interventions is clear.

Effective prevention programs in diverse communities must be tailored to community needs and take into consideration individual factors, such as disability status, sexual orientation and gender identification, and gender appropriateness. These attributes play a significant role in determining health outcomes, behaviors, patterns of health services use, and attitudes across age, racial, and ethnic groups.

Despite some strong rhetoric by a number of organizations and a few influential people, recent data challenge the notion that the United States is totally antigay.[25] This 3-decade move toward opportunity is tempered by several findings. First, although most people who were polled believe that gay and lesbian people should have equal civil rights, they also continue to rank gay people among the most disliked groups of people in the country. And secondly, no public opinion data have been collected nationally on bisexual and transgender persons. Thus, anti-LGBT societal attitudes, coupled with overt and covert acts of discrimination against LGBT people, perpetuate disparities and limit opportunities.

Opportunities

Health promotion programs need to be sensitive to the diverse cultural norms and beliefs of the people for whom the program has been developed. Achieving such sensitivity is a continuing challenge as the Nation's population becomes increasingly diverse. To ensure that interventions are culturally appropriate, linguistically accessible, and appropriate for the needs of racial, ethnic, gender, sexual orientation and gender identity, disability status, and age groups within the community, members of the populations served and their gatekeepers must be involved in the community assessment and planning process.

Community assessment helps to identify the cultural traditions and beliefs of the community as well as the education, literacy level, and language preferences necessary for the development of appropriate materials and programs. In addition, a community assessment can help identify levels of social capital and community capacity. Such assessments help identify the skills, resources, and abilities needed to manage health improvement programs in communities.[26, 27]

Educational and community-based programs must be supported by accurate, appropriate, and accessible information that is firmly grounded in the latest scientific knowledge. Increasing evidence supports the efficacy and effectiveness of health education and health promotion in schools, worksites, health care facilities, and community-based programming.[28] Gaps in research include the dissemination and diffusion of effective programs, new technologies, policies, relationships between settings, and approaches to disadvantaged and special populations.[29]

Beginning in 1990, the Bureau of the Census[30] allowed respondents to identify as unmarried partners. Of the roughly 14.2 million households who completed the long-form census

questionnaire, there are 17,043 same-sex couples identified as unmarried partners, of whom 9,241 are male and 7,802 are female. Some of the demographic characteristics are evidence that same-sex couples identified from the census are quite distinct from the general population—the most notable characteristic being more highly educated than the rest of the population.[31]

Techniques to evaluate community processes and community health improvement methods and models need to be refined and disseminated so that other communities can learn from and duplicate successful strategies. Issues of partnering and the role of collaborative efforts to increase the capacity of individuals and communities to achieve long-term outcomes and improvements in health status are not fully understood[32] and should be evaluated. Mechanisms need to be developed to share what is learned in an appropriate and timely manner with communities.

Summary of LGBT Research

Due to the lack of information about LGBT health issues in traditional education, health care organizations, government agencies, and private-sector systems, LGBT communities and their supporters began promoting awareness of sexual orientation and gender identity health issues in the 1950s. Early efforts focused on declassifying homosexuality as a medical illness,[33] and eventually homosexuality was removed from the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.[34] LGBT communities also created a myriad of professional and volunteer health care initiatives designed to offer nonjudgmental education and services about sexually transmitted diseases (STDs) and mental health concerns related to coming out and social stigma. "Lesbian health nights" were established at several women's health clinics,[35] while gay counseling sessions, peer education groups, and STD screenings were created at mainstream, nongay community health facilities. With the advent of the human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) epidemic, efforts were undertaken to expand mainstream health organizations and to establish organizations focusing specifically on lesbian and gay health education, treatment, and advocacy.[36, 37]

LGBT health encompasses a multiplicity of health care needs, including HIV/AIDS, mental health, cancer, violence, and other serious public health challenges. Many of these LGBT-focused, community-based programs are working to address these needs in a comprehensive, coordinated, and culturally competent way.[38] Some government agencies, professional associations, and mainstream health care organizations also have begun to respond to the unique health care needs of LGBT persons and families. However, studies indicate that many LGBT individuals rely on LGBT-focused community resources and professional organizations to address LGBT-related health needs.[39] The reliance by LGBT persons and families on LGBT community-based resources, however, is not unlike non-LGBT individuals who recognize that health-related solutions fundamentally are at the community level and grounded in prevention and public health.

LGBT persons and their families share health promotion and medical needs in common with their non-LGBT counterparts, but they also have some LGBT-specific health care needs. For LGBT individuals, what is often an issue is not as much the LGBT-related needs as the prevailing attitudes and assumptions carried into the provider encounter, the perceived environment in which health care services are delivered, and the anticipation of negative experiences with providers. Such perceptions and negative anticipations may cause individuals to fail to seek out and act upon health promotion knowledge that could be lifesaving, such as mammography, Pap tests, prostate examinations, and other routine clinical screenings.

Discussion of Healthy People 2010 Objectives

7-1: Increase high school completion.

Many LGBT students are at risk for dropping out of school because of harassment and violence.[40, 41] There is increasing evidence that young people who leave their neighborhoods and homes may be at higher risk for STDs and HIV infection.[42] Data from the 1999 Massachusetts Youth Risk Behavior Survey[43] show that youth who self-identified as lesbian, gay, or bisexual, or who had a history of same-sex sexual behavior reported significantly higher rates of school-related violence than their peers. The study also revealed that sexual minority youth were more than two times as likely as heterosexual youth to have been in a physical fight at school and three times more likely to have been threatened or injured with a weapon at school in the past year. Sexual minority youth also were more than three times as likely as their peers to have carried a weapon to school in the past month, or to have skipped school in the past month because they did not feel safe.[44] Additional analysis of these data showed that gay and bisexual boys in particular reported higher levels of skipping school because they did not feel safe in the school setting.[45]

To help LGBT youth stay in school, the Massachusetts Department of Education and the Governor's Commission on Gay and Lesbian Youth developed in 1993 the Safe Schools Program for gay and lesbian students. The program supports school efforts to implement Board of Education recommendations to develop and maintain antiharrassment policies to protect sexual minorities; to provide training for school personnel; to develop school-based groups for gay, lesbian, and heterosexual students; and to provide support for family members of lesbian and gay students. More information on this program can be found online at www.doe.mass.edu/lss/program/ssch.html.

Schools need to provide a safe space for LGBT youth to socialize and create social ties. In October 2000, Parents, Families, and Friends of Lesbians and Gays (PFLAG) launched a new safe schools campaign, "From Our House to the School House: A Recipe for Safe Schools." The campaign unites PFLAG chapters, representatives, and State councils in creating a wave of safe schools activities. In addition, PFLAG is forming coalitions with other local groups committed to creating safe school environments. The first step in this campaign is to conduct school and community assessments to determine the climate in

schools and school districts toward the safety of LGBT students. More information on PFLAG is available online at www.pflag.org.

Antidiscrimination legislation draws attention to the need to improve the school environment for both LGBT students and children of LGBT families. The California Student Safety and Violence Prevention Act of 2000[46] adds real or perceived sexual orientation and real or perceived gender identity to the State education antidiscrimination code. California was the fourth State to include sexual orientation in such a code, following Connecticut, Massachusetts, and Wisconsin. California was the first State to include gender-related harassment by specifying that all schools receiving Federal funding, with the exception of religious schools that choose to abstain, are required to comply.[47]

Recreational programs can play an important role in decreasing the isolation that LGBT young people experience.[48] In addition to addressing the effect of isolation by increased physical or recreational activities, schools should provide diversity training on sexuality development to school professionals and paraprofessionals. The training should include strategies for confronting homophobia, assisting parent(s) or guardians in creating safe environments, counseling victims of bias-related violence, and demystifying homosexuality.[49]

Suicide among LGBT youth is well documented.[50, 51, 52, 53, 54, 55, 56, 57] A summary of homophobia-related suicide from the 1995 Seattle Teen Health Risk Survey is available online at www.safeschools-wa.org/quant_mh.html. Administrators, teachers, social workers, counselors, and nurses must be trained to identify issues that put LGBT youth at high risk for suicide. Quality counseling should be provided for LGBT youth who need and want it. LGBT youth experience unique stressors that the school system must address in an affirmative manner.[58, 59, 60]

Refusal to attend school is a common problem in visibly transgender adolescents. According to the Harry Benjamin International Gender Dysphoria Association, collaboration between school officials and treating professionals may be necessary if transgender adolescents are to continue their education.[61] Early hormonal interventions in profoundly transgender adolescents may contribute to school completion because treatment delays commonly result in educational and social delays.[62]

7-2: Increase the proportion of middle, junior high, and senior high schools that provide comprehensive school health education to prevent health problems in the following areas: unintentional injury; violence; suicide; tobacco use and addiction; alcohol or other drug use; unintended pregnancy, HIV/AIDS, and STD infection; unhealthy dietary patterns; inadequate physical activity; and environmental health.

Schools provide an ideal setting for comprehensive sex education, including issues on sexual orientation and gender identity, to reduce the risk for HIV/AIDS, drug use, and teen pregnancies. Adolescence has shown to be a time of heightened increase in risk-taking behaviors. Adolescence also is a time of sexual development and maturation. LGBT youth

are at risk for STDs and HIV/AIDS.[63] (See HIV/AIDS focus area and Sexually Transmitted Diseases focus area.) Although schools may provide an opportunity for comprehensive HIV education and prevention, one study found that only 53.5 percent of gay, lesbian, and bisexual youth who skipped school reported receiving AIDS education in school, compared to 86.5 percent of their heterosexual peers.[64]

Transgender youth appear to be at increased risk in many of the six priority health risk behavior areas, notably violence, suicide, drug and alcohol use, and HIV/AIDS and other STDs.[65, 66, 67, 68] However, transgender persons frequently report that traditional educational programs concerning health risk behaviors do not address their needs and often do not seem relevant to their social contexts.[69]

7-3: Increase the proportion of college and university students who receive information from their institution on each of the six priority health-risk behavior areas.

To meet the health needs of LGBT students, colleges and universities should develop LGBT-competent health programs that promote healthy behaviors. Student services should provide training for their professional staff members to enable them to be effective in program development.[70] Because LGBT students undergo the process of sexual identity formation in largely hostile environments, as documented at several community college campuses, they may fail to achieve graduation or they may exhibit other problems, necessitating intervention by the institution.[71] Transgender college and university students appear to be at increased risk in many of the six priority health-risk behavior areas, notably violence, suicide, drug and alcohol use, and HIV/AIDS and other STDs.[72, 73, 74] However, transgender persons frequently report that traditional educational programs concerning health-risk behaviors do not address their unique needs and often do not seem relevant to them.[75]

No data are available on the number of LGBT students in American higher education. One reason for the lack of data is the fear that faculty, staff, and administrators who wish to better understand and address the needs of LGBT students may themselves be perceived as gay.[76] For these educators, the fear of being perceived as LGBT may relate to a fear of losing tenure, losing their jobs, and being unable to teach elsewhere.

College campuses are not thought of as bastions of antigay or antitransgender violence and harassment. However, findings from the only study to examine antigay violence at six community colleges in the San Francisco Bay area indicate that the problem is more widespread than previously thought. In the study, more than one in three community college students had engaged in hate speech or hate crimes on their campus.[77]

A number of college and universities have implemented educational interventions with such names as Safe Zone, Safe Space, Safe Harbor, and Safe on Campus.[78] Although there is no consensus on the origin of the first campus program, most people acknowledge that the distinction belongs to Ball State University in Muncie, Indiana. The Ball State program, implemented during the 1992-93 academic year, was called Staff, Administration, and

Faculty for Equality (SAFE) on Campus.[79] A hallmark of these "Safe" programs is the public identification of allies by placing a "Safe" symbol, usually a pink triangle or rainbow, on office doors or within dormitories.

Student affairs professionals, administrators, and faculty only recently have begun to recognize the potential that heterosexual allies have for increasing tolerance toward LGBT students on college and university campuses. Program interventions such as Safe Zone[80] and Safe on Campus[81] are attempting to develop heterosexual allies while providing support to LGBT students. The tradition of the sticker or sign continues. In addition, there are now training sessions, technical support, Web-based resources including a listserv, campus and community assessments, and questionnaires.

A directory of campuses with LGBT services is available online at www.uic.edu/orgs/lgbt.

Other campuses with LGBT-affirming programs are:

- Western Michigan University's Safe on Campus www.salp.wmich.edu/lbg/GLB/default.html
- Texas A& M Allies Program www.allies.tamu.edu
- Iowa State University Safe Zone www.public.iastate.edu/~clund/safezones
- Northern Illinois University Safe Zone www.niu.edu/lgbt

For many college students, belonging to fraternities and sororities is a positive experience that assists in socialization on campus and leads to the creation of lifelong friendships. However, like other school experiences, the Greek community overall has not been supportive of LGBT persons. A national survey of 340 students found that members of the Greek community were more likely to have an antigay bias than members of the non-Greek community.[82] However, like other parts of society, Greek life also is changing, if slowly. The story of Ryan Grigsby, an openly gay fraternity member at the University of Nebraska, was chronicled in a recent article appearing in Rolling Stone magazine.[83] Some fraternities, such as Sigma Phi Epilon and Zeta Beta Tau, have added sexual orientation to the nondiscrimination clauses in their bylaws.[84, 85]

In lieu of existing fraternities and sororities changing their bylaws, new "gay fraternities" have been formed, such as Delta Lambda Phi.[86] In addition, groups such as Lambda 10 have been organized to raise awareness of gays in the Greek community. The Lambda 10 project is an associate member of the Association of Fraternity Advisors and is housed in the Office of Student Ethics and Anti-Harassment Programs at Indiana University.

Efforts are underway to improve campus life for LGBT students, teachers, and administrators. The American College Health Association (ACHA) has launched several programs to help make campuses safer, more welcoming, and more responsive to LGBT students.[87, 88] ACHA has developed an instrument containing 12 assessment areas, including health centers and health fairs, through which leaders of higher education institutions can assess whether the needs of students, including LGBT students, are being met.

7-4: Increase the proportion of the Nation's elementary, middle, junior high, and senior high schools that have a nurse-to-student ratio of at least 1:750.

Increasing the nurse-to-student ratio in elementary, middle, junior, and senior high schools with nurses who are culturally competent and LGBT-sensitive is important in the health and developmental process of all youth and young adults. It is critical that nurses and other health care providers who interact with school-age students provide culturally competent prevention, treatment, and referral services to LGBT youth. School health personnel—including nurses, health educators, guidance counselors, and school psychologists—also must be adequately trained to meet the psychosocial and health care needs of LGBT youth with whom they interact. If these nurses and other health care professionals are affiliated with school-based health clinics, their roles are enhanced as they become service providers and work jointly with primary care providers. The National Assembly for School-Based Health Care (NASBHC) is an excellent resource for offering an integrated service delivery system to students who may be uninsured, underserved, or vulnerable. More information on NASBHC can be found online at www.nasbhc.org.

School nurses are student advocates who have the organizational ability to implement and evaluate safe schools programs, educate students and staff, connect with resources for information, access medical and counseling referrals, and facilitate support groups for the school population. Other health personnel also can serve as student allies for both LGBT students and children of LGBT parents. School nurses can exercise their responsibility with a nonjudgmental unanimity of commitment to support and advocate for all groups of students in the school setting.[89] Adolescents may feel they are "different" or alone in dealing with sexual orientation issues, and they may avoid or suppress associated anxiety. As a result, they may develop physical or mental symptoms and be at risk for self-destructive behaviors that often come to the attention of the school nurse.[90]

Tolerance of verbal harassment and violence toward any group of people is unacceptable, particularly among school professionals. Gay and lesbian students in schools need help from nurses, administrators, and staff to assure that the school is a physically and emotionally safe place for students.[91] Ultimately, the school health system must be driven by the needs of the students—and the hiring of adequate numbers of school nurses, who are entrusted with the complex physical and emotional health needs of all students.

To foster a safe environment for LGBT students and ensure that they are open, nonjudgmental communicators among all students, school nurses and other health personnel initially must self-assess if they possess and exhibit fears, presumptions, and biases toward LGBT students. School nurse training programs generally provide limited knowledge and information on sexual orientation and gender identity issues. Therefore, school nurses need to educate themselves about LGBT issues in the school setting, just as they educate themselves about other professional health issues. School nurses and their health colleagues can build a base of support toward sexual orientation and gender identity issues within the

school and community. These health professionals can network and collaborate with community agencies and resources that address LGBT adolescent issues.[92]

Nurses and other health professionals should display "inclusive" posters, provide accessible information, and utilize neutral language that indicates their openness to the topic of sexual minorities.[93] LGBT youth need these health professionals to support them by validating them as individuals and educating others in homophobia awareness.[94] Lastly, school nurses must take a leadership role in promoting safe school and antigay harassment prevention programs, as well as promoting a nonhomophobic atmosphere within schools.[95, 96]

The National Association of School Nurses contends that school nurses "should be involved in fostering a safe environment, demonstrating an acceptance of diversity" to help all students, regardless of sexual orientation, to have equal opportunities in the educational system.[97] The school nurse who reaches out to meet the needs of this underserved group of people will also better serve the needs of all youth and school administrators and staff.

The American School Health Association (ASHA) unites the many professionals working in schools who are committed to safeguarding the health of school-aged children. The association, a multidisciplinary organization of administrators, counselors, dentists, health educators, physical educators, school nurses, and school physicians, promotes high-quality school health instruction, health services, and a health-positive school environment. ASHA has more than 2,000 members in 56 countries with more than half of the members working in elementary and secondary schools. To improve school health education, school health services, and school health environments, ASHA promotes interdisciplinary collaboration among all those who work to promote and improve the health, safety, and well-being of children, youth, families, and communities. ASHA offers professional development opportunities for all those associated with school health programs, advocates building and strengthening effective school health programs, and encourages research on school health programs. Given its history, mission, goals, and member composition, ASHA emerges as a key player in ensuring that school health programs prevent, detect, address, and resolve health problems, increase educational achievement, and enhance the quality of life of LGBT youth and their families.

Resolutions issued by the American School Health Association influence not only schools but also communities. In 1990, the ASHA Council on Sexuality issued its "Gay and Lesbian Youth in School" resolution, which was reviewed in 1995 and 1997.[98] The resolution acknowledges the existence and estimated size of the population, the biological and chronological development of sexual orientation, examples of several risk factors, and the lack of support of family and peers unlike that experienced by other oppressed minorities. In declaring the resolution, ASHA encouraged that:

- All young persons should have an equal opportunity for quality education regardless of their sexual orientation.
- Curriculum materials, teaching strategies, and school policies that do not discriminate on the basis of sexual orientation should be implemented in schools.

- Sexual orientation should be addressed in the sexuality component of a comprehensive health instruction curriculum.
- School personnel should discourage any sexually oriented deprecating, harassing, and prejudicial statements injurious to students' self-esteem.
- Every school district should provide access to professional counseling by specially trained personnel for students who may be concerned about sexual orientation.

7-5: Increase the proportion of worksites that offer a comprehensive employee health promotion program to their employees.

Increasing the proportion of worksites that sponsor comprehensive health promotion programs for their employees is relevant to the health concerns of all populations and to promoting prevention-oriented, healthy behaviors. Employers can play an important role in ensuring that worksite health promotion activities and programs are culturally relevant to LGBT populations, increasing access to prevention, treatment, and support services and engaging LGBT employees in culturally and linguistically competent health promotion and improvement programs.

The following are examples of the return on investment experienced by a few companies as a result of their health promotion activities. The figures are expressed as the dollar value returned for each dollar invested.

Coors:	$6.15
Bank of America:	$6.00
Citibank:	$4.58
Travelers:	$3.40
Dupont:	$2.05

Source: Association for Worksite Health Promotion and William M. Mercer, Inc. 1999 National Worksite Health Promotion Survey

Health promotion has been defined as "the science and art of helping people change their lifestyle to move toward a state of optimal health."[99] Change can be facilitated through a combination of efforts to enhance awareness, alter behavior, and create environments that are supportive of wellness. Companies of all sizes increasingly have implemented health promotion initiatives because these strategies are effective ways to reach people at high risk. Health promotion programs, like other preventive interventions, need to be targeted, not broad, as known characteristics of target populations correspond with established health risks.[100] In addition, more than 90 percent of well-designed studies indicate that worksite health promotion efforts are cost-beneficial.[101]

In addition to the Association for Worksite Health Promotion, the Wellness Councils of America (WELCOA) have embraced through their "Well Workplace" program the responsibility for maximizing the health and well-being of their employees. In "Well Workplace," the vision of protecting and enhancing the health and well-being of all employees becomes part of the very fabric of the organization and not something tangential to core business functions. More than 2,000 organizations have joined WELCOA, providing them the evidence-based materials to put theory into practice. Companies belonging to

WELCOA compete for recognition as some of North America's healthiest companies. More information on WELCOA can be found online at www.welcoa.org.

7-6: Increase the proportion of employees who participate in employer-sponsored health promotion activities.

Some LGBT workers may be disinclined to participate in employer-sponsored health promotion activities because they believe that either such programs are not relevant to them, or that participation may focus attention on their sexual minority or gender minority status, and possibly lead to harassment or discrimination. Transgender persons, in particular, frequently report that traditional educational programs concerning health risk behaviors do not address their needs and often do not seem relevant to them.[102]

Despite the reluctance of some LGBT employees to participate in employer-sponsored activities, many other LGBT people feel connected to their worksites because of an increasing sense of community created during health promotion and social activities. The Internet has given LGBT people the means to disseminate information related not only to social events but also to the worksite. LGBT workplace issues are discussed at www.lavendercollar.com. This Web site lists public and private agencies that have LGBT employee groups as well as legal protections. The Employee Assistance Professional Association (EAPA) has published two directories listing nearly 500 companies that have internal LGBT employee groups. The EAPA directories are an important resource for models enabling LGBT people to network within the worksite as well as for EAPA professionals to use as a resource for LGBT employees seeking cultural ties. Employee assistance professionals are trained to address chemical dependency addictions and emotional disorders. According to the EAPA Code of Ethics, ". . . members shall not discriminate because of a client's race, religion, national origin, political affiliation, disability, gender, or sexual orientation."[103]

Currently, 10 States have laws prohibiting discrimination based on sexual orientation.[104] One State and the District of Columbia prohibit employment discrimination based on gender identity.[105] There are other organizations, among them unions, that have supported LGBT people. For example, the American Federation of State, County, and Municipal Employees (AFSCME) has been one of the leaders among union organizations in demanding equal rights for LGBT persons. In 2000, AFSCME passed another resolution acknowledging its continued support for passage of the Employment Non-Discrimination Act.[106]

7-7: (Developmental) Increase the proportion of health care organizations that provide patient and family education.

Health care organizations have multiple opportunities to offer patient and family education to consumers, including LGBT individuals. Given that the predominant financing structure of the American health care system today is some form of managed care (e.g., managed care plans, managed fee for service, health maintenance organizations), most LGBT persons and children of LGBT persons with either private or public health care coverage are most likely

enrolled in some type of managed care program. Most managed care entities proactively promote healthy behaviors and prevention as means to reduce health care costs.

Other health care organizations often play a leading role in responding to consumer needs. For example, in the early days of the HIV epidemic, LGBT-focused community health organizations were influential in educating gay and bisexual men and transgender individuals who have sex with men about HIV, modes of transmission, and effective prevention strategies. In the same manner, community-based organizations arose to focus on such critical issues as breast cancer among lesbians. The National Association of Lesbian and Gay Community Centers hosts an online directory at www.gaycenter.org. The centers vary in fiscal and staff resources and available activities. A few Centers have the infrastructure to offer disease management and family education. There are additional Internet sites that provide patient and family education, including www.gayhealth.com, the Gay and Lesbian Medical Association at www.glma.org, www.FamiliesLikeOurs.com, and www.Homebirthmidwife,com, which offers preconception counseling.

Mainstream health care providers frequently have difficulty discussing more intimate aspects of a patient's behavior. And often, patients who do not necessarily self-identify as lesbian, gay, or bisexual are reluctant to discuss specific behaviors that may put them at increased risk for an array of health problems. Mainstream health care organizations need to create an environment in which LGBT individuals can openly and honestly discuss their health care concerns with providers.

Many LGBT individuals lack access to a reliable and routine source of basic health care because they are uninsured, underinsured, unaware of or too far from an LGBT-friendly source of care, or disenfranchised from traditional or mainstream sources of health care. For-profit health care organizations, nonprofit health care organizations, and other public-sector and community agencies can work in partnership to provide a culturally competent, comprehensive system of care that meets the health education, prevention, and treatment needs of LGBT individuals who may otherwise lack access to care.

7-8: (Developmental) Increase the proportion of patients who report that they are satisfied with the patient education they receive from their health care organization.

Personal and institutional barriers. In addition to difficulties in accessing health care, LGBT individuals often face significant barriers that inhibit open and honest communication with health care providers. Many practitioners—sometimes openly, sometimes secretly—harbor negative attitudes toward LGBT persons. In one study published in 1986, 40 percent of physicians reported they were sometimes or often uncomfortable providing care to lesbian or gay patients.[107] In a nonrandom survey of members of the Gay and Lesbian Medical Association (GLMA) conducted in February 1994, 67 percent of respondents indicated that they had seen gay or lesbian patients receiving "substandard" care because of their sexual orientation.[108] Many lesbians and gay men have reported that their doctors are not sensitive to or knowledgeable about their

particular health risks and needs and do not disclose pertinent information about treatments or prevention.[109, 110, 111]

Disclosure of sexual orientation and sexual behaviors to providers is a highly personal decision, influenced by many issues, including the source of one's medical care, familiarity with the provider, financial independence, basic health knowledge, and where the patient might be in the coming-out process. For example, gay and lesbian adolescents, who often lack financial independence and social networks that can sustain older gay men and lesbians,[112, 113, 114] are likely to delay disclosure of sexuality to clinicians. Homosexually active men and women who identify as heterosexual, or those who are at the early stages of the distinct developmental processes theorists have associated with coming out,[115] also may choose not to disclose their sexual histories to health care providers.

Many gay men and lesbians do not disclose their sexual orientation to health care providers because they do not feel comfortable doing so or they fear receiving substandard care as a result of disclosure. Similarly, transgender persons report several barriers to accessing quality care, including the lack of provider education and knowledge about the health concerns of transgender people.[116] Intake forms covering sexual history rarely include the option for providing information on same-gender sexual partners. Physicians and researchers routinely ask heterosexually biased questions, such as: "Are you married, single, widowed, or divorced?" or "What kind of birth control do you use?" Consequently, disclosure of sexual orientation in a health care setting remains infrequent for the majority of gay men and lesbians.[117, 118, 119, 120, 121] In a 1989 survey of lesbians in Michigan, 61 percent felt unable to disclose their sexual orientation to their providers.[122] Some 9 percent of respondents reported that their health providers had not allowed their female partners to stay with them during treatment or see them in a treatment facility; 9 percent also said that providers had not included their partners in discussions about treatment.[123]

The medical educational system has failed to educate providers and researchers about different aspects of lesbian and gay health,[124] including communication skills, examination techniques, and preventive recommendations. Although homosexuality has been removed from the list of mental disorders in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association,[125, 126] the relationship between homosexuality and sickness has proved more enduring in the minds of many providers. A variety of studies describe provider hostility[127, 128] or instances of gay men or lesbians being described as "deserving" of illness or unworthy of treatment.[129] Tellingly, stigma may be most pronounced in those instances where sensitive treatment is needed. A number of respondents to the GLMA survey, for example, said they had seen doctors performing "rough" or "violent" digital rectal exams on patients after discovering that they were gay.[130] Similarly, patients and parents of children treated according to the traditional model of care for congenital sexual ambiguity have reported a feeling of betrayal because physicians did not disclose the uncertain state of knowledge regarding gender identity development or the long-term consequences of genital plastic surgery on infants and because accurate information about diagnosis and treatment history was concealed or misrepresented. A "paradigm shift" from a model of treatment based on secrecy and early genital plastic

surgery to one based on full disclosure, counseling rather than risky and irreversible surgery, and patient autonomy is underway. Widespread promulgation of this change in the standard of practice will likely increase the proportion of patients (and families) treated for sexual ambiguity who report that they are satisfied with the patient education they receive from their health care organization.[131]

Many clinicians sympathetic to gay men or lesbians may lack a repertoire of questions about social and sexual history appropriate to homosexuals, or they may be unaware that culturally appropriate questions might be necessary. Among physicians interviewed in 1998 by the Mary-Helen Mautner Project for Lesbians with Cancer, half stated that they assumed lesbians were in their practices but did not see any reason to address this in a direct way.[132] These providers expressed an eagerness to learn more about the needs of lesbians and stated emphatically that they would make changes if they had information about what steps would be appropriate.

Physicians are not alone among health providers in facing difficulties in communication with gay and lesbian patients. In a random sample survey of Virginia mental health providers conducted in 1994, respondents acknowledged having lesbians in their practices, yet had little or no training about the special needs of these clients.[133] Some mental health practitioners continue to practice "reparative" therapy for homosexuality,[134] to use inadequate or inappropriate definitions for lesbians and gay men, or to state that they do not think the concerns of gay or lesbian clients are different from those of heterosexuals.[135, 136] Findings were similar in a California study published in 1986 of physicians dealing with lesbians and gay men.[137]

Barriers to communication about the needs and realities of gay and lesbian life are manifested at both systemic and individual levels. In hospitals, emergency rooms, and intensive care units, visitation and medical decisionmaking policies frequently exclude partners of lesbian or gay patients. Public ambivalence toward homosexuality continues. As late as 1998, a poll found the majority of the public considered homosexuality a moral wrong in the same category as adultery.[138] This situation may create censorship or self-censorship of information critical to vulnerable populations.

Health consequences of poor communication. Disclosure of sexual orientation in the health care setting is crucial to the provision of appropriate, sensitive, and individualized care. Failure to establish rapport and communication between physicians and patients is associated with decreased levels of adherence to physician advice and treatment plans, and decreased rates of satisfaction.[139] Additionally, clinicians unaware of their patients' sexual orientation may fail to accurately diagnose, treat, or recommend appropriate preventive measures for a range of conditions. Although more research is needed on the effects of communication related to sexual orientation and medical care, small surveys suggest that successful communication and ease of sexual orientation disclosure may positively affect health risks and screenings. In a study of lesbians in Oregon published in 1997,[140] 90 percent disclosed their sexual orientation to providers, and of these, 92 percent raised the issue themselves.[141] Communication style of the provider was rated by respondents as the

most important characteristic in determining ease of discussion about difficult issues. Lesbians who disclosed their sexual orientation were more likely to seek health and preventive care, to have a Pap test, to be nonsmokers, and to report comfort in communication with providers. By contrast, difficulty communicating with the primary care provider was associated with delay in seeking health care.[142]

One of the most significant barriers to adequate patient education for transgender persons is that most health professionals lack knowledge about transgender identity, sexuality, and health care issues necessary for them to respond adequately to their patients. As a result, patients are usually required to educate their health care providers about transgender issues.[143, 144] Transgender persons are also subject to discrimination from health care professionals based on their gender-variant physical and social presentations.[145] Predictably, this interferes with adequate patient education.

7-9: (Developmental) Increase the proportion of hospitals and managed care organizations that provide community disease prevention and health promotion activities that address the priority health needs identified by their community.

Community health promotion services provided by hospitals and managed care organizations (MCOs) are growing, as illustrated by the expansion of Federal and State managed care reform legislation directed at the creation of a core set of prevention activities across MCOs.[146] The changing demographics of the Nation, broader recognition of the necessity for culturally accessible services for minority populations, and a focus on community-based, integrated systems of care are some of the compelling reasons for consumer and community involvement in fostering a prevention-oriented health care system that evolves around the primary care provider. Primary care providers (PCPs) and other health professionals are increasingly trained across disciplines and to work with community-based outreach.

Primary care is an array of "integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community."[147] The 1995 Sixth Report of the Council on Graduate Medical Education (COGME) acknowledged that "educational programs will have to produce a physician with a new set of skills and new areas of knowledge than previously." The Group Health Association of America, now known as the American Association of Health Plans, delineated the necessary competencies, such as fostering health promotion and delivering disease prevention services; communicating effectively with patients; and detecting, diagnosing, and effectively managing common symptoms and physical signs.[148]

PCPs and the settings in which they practice are not disinterested in prevention. Nonetheless, many are knowledgeable about neither the strategies for stopping the onset or altering the duration of unhealthy behaviors nor the research-based evidence supporting those strategies. In addition, there has been little financial incentive for providers to focus

on preventive medicine, and many believe that they have neither the time nor the energy to engage in the activities. One article appearing in the series published by the Journal of the American Medical Association in 1996 addressed physicians' "inability to teach disease prevention and health promotion."[149] Both private and public payers increasingly are insisting that providers and organizations be held accountable for the outcomes of the interventions provided. The Health Plan Employer Data and Information Set (HEDIS 3.0) developed by the National Committee on Quality Assurance (information online at www.ncqa.org) includes performance measures regarding the effectiveness and use of preventive interventions, similar to those required for treatment interventions. The relevant preventive HEDIS measures have been grouped in five categories:

- Effectiveness of Care Measures with Health Education (e.g., percent of smokers in the plan who received advice to quit from health professionals)
- Effectiveness of Care Measures with Population Screening Implications (e.g., screening for chemical dependency)
- Uses of Services Measures with Health Screening/Aftercare Implications (e.g., percent of 3- to 6-year-olds with well-child visit in past year)
- Access/Availability Measures with Prevention Implications (e.g., availability of language interpretation services)
- Plan Descriptors with Prevention Partnership Implications (e.g., arrangements with public health, education, and social services entities)[150]

Nearly 40 of the community coalitions funded by the Center for Substance Abuse Prevention within the Substance Abuse and Mental Health Services Administration forged linkages with managed care entities. These coalitions offered the full continuum of prevention services as well as treatment and rehabilitation for individuals in the community, especially youth. The established collaboration between coalitions and the managed care system is almost always a mutually beneficial effort.

Historically, two fields have focused on the community as an arena for preventive interventions: public health and mental health. "Communitywide prevention" is the term used in this discussion. (The Healthy People 2010 document, on page 7-27, defines a community-based program as "a planned, coordinated, ongoing effort operated by a community that characteristically includes multiple interventions intended to improve the health status of members of the community.") Communitywide prevention in this context refers to the systematic application of prevention strategies throughout the community in a sustained, highly integrated approach that simultaneously targets and involves diverse social systems, such as families, schools, media, health care centers, workplaces, and other entities composing the defined community entity. Behavioral problems have their roots in the community. Likewise, the community is the repository of solutions. The responsibility for the health or well-being of the community has often been relegated to the caregivers of the

community. However, seldom have PCPs been given the leadership or felt that they should assume the leadership for community-oriented primary care.

As managed care systems grow and assume responsibility for larger segments of the population, especially those financed wholly or in part with public funds such as reimbursement by Medicaid and Medicare, community-based approaches will be a critical complement to individual clinical interventions. The development of community-based prevention linked to community-level risk factor rating analyses is a more targeted approach for MCOs not only to reduce the likelihood of high health care costs but to achieve the final evolutionary step in maintaining community health or well-being.

Desktop mapping using computer software is called a geographic information system (GIS). The vast majority of all databases contain geographic information, which can permit community coalitions and MCOs to answer such questions as: Where are the populations at greatest risk for developing health care problems? Where should services be located? How does service intervention change risks or demands? This computer-based tool combines maps and data to show patterns and relationships. When used collaboratively by both the community and managed care entities, a higher level of consensus can be reached and achieved in policy decisions and funding service needs, such as wraparound services. (Wraparound or enabling services are loosely defined as ancillary services that make it easier for consumers to access and stay in treatment or to obtain better outcomes upon discharge.[151] Examples may include housing, child care, transportation, and employment counseling.)

In addition to software such as GIS packages, the Internet provides a promising and rapidly growing avenue for distant learning. As Internet technology becomes more sophisticated and users more proficient, a myriad of interactive instructional multimedia will become available. For example, "Virtual Patient," available through the Marshall University School of Medicine, allows a primary care provider to interview the patient by typing questions and receiving feasible responses, simulating the diagnostic process. In addition, the program enables the provider to conduct a clinical physical examination that yields lab results and x rays. PCPs should be involved in the development of community-based behavioral health promotion and disease prevention strategies. The effectiveness of disease prevention and health promotion initiatives is enhanced as consumers are informed and empowered to take responsibility for their behavior. Consumers need to be prepared to request that their primary care clinician provide clinical preventive services (e.g., mammograms, Pap tests, fecal occult blood screening, immunizations) appropriate for their age and personal health risk. Increasing the individual's knowledge about and responsibility for preventive self-care should reduce overutilization of health services. Vigorous, well-designed programs of health promotion and disease prevention that involve proactive consumers should help the American health care system evolve from a reactive, medical model to a prevention-oriented system.

Despite the promotion of competition, partnerships, services integration, and other strategies, consumers, providers, purchasers, and managed care organizations must have

financial incentives to promote mental well-being and to prevent negative behaviors. Whether private or public, the ultimate goal of a comprehensive, integrated health care system is improved quality of life for individuals, communities, and society.

7-10: (Developmental) Increase the proportion of tribal and local health service areas or jurisdictions that have established a community health promotion program that addresses multiple Healthy People 2010 focus areas.

Comprehensive and multifaceted health promotion and community health improvement activities should be promoted at the State and local levels. The objective includes activities conducted through local health departments as well as those conducted by other community-based organizations, particularly in those communities not served by a local health department. Assessment activities recognize the need for community involvement and mobilization as basic methods for planning, implementing, and evaluating educational and community-based programs. Public health departments, community health centers, faith communities, civic organizations, voluntary health organizations, businesses, worksites, schools, universities, Area Health Education Centers, and healthy city or community groups are a few of the organizations that plan and deliver such programs in the United States. In the tribal jurisdictions, the Federal agency, the Indian Health Service, oversees with the tribal leadership the tribal health system.

For those American Indians and Alaska Natives receiving services in nontribal service settings, special emphasis needs to be accorded to culturally competent and linguistically accessible services. The Federal Government is obligated by various treaties, laws, and other agreements—dating back as far as 1787—to provide health care to the 547 federally recognized tribes.[152] A study released in June 2000 by the Henry J. Kaiser Family Foundation found that a majority of American Indians—80 percent—do not have access to the limited care provided by the Indian Health Service.[153] HIV/AIDS is rapidly becoming the number one health problem of American Indians and Alaska Natives.[154] Yet, there is virtually no research on Indian perceptions and their responses to the AIDS epidemic.[155]

Health care and related services are provided to American Indians and Alaska Natives through fee-for-service, tribal programs, and other publicly funded programs legislated to serve the uninsured, the underinsured, and high-risk populations. The status of culturally competent health promotion and health education programs and materials for LGBT populations within American Indian and Alaska Native populations is a subject for additional study.

7-11: Increase the proportion of local health departments that have established culturally appropriate and linguistically competent community health promotion and disease prevention programs for racial and ethnic minority populations.

Culture is a significant factor in the context of personal and public health and in how health and related services are delivered, received, and perceived. Few people define themselves in

a monocultural way, although many people acknowledge a dominant culture. Thus, the multicultural model exists because ascription to a single culture is literally impossible.[156] Nonetheless, some people, especially those associated with racial or ethnic groups, are made uncomfortable when LGBT people self-identify themselves within a cultural context.

Almost a half-century ago, Linton defined culture as the "customs, beliefs, values, knowledge, and skills that guide a people's behavior along shared paths."[157] There are now more than 200 definitions of culture, and although there is no overarching definition, there is consensus on defining culture as factors that somehow bind an aggregate of individuals together, resulting in an identifiable group of people. Consumers who are members of a specific cultural group may be much more comfortable receiving services from health providers who share their cultural context.

Sexual orientation and gender identity are cultural issues because they are constructs based on society's stereotypes and prejudices.[158] LGBT people, especially those who are people of color, may be "hidden," thereby losing the critical potential for empowerment and the ability to participate in the design of services and policies that are inclusive of their specific needs.

LGBT communities often have differing health needs than those of members of the majority community. Some members of the LGBT communities—such as people of color, people with disabilities, and people of low socioeconomic status—also may require culturally appropriate and linguistically competent health promotion and disease prevention programs. An excellent example of a culturally appropriate and linguistically competent LGBT health promotion and disease prevention program is the GLBT Health Web page project, sponsored by the public health departments of Seattle and King counties in Washington State. More information can be found online at www.metrokc.gov/health. Additionally, the Network for Battered Lesbians and Bisexual Women in Massachusetts offers support groups, legal advocacy, legal referrals, mental health services, and free English/Spanish translation. More information about the network is available online at www.nblbw.org.

7-12: Increase the proportion of older adults who have participated during the preceding year in at least one organized health promotion activity.

Only a handful of studies consist of samples comprised solely of older lesbians,[159, 160, 161, 162, 163] of older gay men,[164, 165, 166, 167, 168, 169, 170, 171] or of both.[172, 173, 174] Limited research and anecdotal reports suggest that older gay and lesbian adults face a range of challenges in accessing health promotion activities.

A primary obstacle to participation in health promotion activities is discrimination against older gay men and lesbians in the settings in which such activities are commonly held, including nursing homes, assisted living residences, retirement communities, and senior centers. Anecdotal reports indicate various forms of discrimination against older gay and lesbian adults, including forced separation of long-term partners in nursing homes, discriminatory comments made by staff or other residents of retirement communities, and

failure of community or senior centers to provide information or support on gay- or lesbian-specific issues.[175, 176]

Older gay and lesbian adults face other impediments to effective health promotion. Older lesbians and gay men—many of whom have had adverse experiences, such as electroshock treatment or forced institutionalization to "repair" their sexual orientation early in life—may be less comfortable disclosing their sexual orientation in health care settings. Gerontology training rarely includes education about sexual concerns or the health needs of older adults, particularly gay men and lesbians.[177] Gay and lesbian older adults may also be less likely to have children or other family members advocating for their care, a factor that may affect their health-seeking activities as families play an increasingly large role in the provision of care in the United States.[178]

Specific health promotion priorities/impediments for older gay men. From 1991 to 1996, AIDS diagnoses grew fastest among those aged 50 and older,[179] with the greatest number of cases among homosexually active men. Yet, physicians and other health care providers have not routinely recommended either HIV testing or safer sex education to older patients.[180, 181, 182] Physicians may feel less comfortable performing digital rectal exams, which is recommended for men over aged 50, on patients known to be gay. A national survey of members of the Gay and Lesbian Medical Association reported that gay male patients coming in for rectal exams were the objects of jokes and "rough" or "violent" rectal exams.[183] Although significant research has sought to evaluate or reduce risk of erectile dysfunction following treatment for benign prostatic hyperlasia or prostate cancer, no research exists on the effects of such procedures on anal pleasure or exploring less invasive or destructive alternatives.[184]

Specific health promotion priorities/impediments for older lesbians. Potentially important sources of health disparity documented among lesbians—including nulliparity, increased rates of obesity and body mass, increased rates of smoking, and decreased likelihood of obstetric, gynecological, or other health screenings—are all linked to health problems most commonly associated with older adults. Risk of breast cancer, lung cancer, and cardiopulmonary disease increase the importance of health promotion and disease management strategies available for older lesbians.

Specific health promotion priorities/impediments for older transgender individuals. Little research exists on health promotion or special health concerns for older transgender individuals. Research questions in need of exploration include implications and appropriate dosages for long-term hormone use, interactions of testosterone with other medications for chronic conditions, education of aging services providers on appropriate care, and attitudes toward transgender individuals.

Finally, older gay men and lesbians face a number of structural barriers to accessing care. State laws allow one member of a married heterosexual couple to retain a jointly owned house without jeopardizing the other's right to Medicaid, the primary source of payment for long-term care for the elderly. For long-term, same-sex cohabitators, there are no legal

protections regarding inheritance laws, save those that partners institute themselves (e.g., trusts, long-term care insurance, durable powers of attorney, wills, and legal evidence of co-ownership). Legally licensed opposite-sex cohabitators may be eligible to receive a portion of the partner's Social Security payments following his or her death and are granted the ability to transfer wealth or property tax-free in the event of the death of one partner.[185] All of these privileges—in many cases essential for the maintenance of housing and health care—are denied to same-sex cohabitators.

Services—RECOMMENDATIONS

- Community clinics, health maintenance organizations, and other primary care providers should become more knowledgeable about the different needs of LGBT patients and seek ways to make them more welcome in a clinical environment.
- Continuing education for physicians, nurses, technicians, and others who come in contact with LGBT patients in clinical settings should be available through professional organizations, continuing medical education programs, nursing education programs, and other venues to increase understanding and sensitivity.
- Primary care venues that welcome LGBT clients should post symbols or posters that indicate they are nondiscriminatory and patient-sensitive clinics.
- All forms used in school settings, worksites, health care venues, and other community organizations should be culturally sensitive and linguistically appropriate for LGBT individuals or parents.
- All types of managed care organizations, including health maintenance organizations, preferred provider organizations, point-of-service plans, and the hybrid of other financial and organizational structures, should devise a system for providing knowledge about providers who are LGBT or LGBT-friendly. This system must ensure the confidentiality of providers and consumers.

Education and Training—RECOMMENDATIONS

- Continuing education for other community-based services should be available for emerging service providers (e.g., fire, police, 911 teams) and community-service program staff (e.g., food banks, social security offices, emergency housing placement services).
- Health department staff should receive cultural competency and sensitivity training that includes information on LGBT populations and their health needs.
- Training provided to supervisors in both public and private sectors should include information on the health concerns of LGBT individuals along with sexual orientation and gender identity in cultural competency training.

Policy—RECOMMENDATIONS

- Schools must protect LGBT youth from harassment and violence.
- All health care accrediting organizations—such as the National Committee on Quality Assurance, the Joint Commission on Accreditation of Health Care Organizations, and the Council on Accreditation must include sexual orientation and gender identity as components of cultural competency.
- All Medicaid and Medicare regulations should reflect the inclusion of sexual orientation and gender identity within their beneficiary guidelines to ensure provision of care and appropriate reimbursement for medical and related services.
- Community-based organizations that receive Federal funding should be prohibited from discriminating against LGBT persons.

Research—RECOMMENDATIONS

- The National Profile of Local Health Departments survey instrument, administered at intervals by the National Association of City and County Health Officials, where appropriate should include questions related to sexual orientation and gender identity.
- Research is needed on culturally competent health promotion and education programs and materials for LGBT populations within the American Indian and Alaska Native populations.
- Analyses of the 2000 census data should yield more information about unmarried same-sex couples, thereby illuminating the demography of the gay and lesbian population.
- Specific research about LGBT persons is critical for generating baseline data for Healthy People 2010 population-based objectives.
- Longitudinal studies should be conducted to determine how sexual orientation and gender identity is manifested throughout the life cycle.

Terminology

Community: A specific group of people, often living in a defined geographical area, who share a common culture, values, and norms and who are arranged in a social structure according to relationships the community has developed over a period of time.[186]

Community-based program: A planned, coordinated, ongoing effort operated by a community that characteristically includes multiple interventions intended to improve the health status of members of the community.

Community capacity: The characteristics of communities that affect their ability to identify, mobilize, and address social and public health problems.[187, 188]

Community health promotion program: Includes all of the following: (1) community participation with representation from at least three of the following community sectors—government, education, business, faith organizations, health care, media, voluntary agencies, and the public; (2) community assessment, guided by a community assessment and planning model, to determine community health problems, resources, perceptions, and priorities for action; (3) targeted and measurable objectives to address at least one of the following—health outcomes, risk factors, public awareness, services, and protection; (4) comprehensive, multifaceted, culturally relevant interventions that have multiple targets for change; and (5) monitoring and evaluation processes to determine whether the objectives are reached.

Comprehensive worksite health promotion programs: Programs that contain the following elements: (1) health education that focuses on skill development and lifestyle behavior change in addition to information dissemination and awareness building, preferably tailored to employees' interests and needs; (2) supportive social and physical work environments, including established norms for healthy behavior and policies that promote health and reduce the risk of disease, such as worksite smoking policies, healthy nutrition alternatives in the cafeteria and vending services, and opportunities for obtaining regular physical activity; (3) integration of the worksite program into the organization's administrative structure; (4) related programs, such as employee assistance programs; and (5) screening programs, preferably linked to medical care service delivery to ensure followup and appropriate treatment as necessary and to encourage adherence. Optimally, these efforts should be part of a comprehensive occupational health and safety program.[189]

Culturally appropriate: An unbiased attitude and organizational policy that values cultural diversity in the population served. Reflects an understanding of diverse attitudes, beliefs, behaviors, practices, and communication patterns that could be attributed to race, ethnicity, religion, socioeconomic status, historical and social context, physical or mental ability, age, gender, sexual orientation, or generational and acculturation status. Includes an awareness that cultural differences may affect health and the effectiveness of health care delivery. Knowledge of disease prevalence in specific cultural populations, whether defined by race, ethnicity, socioeconomic status, physical or mental ability, gender, sexual orientation, age, disability, or habits.

Excess deaths: The statistically significant difference between the number of deaths expected and the number that actually occurred.

Health: A state of physical, mental, and social well-being and not merely the absence of disease and infirmity.

Health care organizations: Included are hospitals, managed care organizations, home health organizations, long-term care facilities, and community-based health care providers.

Health education: Any planned combination of learning experiences designed to predispose, enable, and reinforce voluntary behavior conducive to health in individuals, groups, or communities.[190]

Health literacy: The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.[191]

Health promotion: Any planned combination of educational, political, regulatory, and organizational supports for actions and conditions of living conducive to the health of individuals, groups, or communities.[192]

Health promotion activity: Broadly defined to include any activity that is part of a planned health promotion program, such as implementing a policy to create a smoke-free workplace, developing walking trails in communities, or teaching the skills needed to prepare healthy meals and snacks.

Healthy community: A community that is continuously creating and improving those physical and social environments and expanding those community resources that enable people to mutually support each other in performing all the functions of life and in developing to their maximum potential.[193]

Healthy public policy: Characterized by an explicit concern for health and equity in all areas of policy and by an accountability for health impact. The main aim of healthy public policy is to create a supportive environment to enable people to lead healthy lives by making healthy choices possible and easier for citizens. It makes social and physical environments health enhancing.[194]

High school completion rate: The percentage of persons aged 18 to 24 who are not currently enrolled in high school and who report that they have received a high school diploma or the equivalent, such as a General Education Development certificate.

Linguistically competent: Skills for communicating effectively in the native language or dialect of the targeted population, taking into account general educational levels, literacy, and language preferences.

Local health service areas: Local health jurisdictions and local health unit catchment areas.

Managed care organizations (MCOs): Systems that integrate the financing and delivery of health care services to covered individuals by means of arrangements with selected providers to furnish health care services to members. Managed care includes health maintenance organizations, preferred provider organizations, and point-of-service plans.

Patient and family education: A planned learning experience using a combination of methods, such as teaching, counseling, skill building, and behavior modification, to promote patient self-management and patient and family empowerment regarding their health.

Postsecondary institutions: Includes 2- and 4-year community colleges, private colleges, and universities.

Quality of life: An expression that, in general, connotes an overall sense of well-being when applied to an individual and a pleasant and supportive environment when applied to a community. On the individual level, health-related quality of life (HRQOL) has a strong relationship to a person's health perceptions and ability to function. On the community level, HRQOL can be viewed as including all aspects of community life that have a direct and quantifiable influence on the physical and mental health of its members.[195]

School health education: Any combination of learning experiences organized in the school setting to predispose, enable, and reinforce behavior conducive to health or to prepare school-aged children to be able to cope with the challenges to their health in the years ahead.[196]

Settings (worksites, schools, health care sites, and the community): Major social structures that provide channels and mechanisms of influence for reaching defined populations and for intervening at the policy level to facilitate healthful choices and address quality-of-life issues. Conceptually, the overall community, worksites, schools, and health care sites are contained under the broad umbrella of "community." Health promotion and health education may occur within these individual settings or across settings in a comprehensive, communitywide approach.[197]

Social capital: The process and conditions among people and organizations that lead to accomplishing a goal of mutual social benefit, usually characterized by four interrelated constructs: trust, cooperation, civic engagement, and reciprocity.[198]

Social ecology: The complex interactions among people and their physical and social environments and the effects of these interactions on the emotional, physical, and social well-being of individuals and groups.[199]

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Health Communication

Healthy People 2010 Goal

Use communication strategically to improve health.

Overview

This chapter describes the principles of health communication and highlights the vehicles through which health information is shared. Multidimensional approaches to health communication are needed from the macro level of entire populations to the micro level of communication between health care provider and consumer. Health communication activities rarely acknowledge the diversity of lesbian, gay, bisexual, and transgender (LGBT) people or develop health promotion campaigns targeted to LGBT people. Numerous barriers often prevent effective communication of LGBT-specific health promotion and disease prevention messages, and inadequate communication between health care providers and LGBT consumers can increase LGBT health disparities. Future health communication efforts should focus on increasing LGBT access to health information resources, including LGBT professionals in the development of appropriate health communication campaigns and materials, enhancing media literacy among LGBT individuals, supporting LGBT-focused research and evaluation of health communication activities, and ensuring that health care providers possess the knowledge, skills, and competency to communicate effectively with LGBT consumers.

Issues and Trends

Health communication is a critical component of efforts to improve personal and public health.[1, 2, 3] For individuals, effective health communication can help raise awareness of health risks and solutions, provide the motivation and skills needed to reduce these risks, help them find support from other people in similar situations, and affect or reinforce attitudes.[4] Health communication also can increase demand for appropriate health services and play an important role in helping consumers make complex choices, such as selecting health plans, care providers, and treatments.[5] For the community, health communication can be used to influence the public agenda, advocate for policies and programs, promote positive changes in the socioeconomic and physical environments, improve the delivery of

public health and health care services, and encourage social norms that benefit health and quality of life.[6]

Health communication alone, however, cannot change systemic problems related to health, such as lack of access to health care; poverty, discrimination, and prejudice; and lack of needed mental health services. Comprehensive health communication programs should include a systematic exploration of all the factors that contribute to health and the strategies that could be used to influence these factors. Well-designed health communication activities help individuals better understand their needs and their communities' needs, so appropriate actions can be taken to maximize health. Public education campaigns seek to change the social climate to encourage healthy behaviors, create awareness, change attitudes, and motivate individuals to adopt recommended behaviors.[7, 8, 9]

The Division of Neuroscience and Behavior Health, Institute of Medicine, National Academy of Sciences, is currently engaged in a project entitled Communication for Behavior Change in the 21st Century: Improving the Health of Diverse Populations.[10] The purpose of this report is to:

- Review existing theory and research applications in health communications and health behavior change, especially as they relate to culturally and demographically diverse populations
- Consider examples of public health interventions to evaluate characteristics that influence the effectiveness of public health campaigns
- Identify promising strategies for public health interventions to achieve a sustained change in the behaviors in diverse populations

Health messages are communicated from the macro level of population to the micro level of individuals. Population-based campaigns rely traditionally on mass communication such as print, radio, and television to deliver health messages. Some campaigns have integrated mass media with community-based programs, whereas others have used social marketing techniques. An emerging area is health communication to support community-centered prevention.[11] Community-centered prevention shifts attention from the individual to group-level change and emphasizes the empowerment of individuals and communities to effect change on multiple levels.

Increasingly, health improvement activities use digital technologies, such as CD-ROM and the World Wide Web (Web), that can target audiences, tailor messages, and engage people in interactive, ongoing exchanges about health.[12, 13, 14] Today's health care professionals are developing and applying new concepts for telecommunications-based health care systems, or telehealth. The Health Resources and Services Administration (HRSA) cochairs the Departmental Joint Working Group on Telemedicine, a Federal interagency group working to coordinate telehealth activity. Examples of health telecommunication projects funded by the Federal Government include:

- Systems that improve the care and treatment of patients in the home environment, especially with American Indian populations
- Telemedicine systems that offer new approaches to extending medical expertise to rural or underserved urban areas or nontraditional settings, such as schools
- Projects designed to improve communication between health care providers and patients and to enable consumers to participate more actively in their health care
- Projects to extend trauma care services beyond the emergency room
- Networks or information services aimed at disease prevention and health promotion

Despite the great importance and obvious success of electronic communication and social marketing, interpersonal communication remains indispensable. Personal communication reinforces every other health communication channel and can be most effective if there is attenuation to personal situations that necessitate recognition of particular situations or uncommon circumstances.

Communication occurs in all contexts (e.g., school, home, work); through multiple channels (e.g., interpersonal, electronic, mass media) with a variety of messages; and for innumerable purposes. People do not attend to all communications they receive but selectively attend to and purposefully seek out specific messages.[15]

LGBT people are exposed to traditional and emerging health communication sources; however, few sources acknowledge LGBT communities as a group or target health concerns of LGBT people. There are specific LGBT community-based newspapers, magazines, journals, directories of services and accommodations in States and cities, Internet sites, television, cable, satellite broadcasts, and radio media. (For specific information about each source, more information is available online at www.gaydata.com.) In addition, there is a National Lesbian and Gay Journalists Association (NLGJA) that was founded in 1990. The purpose of NLGJA is to work within the news industry to foster fair and accurate coverage of lesbian and gay issues and oppose newsroom bias against lesbians, gay men, and all other minorities. (More information is available online at www.nlgja.org.)

The Annenberg School of Communication recently released its second report of Lesbians and Gays in the Newsroom: 10 Years Later.[16] The following is part of Dean Geoffrey Cowan's Message concerning the report:

> "While treatment in the newsroom has apparently improved for gays and lesbians, the respondents felt that serious treatment in print and broadcast media had failed to keep pace, particularly with regard to local and regional issues. Their findings deserve widespread attention, for it would be a shame if the media have shown less initiative in covering local and regional issues involving gays and lesbians when bias based on sexual orientation remains a central societal issue."

The report gives accolades to the widespread coverage of dramatic and event-based stories, such as comic Ellen DeGeneres' "coming out" and the murder of Matthew Shepherd. However, the most negative judgments point out the void in covering local events in the daily lives of LGBT people, especially people of color.

The importance of multidimensional, audience-centered efforts. A one-dimensional approach to health communications, such as reliance on mass media campaigns or other single-component communication activities, has been shown to be insufficient to achieve program goals. Research indicates that effective health promotion and communication initiatives adopt an audience-centered perspective, which means that promotion and communication activities reflect audiences' preferred formats, channels, and contexts.[17] These considerations are particularly relevant for LGBT communities as health communicators must understand that the LGBT community mirrors the general population, from young to old, rural and urban, disadvantaged and not disadvantaged, and across all other minority and ethnic population groups. LGBT health communication materials must be culturally competent and linguistically accessible to the local community for which the materials are developed. A diverse range of customized messages should be developed so that the health needs of LGBT people can be adequately addressed. Public-private partnerships and collaborations need to be created involving LGBT organizations and consumers as coparticipants in designing, implementing, and disseminating health communication activities.

Advances in medical and consumer health informatics are changing the delivery of health information and services and are likely to have a growing effect on individual and community health.[18, 19, 20, 21] The convergence of media (computers, telephones, television, radio, video, print, and audio) and the emergence of the Internet create a nearly ubiquitous networked communication infrastructure. This infrastructure facilitates access to an ever-increasing, and sometimes confusing, array of health information and health-related support services and extends the reach of health communication efforts. Use of the Internet is changing how health professionals and health organizations inform consumers and reach potential patients and how consumers with shared interests or similar diseases or conditions interact with each other, such as in online support groups.

As with the general population, the lack of culturally appropriate, LGBT-specific health communication information may have LGBT individuals receiving guidance from health information sources that may be misleading, inaccurate, or inappropriate, thereby putting LGBT consumers at risk. For example, although many health professionals agree that the Internet is a boon for consumers because of easier access to more information, health care professionals also are concerned that the potential lack of credible information may jeopardize health rather than enhance wellness. In addition, concerns continue regarding privacy and confidentiality of personal health information. These are major issues for consumers when personal information is collected, stored, and made available online.[22] Given that some States may have laws prohibiting certain sexual behaviors, personal information is of particular concern to some LGBT individuals.

The trend in rapidly expanding opportunities in health communication intersects with recent demands for more rigorous evaluation of all aspects of the health care and public health delivery systems and for evidence-based practices.[23] Numerous studies of provider-patient communication support the connection among the quality of the provider-patient interaction, patient behavior, and health outcomes.[24] As the knowledge base about provider-patient interaction increases, a need becomes apparent for the development of practice guidelines to promote better provider-patient communication, including communication that occurs between health care providers of all disciplines and LGBT consumers.

National data systems will not yield the data needed to track many of the Healthy People 2010 population-based objectives in the first half of the decade. One area that currently has no tracking data is in evaluating health communication. Although it is not addressed in the Health Communication focus area, it is found in the Educational and Community-Based Programs focus area: consumer satisfaction with the health education and health information they received during their most recent search for such information. Health-conscious consumers increasingly are proactive in seeking out health information. Both the public health and medical communities share an interest in promoting and sustaining informed decisions for better health. Surveys suggest that people want to get health information from a professional and that counseling by health professionals can be effective both in reducing lifestyle risks and supporting self-management of chronic diseases like diabetes. (See Access to Quality Health Services focus area and Educational and Community-Based Programs focus area.) However, reduced time between provider and patient in clinical visits, along with some clinicians' discomfort with open communication, negatively impact an optimal information exchange. Health information should be not only easily accessible but also of good quality and relevant for the needs of the person. For LGBT communities, these challenges are of utmost concern because of numerous barriers that tend to inhibit open and honest communication with health professionals, such as fear of disclosing one's sexual orientation or gender identity, provider biases against or misunderstanding of sexual minorities, and limited access to culturally appropriate health care services.

Disparities

Individuals with the greatest health burdens often have the least access to information, communication technologies, health care, and social services. Even the most carefully designed health communication programs will have limited impact if underserved communities lack access to the appropriate health professionals, needed services, and communication channels that are components of a health improvement project. For LGBT individuals, the cultural relevance of health communication activities—whether they are implemented in provider offices, community-based programs, the mass media, or another venue—plays an important role in determining whether health promotion and disease prevention messages are heard, understood, accepted, and practiced.

Opportunities

For health communication to contribute to improvements in the health status of LGBT individuals and communities during the first decade of the 21st century, stakeholders—including LGBT consumers and organizations, health professionals, researchers, public officials, and the lay public—must collaborate on a range of activities. These activities include:

- Initiatives to build a robust health information system that provides equitable access for LGBT individuals
- Development of high-quality, LGBT-competent information and support services for specific health problems and health-related decisions for all segments of the LGBT population, especially underserved LGBT persons
- Training of health professionals in the science of communication, the use of communication technologies, and how to apply this knowledge appropriately and sensitively to the provision of health care services for LGBT communities
- Evaluation of LGBT-specific interventions and the testing of interventions that have demonstrated success in the general population to determine if they are likely to yield similar success in LGBT communities
- Promotion of a critical understanding and practice of effective health communication

The Stepping Stone is a San Diego provider of services related to human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) and substance abuse. Headquartered in the heavily LGBT Hillcrest neighborhood, the Stepping Stone was the recipient of county contract funds to conduct alcohol prevention activities for the city's large LGBT population. Its initial Community Needs Assessment survey reported that members of San Diego's LGBT community were largely uninformed about substance abuse-related health topics. Reviewing LGBT-targeted publications available in the city, the survey noted a near-total absence of articles relating to alcohol, tobacco, and other drugs. Although it gave local media high marks for their extensive coverage of HIV/AIDS, the survey found a lack of discussion in this coverage of the known association of substance abuse and HIV/AIDS. Concluding that the apparent dependence of the LGBT press on alcohol and tobacco advertising had effectively silenced this important voice for health communication, the survey then looked at 25 LGBT-serving organizations in San Diego County. Here, the Stepping Stone writers also identified a conflict between funding sources and organizational policies, advocacy, and public health education and communication. Similarly, it was noted in the report that the four major annual gay pride and HIV/AIDS awareness events held in San Diego had substantial alcohol sponsorship funding, resulting in public events where alcohol abuse was commonplace.

Effective health communication—regardless of the method or context through which it occurs—has the potential to be a powerful force in improving LGBT health. For example,

health communication between a lesbian and her health care provider may be evaluated according to its responsiveness to her personal cultural context and her individual desire for specific information, possibly with reference to her relationship status, domestic issues, reproductive health, or relevant cancer risk. Similarly, health information directed to subsets of the LGBT community in a given geographic region should address emerging health issues (such as the rebound of syphilis among men who have sex with men [MSM] in a number of urban centers in the United States) in a meaningful and timely manner.

However, advocates for LGBT-competent health communication should not reduce community norms, values, information needs, and literacy levels to a single archetype. For example, the socially connected, urban adult gay men may be assumed to have a level of HIV risk information above that of the average person in the United States. However, MSM who live in rural areas, are young, do not self-identify as gay or bisexual, or are members of communities of color may be expected to have specialized health information needs that differ greatly from any assumed norm. The same is true for lesbians and bisexual women, transgender individuals, and other LGBT populations that could be accurately characterized by socioeconomic, racial/ethnic, geographic, and cultural diversity.

Social marketing and empowerment approaches to health communication have been developed and evaluated extensively in the gay male community, specifically around HIV prevention,[25, 26, 27, 28, 29, 30, 31] and in hard-to-reach LGBT populations, such as MSM who do not identify as gay, women who engage in sex for drugs, injection drug users, female sex partners of injection drug users, and high-risk youth.[32] These approaches, however, have yet to be broadly applied to the multiple health issues facing LGBT individuals (such as breast cancer, domestic and other interpersonal violence, sexually transmitted diseases (STDs), substance use or abuse, and health problems associated with aging).

Summary of LGBT Research

Accessing the appropriate health care services is not the only barrier that LGBT individuals face when seeking health care services. Communication with health care providers also presents a serious challenge. Many practitioners openly or secretly harbor negative attitudes toward LGBT individuals. Some physicians have even reported that they are uncomfortable providing care to lesbian and gay patients.[33]

Where a person is in the "coming-out" process also plays an important role in an individual's disclosure of his or her sexuality and sexual behaviors to providers. For example, gay and lesbian adolescents are likely to delay disclosure of their sexuality to clinicians, as are many homosexually active men and women who identify as heterosexual. Many gay men, lesbians, and bisexual men and women, moreover, do not disclose their sexual orientation to health care providers because they do not feel comfortable doing so or they fear receiving substandard care as a result of disclosure. Similarly, transgender persons report several barriers to accessing quality care, including the lack of provider education and knowledge on the unique health concerns of transgender individuals.[34] Consequently, disclosure of sexual orientation in a health care setting remains infrequent for the majority

of gay men and lesbians.[35, 36, 37, 38, 39] In addition, some LGBT people do not understand that they have specific health care needs related to their sexual orientation or gender, and so feel no need to disclose their status and thus risk discrimination.[40]

Physicians are not alone among health providers in facing difficulties in communicating with gay and lesbian patients. In a random sample survey of Virginia mental health providers, respondents acknowledged having lesbians in their practices, yet had little or no training about the special needs of these clients.[41] Some mental health practitioners continue to practice "reparative" therapy for homosexuality,[42] to use inadequate or inappropriate definitions for lesbians and gay men, or to state that they do not think the concerns of gay or lesbian clients are different from those of heterosexuals.[43, 44] Findings were similar in a California study of physicians dealing with lesbians and gay men.[45]

When faced with an uncomfortable interaction with a clinician, LGBT persons may lack the skills or self-efficacy to defend themselves. They may feel unable to change the provider's conduct, to resolve an uncomfortable situation, or to speak openly with a clinician about their discomfort. This may stem from a history of discrimination and the power imbalance often experienced between clinician and patient or from past negative experiences.

For example, in a study reported in 1997, LGBT youth in Washington State were asked to assess their access to health care and the quality of care they received. The study found that 66 percent of youth stated that their health provider had never brought up issues of sexual orientation. Many received inappropriate treatment and health education based on their provider's heterosexual assumptions and ignorance of the patient's true sexual orientation.[46] In focus groups conducted in seven cities with LGBT youth in preparation for HRSA's 1994 conference on the primary care needs of lesbian and gay youth, only one-third of youth reported that they could talk openly with providers about their sexual orientation. Four-fifths were sexually active. Yet, only half of their providers had discussed STDs and sexual activity with them, and only 55 percent of providers had discussed HIV risks. Although 61 percent of the youth had been tested for HIV, testing had been suggested by only 16 percent of primary care providers, and a majority of providers assumed their adolescent patients were heterosexual.[47]

Health consequences of poor communication. Disclosing one's sexual orientation to a health care provider is crucial to the provision of appropriate and sensitive care that is tailored and responsive to each individual's unique needs. Failure to establish rapport and communication between physicians and patients is associated with decreased levels of adherence to physician advice and treatment plans, and decreased rates of satisfaction.[48] Additionally, clinicians unaware of their patients' sexual orientation may fail to accurately diagnose, treat, or recommend appropriate preventive measures for a range of conditions. Although more research is needed on the effects of communication related to sexual orientation and medical care, small surveys suggest that successful communication and ease of sexual orientation disclosure may positively affect health risks and screenings. In another study, reported in 1997, of lesbians in Oregon,[49] 90 percent disclosed their sexual orientation to providers, and of these, 92 percent raised the issue themselves.[50]

Communication style of the provider was rated by respondents as the most important characteristic in determining ease of discussion about difficult issues. The lesbians who disclosed their sexual orientation were more likely to seek health and preventive care, to have a Pap test, to be nonsmokers, and to report comfort in communication with providers. By contrast, difficulty communicating with the primary care provider was associated with a delay in seeking health care.[51]

One of the most significant barriers to adequate patient education for transgender persons is that most health professionals lack the knowledge of transgender identity, sexuality, and health care issues necessary for them to respond adequately to their patients. As a result, responsibility for educating health care providers about transgender issues far too often falls on the patient.[52,53] This presents a formidable challenge for transgender persons who are also subject to discrimination from health care professionals based on their gender-variant physical and social presentations.[54]

Discussion of Healthy People 2010 Objectives

11-1: Increase the proportion of households with access to the Internet at home.

Healthy People 2010 notes that Internet access at home is necessary to supplement Internet access at work and in public facilities, such as libraries and schools, because "several limitations affect the use of online health information and support in these [latter] settings." These limitations include "privacy and confidentiality concerns" and "the potentially sensitive nature of health-related uses of the Internet." However, for youth, as well as other dependent persons, seeking information about LGBT-related health issues, simply having access at home may not resolve these concerns. LGBT youth may not be "out" to their parents and thus not able to access needed information openly. In addition, they may not have privacy for accessing the Internet at home, or their access to LGBT-related health information may be blocked, accidentally or deliberately, by commercial filtering software that fails to distinguish between health information and erotica.

Planet Information, located in Boston, is a free computer drop-in center open to the HIV/AIDS community in Boston. It offers Internet access, training in computer and wordprocessing programs, and assistance in finding online AIDS information. It was originally created to help people living with HIV infection learn more about their health. Over time, the program has expanded its scope to include housing and employment support.

To fulfill the underlying purpose of objective 11-1, it must be recognized that, for LGBT youth in particular, home access alone is not sufficient to overcome privacy and confidentiality concerns and to guarantee access to sensitive information. Access to LGBT-related health information must also be available in public settings, such as schools and libraries. Moreover, it is critical that commercial Internet filtering software, whether it is used in public facilities or in private homes, does not filter out legitimate LGBT health-

related information. For example, grants to local school districts for library services might be contingent upon allowing access to such health-related information without filtering, and software vendors should be given economic incentives not to produce software for either home or institutional use that filters LGBT-related health information.

Families and patients dealing with intersexuality (congenital sexual ambiguity) have expressed strong wishes to meet others dealing with similar conditions. Because intersexuality is relatively uncommon (about 1 in every 2,000 births), and because parents, patients, and clinicians have been reluctant to discuss sexual issues openly, this desire has often been met with frustration. The Internet provides an excellent opportunity to meet these types of communication needs. The ability to access information on health care and prevention and to discuss specific diseases or medical conditions in the privacy of one's own home is a revolutionary change. Support groups for intersexuality are flourishing on the Internet, and referrals to these important sources of information and peer support fulfill a compelling need.

11-2. (Developmental) Improve the health literacy of persons with inadequate or marginal literacy skills.

The existence of grassroots agencies and LGBT community media presents an important opportunity to reach and educate LGBT individuals with critical health promotion and disease prevention messages. For example, many public health advocates are concerned about the impact of accepting alcohol and tobacco industry funding on the policies and practices of public benefit organizations. They also fear that accepting tobacco and alcohol funding may effect policy and programmatic choices. Mosher and Frank surveyed 62 national nonprofit organizations to assess their support for nine alcohol policy measures and to identify whether or not they had an organizational policy related to accepting or rejecting alcohol funding.[55] The study found strong overall support for alcohol policy measures, particularly among medical associations, alcohol and drug agencies, and faith communities. Two-thirds of the sample reported the existence of a policy or practice opposing the acceptance of alcohol industry funding. The presence of organizational policies and practices related to acceptance or rejection of alcohol funding was correlated with support for broader alcohol policy measures. Organizations accepting alcohol funding were less likely to endorse policy measures. Indeed, three of the organizations demonstrating strong advocacy for alcohol policy initiatives (Mothers Against Drunk Driving, Students Against Drunk Driving, and the National Council on Alcohol and Drug Dependencies) took these positions only after electing to refuse alcohol industry funding. Although alcohol problems are a significant health concern for organizations representing diverse populations, the rate of support for alcohol policy measures was low in this category apparently (based on comments during interviews) because these organizations are engaged in addressing issues of greater immediate concern to their constituents and have not yet considered alcohol policy issues. Lesbian and gay communities may have low rates of support for alcohol policy initiatives for similar reasons as other organizations representing diverse populations, but surveys specific to lesbian and gay organizations have yet to be conducted.

LGBT Health Web Sites

Advocates for Youth	www.advocatesforyouth.org
Asian and Pacific Islander Wellness Center	www.apiwellness.org
BiNet, U.S.A.	www.binetusa.org
Gay and Lesbian Association of Retiring Persons	www.gaylesbianretiring.org
Gay and Lesbian Medical Association	www.glma.org
Gay and Lesbian National Hotline	www.glnh.org
Gay, Lesbian, and Straight Education Network	www.glsen.org
Gay Men of African Descent	www.gmad.org
Gay Men's Health Crisis	www.gmhc.org
Human Rights Campaign Resource to Coming Out	www.hrc.org/ncop/guide.html
Lesbian, Gay, Bisexual, and Transgender Caucus	www.stophiv.com/~lgbc
Lesbian Health Foundation	www.lesbianhealthfoundation.org
Mautner Project for Lesbians with Cancer	www.mautnerproject.org
National Clearinghouse for Alcohol and Drug Information LGBT Web site	www.health.org:80/features/lgbt/index.htm
National Latina/o Lesbian, Gay, Bisexual, and Transgender Organization	www.llego.org
National Youth Advocacy Coalition	www.nyacyouth.org
Parents, Families, and Friends of Lesbians and Gays	www.pflag.org
Senior Action in a Gay Environment	www.sageusa.org

Advertising in gay publications is increasing, with the top categories of advertisers including pharmaceutical companies, travel, fashion, and alcohol.[56] Advertising may influence content of gay and lesbian publications, like other mainstream publications. A San Diego community assessment found high rates of alcohol ads and substantial coverage of general HIV/AIDS issues in local lesbian and gay publications. However, the assessment also revealed little coverage of alcohol and other drug problems and no mention of the link between HIV and substance use.[57]

A number of articles in alcohol industry publications document the increase in target marketing to LGBT communities. An article on the evolution of advertising of mainstream products, particularly advertising campaigns by Philip Morris (a tobacco manufacturer) and three alcohol importers, quotes a business manager who specializes in markets: "If you are in a business that has declining volume and share, you have to identify franchises . . . For a liquor company not to be targeting someone like that is ludicrous."[58] Clearly, companies target LGBT communities, and the strategies they employ include running mainstream ads in the gay media, creating gay-themed ads for the gay media, and, in some instances, running gay-themed ads in mainstream media.[59]

11-3: (Developmental) Increase the proportion of health communication activities that include research and evaluation.

The multiple negative health risks faced by LGBT individuals demand the highest levels of health communication, risk communication, and health promotion. However, evidence of effective health communication interventions for LGBT communities is largely limited to the HIV prevention and treatment adherence literature.

In terms of health communication initiatives, innovations in the creation of helping relationships with gay male community members,[60] assessments of the communication quality of gay men in clinical settings,[61, 62] application of opinion leader models, and other community-level prevention interventions[63, 64, 65] have all established best practices and an extensive literature base in the realm of HIV-related health communication. However, no such depth of research and evaluation exists for other LGBT health areas.

Limited literature is beginning to develop around the effectiveness of clinical care[66, 67] and broader health promotion[68] programs for lesbian and bisexual women. Yet, there is ample room for the examination and rigorous evaluation of historic and emergent approaches to targeted health communication across sexual minorities and their cultural subsets. In addition to examining and assessing singular health communication methodologies and venues that show promise, additional success documented among gay and bisexual men around HIV prevention goals point toward more comprehensive and integrated health promotion approaches. These pose significant research challenges. Yet the relative success of mainstream campaigns around tobacco control, cardiovascular health, and childhood immunization—all of which rely on the combination of clinical preventive care, individual education, social marketing, media campaigns, and peer influence to effect behavioral change—challenges LGBT health professionals to develop equivalent, comprehensive health promotion efforts that are monitored for effectiveness.

There continues to be a lack of LGBT-specific research and evaluation on health communication activities. Funding for the development and evaluation of such messages should be provided by government, foundations, and private sources. A small but growing body of work integrates consideration of environmental factors in lesbian and gay alcohol, tobacco, and drug-related problems.[69, 70, 71, 72] There is also a growing literature related to policy considerations and advancing public health strategies to address the intersecting concerns of substance use and HIV/AIDS.[73, 74, 75, 76, 77, 78, 79, 80] For example, recommended action steps from a meeting convened to discuss HIV prevention and alcohol and other drug use prevention among MSM included the development of tools to evaluate programs using social and environmental change to promote individual change among MSM, closer collaboration between researchers and community-based prevention programs, and further research on cultural and societal factors in addressing HIV and substance abuse prevention among MSM of color.[81] Other experts in HIV/AIDS and substance abuse prevention call for public health initiatives that address environmental issues and build on community assets. Such ideas include use of social interventions and community building for HIV prevention[82] and adopting a marketing approach that integrates prevention activities into arenas that

people are already willing to engage in (e.g., health clubs, social services).[83] Increasing availability of population-specific alcohol and drug treatment programs and prevention services may also serve to reduce HIV/AIDS and other health problems.[84]

11-4: (Developmental) Increase the proportion of health-related World Wide Web sites that disclose information that can be used to assess the quality of the site.

Disclosure of privacy and confidentiality policies by health-related Web sites is of special importance to LGBT users because many such users may not be out to their families, schools, or employers, and might not want information on themselves and the health topics they have researched to be shared with others. An example of a Web site that provides LGBT-related health information and that conforms to the essential information disclosure guidelines of Healthy People 2010 is the GLBT Health Web page (www.metrokc.gov/health) sponsored by the Seattle and King counties departments of public health in Washington State.

11-5: (Developmental) Increase the number of centers for excellence that seek to advance the research and practice of health communication.

Several centers have been developed or are under development at universities around the country. These include the Center for Research on Health and Sexual Orientation at the University of Pittsburgh; the Center for Lesbian Health Research at the University of California at San Francisco;

Day treatment programs have demonstrated success in providing patients in mental health systems with community-based support services and preventing rehospitalization for patients with persistent mental illness. Outpatient nonmethadone treatment programs or day treatment programs have been found to be comparable to residential treatment programs in terms of outcomes, such as drug use, criminal activities, and productivity. The benefit/cost ratio of an outpatient program was found to be higher than those of residential programs. In spite of the application of day treatment programs in the mental health and drug treatment systems, the efficacy of retreat (camp-out) and day treatment (camp-in) programs on the reduction of HIV risk behaviors has not been systematically evaluated.

The Asian and Pacific Islander Wellness Center (APIWC), a San Francisco-based AIDS service organization targeting people of Asian and Pacific Islander descent, has an 8-week HIV prevention retreat program that is being tested for Asian and Pacific Islander MSM, youth, and HIV-positive MSM. The comparison group receives standard, prevention-oriented case management.

Participants have informally expressed their satisfaction with the camp-out program, noting increased bonding with other participants and increased access to nonfamily social networks. In particular, the camp-out program appears to provide a safe place for youth to talk openly about their sexuality and to receive personal support from both family and nonfamily members. Staff at APIWC noted that the camp-out program culturally fits Asian and Pacific Islander MSM and that participants seem to sustain protective behaviors after participating in the program.

the Center for Lesbian, Gay, Bisexual, and Transgender Health at the Joseph L. Mailman School of Public Health at Columbia University and its affiliated Lesbian Health Research Institute; and the Institute on Sexuality, Inequality, and Health at San Francisco State University. Such centers for excellence on LGBT health should be supported, enhanced, and expanded. Information on best practices and successful models that come out of these LGBT-focused centers for excellent should be broadly disseminated to public- and private-sector health professionals and health plans.

11-6: (Developmental) Increase the proportion of persons who report that their health care providers have satisfactory communication skills.

Many of the specific barriers that inhibit effective communication between health care providers and LGBT health care consumers are discussed earlier in this chapter in the Summary of LGBT Research and in the Access to Quality Health Services focus area and in the Educational and Community-Based Programs focus area in objective 7-8.

Services—RECOMMENDATIONS

- Clinical care providers for LGBT individuals should create opportunities to examine risk patterns as well as behaviors and options for risk reduction and to promote the adoption of health promotion practices through the establishment of safe and culturally responsive environments.
- Targeted health information should be delivered to high-risk and hard-to-reach LGBT individuals directly in their social contexts, including neighborhoods, socializing spaces, sexual environments, and workplaces.
- LGBT individuals identified as at risk should have access to individual and small group interventions founded on intervention research published in peer-reviewed health journals. These interventions should focus on relevant behavior patterns and should work to build motivation and skills to reduce harm associated with these behaviors.
- Community-level interventions targeted to various LGBT communities should be further developed to address large-scale patterns of risk and to influence health-supporting practices. These should include social marketing and electronically based forms of health communication.

Education and Training—RECOMMENDATIONS

- Health care providers of all disciplines should be provided with education and training on how to communicate with LGBT consumers and families in a culturally competent way and how to reduce barriers to effective communication.

Policy and Advocacy—RECOMMENDATIONS

- Health communication directed toward LGBT people should build upon the considerable health promotion literature and be founded on established principles predictive of successful outcomes.

Research—RECOMMENDATIONS

- Research is needed to determine if access to LGBT-specific health information improves health-seeking behaviors, increases access to care, enhances knowledge, and yields better health outcomes for LGBT consumers and families.
- At each level of intervention, a rigorous assessment, process monitoring, and outcome/impact measurement should be performed to assess the application of interventions previously tested with non-LGBT populations and subsets of the LGBT community not previously studied.
- Research is needed to determine the most appropriate health communication strategies for hard-to-reach LGBT populations such as those in rural areas, Native Americans, and persons with disabilities.

Terminology

Advocacy: Communication directed at policymakers and decisionmakers to promote policies, regulations, and programs to bring about change.

Availability: Content (whether a targeted message or other information) that is delivered or placed where the audience can access it. Placement varies according to audience, message complexity, and purpose—from interpersonal and social networks to billboards, mass transit signs, prime-time TV, and radio and from public kiosks (print or electronic) to the Internet.

Consumer health informatics: Interactive health communication focusing on consumers. (See also Interactive health communication.)

Cultural competence: The design, implementation, and evaluation process that accounts for special issues of select population groups (ethnic and racial, linguistic) as well as differing educational levels and physical abilities.

Health communication: The art and technique of informing, influencing, and motivating individual, institutional, and public audiences about important health issues. The scope of health communication includes disease prevention, health promotion, health care policy, and the business of health care as well as enhancement of the quality of life and health of individuals within the community.[85]

Health education: Any planned combination of learning experiences designed to predispose, enable, and reinforce voluntary behavior conducive to health in individuals, groups, or communities.[86]

Health literacy: The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.[87] (See also Literacy.)

Health promotion: Any planned combination of educational, political, regulatory, and organizational supports for actions and conditions of living conducive to the health of individuals, groups, or communities.

Interactive health communication: The interaction of an individual with an electronic device or communication technology to access or transmit health information or to receive guidance on a health-related issue.[88]

Internet: A worldwide interconnection of computer networks operated by government, commercial, and academic organizations and private citizens.

Literacy: The ability to read, write, and speak in English and to compute and solve problems at levels of proficiency necessary to function on the job and in society, to achieve one's goals, and to develop one's knowledge and potential.[89]

Outcome evaluation (sometimes called impact evaluation): Examines the results of a communication intervention, including changes in awareness, attitudes, beliefs, actions, professional practices, policies, costs, and institutional or social systems.

Patient communication: Information for individuals with health conditions to help them maximize recovery, maintain therapeutic regimens, and understand alternative approaches. Patient communication includes educational resources, provider-patient communication, and, increasingly, peer-to-peer communication.

Reach: Information that gets to or is available to the largest possible number of people in the target population.

Risk communication: Engaging communities in discussions about environmental and other health risks and about approaches to deal with them. Risk communication also includes individual counseling about genetic risks and consequent choices.

Social marketing: The application of marketing principles and techniques to program development, implementation, and evaluation to promote healthy behaviors or reduce risky ones.[90, 91]

Targeting: Creating messages and materials intended to reach a specific segment of a population, usually based on one or more demographic or other characteristics shared by its members.[92]

Telehealth: The application of telecommunication and computer technologies to the broad spectrum of public health, medicine, and health.

Telemedicine: The use of electronic information and communication technologies to provide clinical care across distance.[93]

Underserved: Individuals or groups who lack access to health services or information relative to the national average. The underserved population may include residents of rural, remote, or inner-city areas; members of certain racial and ethnic groups; socioeconomically disadvantaged persons; or people with disabilities.

World Wide Web (Web): An international virtual network composed of Internet host computers that can be accessed by graphical browsers.

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HIV/AIDS

Healthy People 2010 Goal

Prevent human immunodeficiency virus infection and its related illness and death.

Overview

Healthy People 2010 provides an extensive discussion of HIV/AIDS trends among heterosexual populations. It also places strong emphasis on reducing new HIV/AIDS cases among adolescents and adults. However, Healthy People 2010 does not adequately address recent trends among men who have sex with men, even though this population makes up both the majority of those in the United States currently living with HIV infection (including those who since 1981 have been diagnosed with AIDS). The Companion Document for LGBT Health has been written to present a relevant discussion of HIV/AIDS among other sexual minorities including bisexual individuals, lesbians, and transgender persons. This chapter also provides a brief, critical review of the impact of HIV/AIDS on lesbian, gay, bisexual, and transgender (LGBT) populations and presents issues and trends affecting the general population as well as LGBT communities.

The chapter outlines existing disparities, opportunities to help achieve Healthy People 2010 goals, and LGBT-specific HIV/AIDS research. After the discussion of the Healthy People 2010 objectives as they relate to LGBT communities, the chapter offers recommendations for future action.

Issues and Trends

In 1981, a new infectious disease, acquired immunodeficiency syndrome (AIDS), was identified in the United States.[1] Several years later, the causative agent of AIDS—human immunodeficiency virus (HIV)—was discovered. This discovery coincided with the growing recognition of AIDS in the United States as part of a global infectious disease pandemic.

Currently, HIV/AIDS has been reported in virtually every racial and ethnic population, every age group, and every socioeconomic group in every State and most large cities in the

United States.[2] Initially identified among men who have sex with men (MSM)* primarily in major urban areas on the east and west coasts of the United States,[3] the AIDS epidemic is now characterized by its diversity. The proportion of AIDS cases among MSM has decreased from nearly 65 percent of cases diagnosed in 1985 to approximately 40 percent of cases diagnosed since 1998.[4] The estimated number of persons living with AIDS has increased for each region between 1993 and 1998. The proportional distribution by region has changed slightly with an increase in the South from 34 to 37 percent and a decrease in the West from 23 to 20 percent.[5] Epidemiologic research demonstrates that there are increasing numbers of people living with HIV and AIDS in rural America.[6, 7]

Since 1981, 733,374 cases of AIDS have been reported to the Centers for Disease Control and Prevention (CDC).[8] The total number of cases reported each year is decreasing, after a large increase in 1993 when the case definition was expanded to include persons at an earlier stage of HIV disease.[9] Fifty-nine percent of adults and 58 percent of children with diagnosed AIDS have died.[10] The annual number of deaths among persons with AIDS has decreased although AIDS remains one of the leading causes of death among persons 25 to 44 years of age.[11]

The decrease in deaths partly reflects the leveling of AIDS-opportunistic illness incidence and improved survival among persons with AIDS due to improvements in medical therapeutics.[12] Providers must correctly use the rapidly accumulating new drugs for the treatment of HIV disease in order to treat persons with HIV most effectively.[13, 14]

AIDS surveillance has been the cornerstone of national efforts to monitor the spread of HIV infection in the United States and to target HIV prevention programs and health care services.[15] The advances in treatment diminished the ability of AIDS surveillance data to represent trends in the incidence of HIV infection or the impact of the epidemic on the health care system due to the significant lengthening of the time between acquisition of HIV infections and development of AIDS.[16] In response, CDC and the Council of State and Territorial Epidemiologists recommended that all States and territories include surveillance for HIV infection as an extension of their AIDS surveillance activities.[17] In 1999, 34 States conducted HIV surveillance and reported 21,048 new cases of HIV infection in adults and adolescents and a cumulative total of 127,648 people with HIV infection.[18]

Since the early 1980s, surveillance studies have identified five distinct populations and issues that have affected the epidemic in these populations (racial and ethnic minorities are disproportionately represented in these risk groups):

- MSM who frequently change sex partners and engage in high-risk sexual behaviors
- Injection drug users who share needles and syringes, especially those contaminated with HIV-infected blood

* The term "MSM" is used here to refer to men who engage in same-sex sexual behaviors with other men. No assumption is made about their sexual identity. A man who has sex with another man may self-identify as gay, bisexual, heterosexual, or reject all such categorizations. Therefore, the term "MSM" is used because it specifically denotes behavior that is the targeted by HIV prevention and intervention efforts. The terms bisexual, lesbian, and transgender are used to connote some sort of sexual identity.

- Heterosexual people who engage in high-risk sexual behaviors and/or injection drug use
- Incarcerated individuals who may be exposed to high-risk sexual behaviors
- Perinatal transmission among infants, caused by undetected or untreated HIV infection in pregnant females

The proportion of different population groups affected by HIV/AIDS has also changed over time. By 1998, 83 percent of the cumulative AIDS cases had occurred in males, 16 percent in females, and 1 percent in children under 13 years of age.[19] Forty-five percent of men and 43 percent of women were 30 to 39 years of age at diagnosis. Sixteen percent of men and 21 percent of women were in their twenties, and 27 percent of men and 22 percent of women were in their forties.[20]

The true extent of the epidemic remains difficult to assess for several reasons, including the following:

- Because of the long period of time from initial HIV infection to AIDS and because highly active antiretroviral therapy has slowed the progression to AIDS, new cases of AIDS no longer provide accurate information about the current HIV epidemic in the United States.[21]
- Because of a lack of awareness of HIV serostatus—as well as delays in accessing counseling, testing, and care services by individuals who may be infected or at risk of infection—some populations do not perceive themselves to be at risk. As a result, some HIV-infected persons are not identified and provided care until late in the course of their infection.[22]

HIV infection rates appear to have stabilized since the early 1990s at about 40,000 new infections per year, which represents a slowing from growth rates experienced in the mid-1980s.[23] At least 800,000 persons are infected with HIV, with more than 200,000 to 250,000 persons who are not aware of their infection.[24] About 335,000 persons are estimated to be in treatment with new antiretroviral treatment therapies, but some 215,000 are not currently in treatment.[25, 26, 27]

HIV prevention efforts save human suffering. Estimates of care and services costs per case of HIV/AIDS vary widely but are recognized as significant, hence the strong focus on prevention of HIV transmission. Prevention efforts include availability of culturally and linguistically appropriate HIV counseling and testing, partner counseling, and referral systems for individuals at high risk for HIV infection; needle and syringe exchange programs; and information, education, treatment, and counseling for injection drug users.[28, 29]

In late 1982, cases of AIDS attributed to blood transfusions were first reported in the United States.[30, 31] The publication, dissemination, and implementation of specific guidelines and recommendations to prevent HIV infection among health care workers and to test donated

blood for HIV[32, 33, 34, 35] have resulted in a reduction in transfusion-related AIDS and increased safety among health workers.

Another prevention success has been the 66-percent decline in perinatal transmission from 1992 to 1997.[36] With the finding that perinatal HIV transmission rates could be reduced substantially with zidovudine therapy during pregnancy, the U.S. Public Health Service issued guidelines recommending that HIV counseling and voluntary testing become a part of routine prenatal care for all pregnant women.[37] This policy ensures that HIV-infected pregnant women have access to important health care for themselves and have the opportunity to reduce the risk of HIV transmission to their infants. Subsequent declines in new AIDS cases among children demonstrate that these strategies are showing success in reducing mother-to-infant HIV transmission.[38, 39]

Deaths from AIDS continued to decline throughout 1997 and 1998 (down 42 percent and 20 percent, respectively, compared to 1996). The number of persons living with AIDS (AIDS prevalence) in 1997 and 1998 increased by 12 percent and 10 percent, respectively.[40,41] Declines in newly diagnosed AIDS cases and in AIDS deaths mean that an increasing number of persons are living with HIV infection. There is a need for improved HIV surveillance and increased early diagnosis to better direct prevention and treatment services to people with asymptomatic infection or mild illness.

Principal health determinants. Behaviors (sexual practices, substance abuse, and accessing prenatal care) and biomedical status (having other sexually transmitted diseases [STDs]) are major determinants of HIV transmission.[42] Unprotected sexual contact, whether homosexual or heterosexual, with a person infected with HIV and sharing drug-injection equipment with an HIV-infected individual account for most HIV transmission in the United States.[43, 44, 45] Increasing the number of people who know their HIV serostatus is an important component of a national program to slow or halt the transmission of HIV in the United States as it is estimated that up to one-third of infected persons do not know their HIV status.[46]

For persons infected with HIV, behavioral determinants also play an important role in health maintenance. Although drugs are available specifically to prevent and treat many opportunistic infections, individuals living with HIV infection also need to make lifestyle-related behavioral changes to increase the quality and quantity of life. The new HIV antiretroviral drug therapies for HIV pose certain difficulties. These therapeutics are expensive and the medication schedules can be more complex than other medications, thereby raising both access and adherence issues.[47] As HIV infection weakens the immune system, people with tuberculosis (TB) infection and HIV infection are at very high risk of developing active TB disease.[48]

Interventions. Interventions for combating HIV are behavioral as well as biomedical. There are over 200 guidelines on the Web site (www.guideline.gov) related to HIV/AIDS. Recent advances in antiretroviral therapy have been credited with dramatic declines in deaths associated with HIV/AIDS. However, declines in overall AIDS cases, particularly in the early epicenters of the epidemic such as San Francisco and New York City, predate the

advent of antiretroviral therapies and support the belief that behavior-based prevention programs are effective. In San Francisco, for example, new cases of AIDS among MSM began dropping in 1992, suggesting that sustained, comprehensive prevention activities begun in the 1980s succeeded in reducing HIV transmission in this group.[49]

The National Guideline Clearinghouse (NGC) is a public resource for evidence-based clinical practice guidelines. NGC is sponsored by the Agency for Healthcare Research and Quality (formerly the Agency for Health Care Policy and Research) in partnership with the American Medical Association and the American Association of Health Plans.

Behavioral interventions to prevent HIV vary, depending on the target, the designers, and available funding. Effective community-level prevention strategies in the United States have included social marketing interventions to increase condom use and messages about safer sex and needle sharing that rely on popular opinion leaders and role model stories.[50, 51, 52, 53, 54, 55] Effective small and large group interventions have aimed at increasing safer sex practices for high-risk HIV-infected men and women and have tended to employ cognitive behavioral and skill-building methods.[56]

Several effective individual counseling or education interventions have focused on increasing condom use and other safer sex practices for persons with HIV infection.[57] For example, at the individual level, client-centered HIV counseling and testing appear to be effective in preventing high-risk uninfected persons from becoming infected and in helping HIV-infected persons prevent transmission to uninfected partners.[58] Venues vary for interventions and include STD clinic waiting rooms, drug treatment centers, schools, community agencies, street settings, churches, mobile vans, and other community settings.[59]

Although HIV testing in STD clinics is an important intervention, detection and treatment of other STDs also are an important biomedical component of an HIV prevention program that should include both behavioral and biomedical interventions. STD prevention programs must address STD concerns and their cofactor role in HIV transmission. Early STD detection and treatment is a biomedical tool for lowering the risk for sexual transmission of HIV infection. Behavioral interventions emphasize reducing the number of sex partners, knowing the serostatus of one's partner, using condoms consistently and correctly, and avoiding risky sexual behaviors.[60, 61, 62]

Disparities

In the United States, compared to other racial and ethnic groups, African Americans and Hispanics are disproportionately affected by HIV/AIDS. Through December 1998, 688,200 cases of AIDS had been reported among persons of all ages and racial and ethnic groups, including 304,094 cases among Whites, 251,408 cases among African Americans, and 124,841 cases among Hispanics. Although 55 percent of the reported AIDS cases occurred among African Americans and Hispanics, these two population groups represent an estimated 13 percent and 12 percent, respectively, of the total U.S. population.[63]

In 1997, AIDS remained the leading cause of death for all African Americans aged 25 to 44—the second leading cause among African American females and the leading cause among African American males.[64] In 1996, for the first time, African Americans accounted for a larger proportion of AIDS cases than Whites, and this trend has continued. The AIDS case rate among African Americans in 1998 was 66.4 per 100,000 persons, or eight times the rate for Whites (8.2 per 100,000) and more than twice the rate for Hispanics (28.1 per 100,000).[65]

Among women with AIDS, African Americans and Hispanics have been especially affected, accounting for nearly 77 percent of cumulative cases reported among women by 1998. Of the 109,311 AIDS cases in women reported through December 1998, 61,874 cases occurred in African American women, and 21,937 occurred in Hispanic women.[66]

For young adults aged 20 to 24 years, 24,437 cumulative AIDS cases were reported through December 1998. Of this total, 10,107 (41 percent) occurred among African Americans, 8,804 (36 percent) among Whites, and 5,203 (21 percent) among Hispanics. Overall, 73 percent (17,797) of the AIDS cases in this age group occurred among males and 27 percent (6,640) among females. Among African Americans in this age group, 63 percent were male, and 37 percent were female. Among Hispanics, 74 percent were male, and 26 percent were female. Because the time from initial infection with HIV to the development of AIDS is long and variable (often 8 to 10 years or more), many of these young adults likely acquired their infections while in their teens.[67]

Among teenagers aged 13 to 19 years, 3,423 cumulative AIDS cases had been reported through December 1998. In this age group, 1,047 cases (31 percent) occurred among Whites, 1,654 (48 percent) among African Americans, and 668 (20 percent) among Hispanics. Overall, males accounted for 61 percent and females accounted for 39 percent of the AIDS cases in this age group. Among African American teenagers with AIDS, 46 percent were male, and 54 percent were female. Among Hispanic teens with AIDS, 67 percent were male, and 33 percent were female. Among White teenagers with AIDS, 79 percent were male, and 21 percent were female.[68]

The disproportionate impact of HIV/AIDS on non-White individuals underscores the importance of implementing and sustaining effective health education and prevention efforts for other racial and ethnic populations as well as populations at increased risk. For example, although Asian and Pacific Islanders account for 0.7 percent of adult male-reported HIV/AIDS cases, the service needs of gay and bisexual men from Asian and Pacific Islander communities are very important because 81 percent of these men with AIDS have sex with men, compared to 61 percent for all races and ethnic groups combined.[69] Gay and bisexual men with HIV/AIDS from American Indian and Alaska Native communities also are disproportionately represented.[70] HIV prevention efforts must take into account not only the multiracial and multicultural nature of society, but also other social and economic factors—such as poverty, underemployment, and poor access to health care.

Healthy People 2010 recommends an increase in the percentage of Americans who know their HIV status. Major health system barriers are limiting progress in this area. Cultural insensitivity by health care workers and organizations creates an environment in which potential HIV risks are not identified and may prevent individuals from seeking care and HIV testing, particularly because individuals do not feel comfortable in disclosing their sexual minority status or risk behaviors.[71, 72] Living in rural areas also is a risk factor for late diagnosis and entry into care. Heckman et al. (1996) noted that "several barriers to life-care services impacting rural persons with HIV/AIDS include the lack of adequately trained medical specialists, geographical distances and isolation from social support, insufficient or unreliable sources of transportation, and the lack of a cohesive support community for infected gay men and woman."[73] Finally, assumptions cannot be made that the positive and attitudinal changes seen among older MSM also apply to younger men. Research among gay and bisexual men suggests that some individuals are now less concerned about being infected than in the past and may take more risks.[74]

Opportunities

New, highly active antiretroviral therapy (HAART) has played a substantial role in reducing AIDS deaths and reducing opportunistic infections.[75] Although the long-term effects of combination treatment regimens are largely unknown, a growing body of evidence suggests that there is an association with hyperlypidemia, diabetes, and lipodystrophy.[76] Some of these conditions contribute to premature cardiovascular disease and mortality. Although effective HAART will reduce the HIV load in plasma, individuals on HAART may still be infectious. Drug-resistant strains of HIV have emerged and have been detected in as many as 16 percent of those who recently contracted HIV, [77] which raises serious concerns regarding treatment, safer sexual practices, and reinfection—especially as more and more people with HIV live longer and remain sexually active.

A retrospective case-control study of HIV-exposed health workers conducted by CDC, and extrapolation from the use of antiretrovirals to halt perinatal transmission, has led many experts to consider the possible use of postexposure prophylaxis to help contain viral replication in individuals who may recently have been exposed to HIV—either sexually or through injection drug use.[78] Studies are underway to evaluate this preventive approach, but these programs are expensive, are logistically difficult, and have experienced low utilization. This is not likely to be a practical prevention strategy.

Before the advent of HAART, a diagnosis of HIV/AIDS meant leaving the workplace, often permanently. HIV-infected individuals who were symptomatic frequently went on permanent disability, and most of them went home to die. Now, because of treatment, many people can continue to work, with few or no absences related to their illness. Those who have left the workplace temporarily are able to return to their old jobs or seek new ones.

Managing HIV at work presents unique problems and issues, with implications in the legal, medical, and psychosocial arenas as well as real challenges to time-management skills. The question of whether the health of people living with HIV/AIDS can be properly managed

along with full- or part-time work is first and foremost a situation to discuss with health care providers.[79] For some people who return to work, the benefits can be psychological as well as financial. However, for others, the stress of work may speed the progression from HIV infection to AIDS.[80]

Given the tremendous expense of antiretroviral therapy and other HIV/AIDS medications, some pharmaceutical companies offer indigent patient assistant programs. For example:

- Zidovudine (AZT, ZDV or Retrovir)
  Glaxo Wellcome Company
  1-800-722-9294
- Didanosine (ddl, Videx)
  Bristol-Myers Squibb
  1-800-426-7644
- Zalcitabine (ddc, Hivid)
  Hoffman-LaRoche
  1-800-526-6367
- Lopinavir (Kaletra)
  Abbott Laboratories
  1-800-222-6885

The employment provision of the Americans with Disabilities Act (ADA)[81] makes it unlawful to discriminate against people who have or are perceived to have disabilities. The ADA, which applies to public- and private-sector employers with 15 or more employees, covers HIV-infected individuals even when they are asymptomatic. At no time during the hiring process may an employee be required to disclose details of a disability. Disabled persons have the right to request and be granted "reasonable accommodations" that will enable them to participate in the application process and/or to perform functions essential to the job. The ADA also prohibits employers from discriminating on the basis of disability in the provision of health insurance to their employees and/or entering into contracts with health insurance companies that discriminate on the basis of disability. Thus, for example, blanket preexisting condition clauses do not violate the ADA unless a preexisting condition clause excluded only the treatment of HIV-related conditions.[82]

People with HIV/AIDS may qualify for disability benefits from the Social Security Administration (SSA) under two programs: Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI).[83] The medical eligibility rules for receiving SSDI and SSI are the same, but there are differences between the two programs. The amount of the monthly benefits of SSDI depends upon earnings while employed. Individuals qualify for Medicare if SSDI benefits have been received for 24 months. Medicare helps pay for hospital and hospice care, laboratory tests, home health care, and other medical services. People who have not worked long enough to qualify for Social Security, or whose Social Security benefits are low, may qualify for SSI payments if they have low income and limited resources. Children with disabilities who live in low-income households also may qualify for SSI. If people receive SSI, they also may be eligible for food stamps and Medicaid, a State-funded medical assistance program. Medicaid reimburses for medical bills including hospitalization and outpatient care. In some States, Medicaid pays for hospice care, a private nurse, and prescription drugs for HIV disease. If people return to work, benefits may still continue.[84]

Employer-provided health insurance programs allow workers and their families to take care of essential medical needs. These programs can be one of the most important benefits provided by an employer. Prior to 1985, group health insurance was available only to full-time workers and their families, but the condition of full-time employment changed in 1985 with the passage of certain health benefit provisions in the Consolidated Omnibus Budget Reconciliation Act (COBRA).[85] The COBRA contained health care provisions giving former employees, retirees, spouses, and dependent children the right to temporary continuation of health coverage group rates. COBRA coverage, however, had some gaps, most of which were closed with the passage of the Health Insurance Portability and Accountability Act (HIPAA).[86] Health insurance policies tended to differ widely relative to preexisting conditions and pharmaceuticals, and the HIPAA was designed to provide some consistency in coverage issues.

Managed care, the dominant organization and financing of health care services, is changing its policies and benefit packages for people who have HIV/AIDS. Although managed care organizations (MCOs) have little experience treating nontraditional populations such as people living with HIV/AIDS, States now offer Medicaid managed care for persons with HIV/AIDS.[87] One of the first Medicaid managed care programs in the United States was the Moore Clinic, a grantee program established by the Johns Hopkins University as a Ryan White CARE (Comprehensive AIDS Resources Emergency) Act's Special Project of National Significance funded by the Health Resources and Services Administration (HRSA).[88] Treating people with HIV/AIDS is not restricted to public-sector managed care. Kaiser Permanente Mid-Atlantic has a strong case management cooperative system.[89] In addition to MCOs, some other types of health insurers have changed their policies. For example, after fighting all the way to the U.S. Supreme Court, Mutual of Omaha Insurance announced plans to lift special restrictions on medical coverage for HIV/AIDS-related care.[90]

Health care providers and/or community counselors can assist people who have HIV/AIDS to live their lives with quality. Although Healthy People 2010 recommends an increase in the percentage of people who know their HIV status, major barriers are limiting progress in this area. Cultural insensitivity by health care workers and organizations creates an environment in which potential HIV risks are not identified and may prevent individuals from seeking care and HIV testing, particularly because individuals do not feel comfortable in disclosing their sexual minority status or risk behaviors.[91]

HIV prevention works. There are a wide range of proven strategies to reduce behaviors that increase the risk of transmitting or acquiring HIV.[92] With better treatment, more Americans are living with HIV/AIDS than ever before. However, this increase in the HIV-infected population creates more opportunities for transmitting the virus and thus a greater need for prevention.

There also is compelling evidence that testing and treatment of STDs can be an effective tool in preventing the spread of HIV.[93] Comprehensive HIV prevention programs may develop linkages with STD programs to incorporate:

- Community-based efforts to improve STD care-seeking behavior
- Quality onsite STD detection and treatment services at a variety of settings for HIV-infected persons and other persons at risk for HIV or other STDs and their partners
- Improved STD treatment for sex partners of infected persons
- Expanded STD surveillance systems

Because many adolescents across the country remain at risk for HIV, STDs, and unintended pregnancy, expanded efforts are required of families, schools, youth-serving organizations, and other social institutions that can influence adolescents to modify risky behaviors. The following actions are necessary:

- Encourage all young people to be involved in reducing their risk and spread of HIV/AIDS, to educate peers, and to develop responsible, healthy lifestyles
- Develop policies that protect the rights of youth to be informed and educated about HIV/AIDS and other STDs
- Establish or expand programs that increase access to quality, culturally competent health care services, and support groups for young adults with HIV
- Ensure that young people are protected from discrimination or exploitation resulting from their sexual orientation, gender identity, or HIV status.

LGBT persons living with HIV/AIDS who are members of population groups that lack access to preventive services—such as African Americans, Latino or Hispanic Americans, those with serious mental illness, substance users, and individuals who are homeless or incarcerated—require culturally competent, linguistically accessible services that meet their complex needs. LGBT persons living with HIV/AIDS and other medical or mental health problems also require a comprehensive array of health and related services, interventions, and supports, including housing, financial, and social support systems. The outcomes of 11 Federal demonstration projects serving persons living with or affected by HIV/AIDS consistently show that "Efforts to reach this alienated and heavily stigmatized population require specialized and

The HIV/AIDS Treatment Information Service (ATIS) is a central resource for Federally approved treatment guidelines for HIV and AIDS. ATIS is staffed by multilingual health information specialists who answer questions on HIV treatment options, using a broad network of Federal, national, and community-based information resources. Callers can reach this confidential, personalized service at 1-800-HIV-0440 (1-800-448-0440). More information is available online at www.hivatis.org.

targeted approaches that involve close collaboration among a broad range of disciplines and service providers." [94]

In October 1998, the Clinton administration declared HIV/AIDS in racial and ethnic minority communities a "severe and ongoing health crisis." [95] In 1998, the administration and the U.S. Department of Health and Human Services in collaboration with the Congressional Black Caucus announced a new $156 million initiative to address this crisis through increased funding and outreach to these communities. In fiscal year 1999 (October 1, 1998, through September 30, 1999), the Initiative targeted African Americans and Hispanic communities. In fiscal year 2000, the Minority AIDS Initiative was created to include all communities of color, and the funding to support the expanded programs was increased to more than $245 million. (For a breakdown of the Federal agencies and specific programs, more information can be found online at www.sfaf.org/policy/mhai_funding.html.)

Summary of LGBT Research

HIV prevention and treatment. HIV prevention and treatment presents a serious public health dilemma that is complicated by a myriad of social, environmental, and health system factors. Research and prevention materials typically target men who identify as gay, whereas others group gay and bisexual men as a single group.[96] Consequently, men of color, who may not identify as gay and may be at highest sexual risk for HIV, are often ignored in research and prevention, as are transgender individuals, lesbians, and women who have sex with women. For example, studies of bisexual behavior among men have found an association with reduced intentions to use condoms, knowing fewer HIV-positive people, insufficient knowledge and understanding of safer sexual practices,[97] and elevated rates of high-risk sexual activity.[98] The LGBT community recognizes that "survival sex"—including convenience sex, sex for drugs, or sex for food—are key behaviors in HIV transmission. Additional research and education materials are sorely needed, especially for men who have sex with both sexes and transgender persons. In addition, HIV-positive men who have sex with both sexes but do not identify with the gay and bisexual communities may not have access to the prevention, treatment, support, and health improvement systems readily available in many gay and bisexual communities.[99] The lack of identification with gay and bisexual communities and the range of support and health services they offer may raise similar barriers for transgender persons living with, or at risk for, HIV infection.

Behavioral interventions intended to reduce the risk of HIV transmission are the only means that have demonstrated effectiveness in slowing the spread of HIV.[100] Prevention and education efforts often are stymied by the reality that the LGBT population includes individuals from all walks of life, including those who identify themselves as gay, bisexual, and heterosexual and those who reject any such categorization. These challenges are further complicated by the fact that assessing one's sexuality, variations in levels of actual or perceived homophobia within various cultural and ethnic groups, and conflicts between ethnicity and sexuality may make it difficult for men to identify themselves as gay and contribute to denial regarding HIV risks.[101, 102] The fact that men who have sex with both

sexes often do not disclose their bisexuality to their female partners is also well documented.[103, 104] Likewise, LGBT partners may not disclose or be aware of their own serostatus or risk factors.[105]

LGBT communities of color in the United States have faced additional challenges associated with the management and prevention of HIV infection. In spite of recent Federal initiatives designed to bolster HIV prevention efforts, the feelings of inevitability and fatalism within these communities may hamper the effectiveness of the community's response. Even in the light of significant improvements in access to HIV treatment, communities of color, especially African Americans, continue to be underrepresented among individuals living with HIV who are in treatment.[106]

The efficacy of HAART therapies has created yet another unforeseen negative outcome for some LGBT people living with HIV. Treatment advances have contributed to a perception that AIDS has become a manageable, chronic illness in some communities. One study revealed that 18 percent of HIV-positive gay men practice safe sex less often than they previously did because of advances in treatment.[107] Although longevity has dramatically increased, HIV prevention efforts among MSM have not adapted to changes in the epidemic, and prevention efforts need to be reinvigorated and expanded with a particular focus on those MSM at greater risk for infection—youth, African Americans, Latinos, and substance users.

HIV/AIDS among MSM. HIV prevalence continues to be high among MSM (especially young MSM). In a recent study of young MSM aged 18 to 22 in seven urban areas from 1994 to 1998, a 7 percent infection rate was noted,[108] a rate significantly higher than the general U.S. population. Although HIV/AIDS is still widely considered by many as a public health concern that primarily affects gay White men, African American and Latino men in recent years have constituted the majority of AIDS cases among MSM.[109] In 1999, the AIDS incidence rate in African American MSM (55.5 cases per 100,000 men) was more than five times that for White MSM (10.9), and the rate for Latino MSM (26.8) was almost two and a half times greater than that for Whites. In contrast, the AIDS rate for American Indian MSM (10.9) was the same as that for White MSM, and the rate for Asian and Pacific Islander MSM (5.5 percent) was half. Meanwhile, within Asian and Pacific Islander communities, a majority of the AIDS cases (close to 70 percent) are MSM. However, statistics pertaining to Asians and Pacific Islanders and American Indians are complicated by the fact that the data statistically group both under the population category of "other." Also, many States still group these populations under "other." As a result, an "accurate base rate" of the two groups is not known. HIV reporting data are inadequate for MSM. The data do not reflect the HIV/AIDS epidemic among MSM. States that account for most of the infections in MSM do not have HIV reporting, and the data do not represent the affected populations. African Americans are overrepresented, and Latinos and Asians and Pacific Islanders are underrepresented.

HIV/AIDS among lesbians. The impact of HIV/AIDS on lesbian populations is not discussed in Healthy People 2010. The prevalence of HIV among lesbians and the risks

associated with female-to-female transmission (some women who have sex with women may not identify themselves as lesbians) have gone largely unstudied.[110] However, several reports have documented concomitant HIV risks, including injection drug use and bisexual male partners, among some subgroups of lesbians, in spite of known high rates of new infections among women and other marginalized communities. One San Francisco study of HIV-positive women reporting female sexual partners found that the HIV-positive women were twice as likely to have used drugs and significantly more likely to have had anal intercourse with a man than those who did not report having a female sexual partner.[111]

HIV/AIDS among transgender individuals. There are now sufficient recent studies to document high HIV seroprevalence rates among some groups of male-to-female (MTF) transgender persons in the United States. Seroprevalence rates ranging from 22 to 47 percent have been documented within urban subpopulations of MTF transgender individuals across the United States.[112, 113, 114, 115, 116] HIV seroprevalence rates appear to be especially high among African American MTF transgender persons.[117, 118] Despite numerous studies showing high levels of HIV infection and high-risk sexual behavior among MTF transgender individuals, the prevention needs of transgender persons continue to go largely unaddressed at the national level. Moreover, even less is known about men who have sex with MTF transgender persons, especially those who have sex with MTF sex workers. These men may also have male and female sex partners, representing a significant, yet unmeasured means of HIV transmission.[119] In addition, very little is known about the HIV risks for female-to-male (FTM) transgender individuals, who constitute a largely invisible population with regard to sexual risk behaviors.[120, 121] In a recent policy statement, the American Public Health Association urged that both MTF and FTM transgender individuals should be recognized by research and health care communities as populations whose needs are unique and distinct from those of gay men and lesbians.[122]

HIV/AIDS and adolescents. Gay youth are a subgroup of MSM that are more likely to engage in high-risk behavior and are at increased risk for HIV infection. The same may be true for young transgender individuals. HIV infection rates among adolescents and young adult MSM remain very high. One sample of young, urban MSM aged 15 to 22 found that 7 percent were infected with HIV, with the highest rates among African American (14 percent) and Latino youth (7 percent) being disproportionately represented. (The rate among Whites was 3 percent).[123, 124] Another study of inner-city youth participating in a gay community center program reported consistent condom use in only 13 percent of adolescent MSM, whereas one-quarter were engaged in prostitution and all subjects reported at least some sexual activity.[125] Rates of new infections tend to be high among people of color. School health education on HIV and STD prevention is another opportunity for progress that has gone largely untapped. (See Educational and Community-Based Programs focus area.)

HIV/AIDS, stigma, comorbidity, and culture. HIV/AIDS disproportionally affects ethnic minority populations where rates of poverty, homelessness, mental health disorders, and substance abuse are higher. Presumably, the numbers of LGBT persons in these populations is proportionate to the numbers in the population as a whole—5 to 10 percent.[126]

Discussion of Healthy People 2010 Objectives

13-2: Reduce the number of new AIDS cases among adolescent and adult men who have sex with men.

Community-based education has long been a mainstay in efforts to reduce the risk of HIV exposure.[127] However, persistently high rates of HIV infection among MSM indicate that HIV/AIDS prevention messages are no longer adequate, especially in light of recent advances in HIV therapy—most notably, the introduction of potent antiretroviral therapy.[128]

Current prevention efforts may be less effective than before because the nature and the magnitude of the epidemic has changed. Social marketing techniques and strategies that are responsive to new sexual attitudes and practices (e.g., the Internet) are seldom used. In addition, many messages have presumed that MSM are gay and therefore engage only in homosexual behavior. However, MSM may also have sex with other partners including women and transgender people. There is a strong behavioral bias in messages such as "consistent condom use" with all sexual partners. Although condoms have demonstrated success in helping to prevent the spread of HIV, the process by which different individuals determine whether or not they are going to use condoms is often complex. In anecdotal conversations, gay men who sometimes "slip," argue that condom use takes away their romance and intimacy. As for women, it is often an issue of power and negotiation between them and their sexual partners.[129]

Assumptions have been made that the epidemic is less severe because of health-positive images in commercial advertising targeting gay and bisexual men (and perhaps transgender individuals) that promote images of physical vigor and vitality associated with HIV.[130]

Another major concern is the transmission of HIV strains that are resistant to antiretroviral therapies. Such strains have been reported in 5 to 16 percent of those infected.[131] This raises new challenges for promoting safer sexual practices and educating infected persons about ways to prevent reinfection. It also underscores the need for additional research and effective, culturally competent health promotion. This could result in the possible sexual transmission of resistant strains from one HIV-infected person to another, which could in turn jeopardize the efficacy of antiretroviral therapy.

13-3: Reduce the number of new AIDS cases among females and males who inject drugs.

After nearly two decades of research on the HIV/AIDS epidemic, much is known about different populations impacted by the disease, including those affected directly or indirectly by drug use. Men who have sex with other men who use drugs have not received the same research attention as other drug users, despite the fact that they represent nearly one-fifth of AIDS cases.[132, 133, 134]

Additional research is needed to better understand the degree to which LGBT populations, especially youth, are at increased risk for HIV infection because of recreational drug use or hormonal injection among transgender individuals.

13-6: Increase the proportion of sexually active persons who use condoms.

As stated earlier, there is increasing evidence that high-risk sexual behavior may be on the rise. The advances in HAART may create a sense of false security among MSM that HIV is a manageable chronic infection.[135] Research has found that, although most gay men have protected sex most or all of the time, as many as one in three MSM report having unprotected anal sex.[136, 137] Possible reasons for such high rates of unprotected sex and perceived lower risks include selected risk-reduction strategies (e.g., having unprotected sex primarily or exclusively with partners they believe to share the same serostatus),[138, 139] low self-esteem, lack of social supports, "mood" prior to the sexual encounter, optimism, fatalism, age, education, and alcohol or drug use.[140] No data on rates of unprotected sex among transgender individuals are available. New strategies need to be developed to reach young MSM who do not identify as gay or bisexual and may be "underground." This will most likely involve researching, testing, and communicating alternative prevention messages, through nontraditional communications vehicles, to reach young MSM. Schools are the ideal setting for teaching LGBT youth before they become sexually active.

Older LGBT individuals receive less HIV-related information and are typically ignored by HIV education and prevention programs.[141] Additional efforts are needed to ensure that older LGBT populations are included in HIV prevention and education activities.

There is also a need to increase the availability of condoms to incarcerated individuals. The categorization of "MSM" captures a diverse array of subpopulations that may identify as gay, bisexual, or heterosexual. However, "MSM" does not typically include transgender individuals because they often do not identify themselves as such or are excluded either by organizations conducting prevention activities or by the community being targeted for prevention. As a result, the preventive health needs of transgender persons largely go unaddressed.

13-7: (Developmental) Increase the number of HIV-positive persons who know their serostatus.

Men who do not identify as gay are less likely to perceive themselves at risk for HIV and thus may avoid HIV screening.[142] Among other LGBT populations (e.g., Asians and Pacific Islanders), testing for HIV may be a function of health beliefs and choice of medical procedures (e.g., standard blood test vs. OraSure,). That is, help-seeking behaviors (e.g., see a doctor or health care provider for HIV versus diet) is a function of a complex social arrangement. Without taking these health beliefs or norms into consideration, achieving this objective will be a challenge. And as indicated earlier, the lack of anonymous testing is a barrier to increasing the number of persons with HIV who know their serostatus.

13-9: (Developmental) Increase the number of State prison systems that provide comprehensive HIV/AIDS, sexually transmitted diseases, and tuberculosis (TB) education.

Homosexual activity among males occurs in prisons. However, many prison systems do not officially acknowledge this activity and therefore do not provide condoms. Several recent court cases indicated that incarcerated transgender individuals may be more likely to be sexually assaulted while in prison.[143, 144] Thus, comprehensive HIV education should be made available in all correctional facilities and systems.

13-10: (Developmental) Increase the proportion of inmates in State prison systems who receive voluntary HIV counseling and testing during incarceration.

Health-related services (e.g., access to condoms, counseling, testing) should be made available in all correctional facilities and systems.

13-14: Reduce deaths from HIV infection.

There is a growing perception that LGBT individuals, particularly those from disenfranchised communities (e.g., younger, poorer, from communities of color) are not tested for HIV as often as necessary. Delays in seeking testing services ultimately results in delays in accessing treatment for those who test positive. Transgender individuals may not be tested as frequently as appropriate.[145, 146] Culturally sensitive testing and counseling is necessary to reach out to LGBT communities that have been traditionally marginalized and have avoided seeking testing and counseling.

In spite of recent advances in HIV treatment, available medications are not necessarily effective for all patients due to patient nonadherence to the treatment regimen, toxicity, or the ability of HIV to become resistant. These factors can lead to increased morbidity and mortality. Proper adherence to the medical treatment regimen is essential and can dramatically improve the quality of life for individuals living with HIV. It is also critical for adherence education to be culturally specific. Renewed efforts are needed to promote early and appropriate treatment as soon as possible after HIV diagnosis.

Services—RECOMMENDATIONS

- Public and private-sector systems of care should implement comprehensive strategies to promote culturally competent, appropriate, and linguistically accessible HIV prevention messages to high-risk youth, particularly LGBT adolescents.
- Efforts are needed to better integrate prevention and treatment strategies for HIV/AIDS and primary care.
- There is a need for a national HIV prevention strategy for gay and bisexual men, the population at greatest risk for infection. Such a strategy should reflect the racial, ethnic, geographic, cultural, and age diversity of the gay and bisexual community and should be

easily adaptable for population-specific marketing, including men of color, older gay and bisexual men, youth, gay and bisexual men in rural areas, and other diverse groups.

- There is a need to increase, through multiple measures, the percentage of individuals who know their HIV status.

Education and Training—RECOMMENDATIONS

- Health education materials need to be culturally specific to address the needs of transgender people and other sexual minority communities.[147, 148, 149]
- Cross-training is needed among all health care workers, especially those working with youth, acknowledging the interrelatedness of risky behaviors.

Policy—RECOMMENDATIONS

- Health departments need to form alliances with community-based organizations to address the epidemic at the local level by conducting needs assessments and funding community-based prevention and treatment strategies.
- Health insurance companies and managed care organizations should create incentives for health plans, providers, and provider organizations to develop targeted preventive interventions and accompanying early intervention services.

Research—RECOMMENDATIONS

- More data are needed on the incidence and prevalence of HIV infection in specific communities, the means by which individuals become infected, and how they identify themselves (LGBT, heterosexual, or otherwise).
- Additional studies are needed to better understand the potential risks associated with using recreational drugs, hormonal therapy (including transgender-related hormone therapy and anabolic steroid use among men), and other medications while on antiretroviral therapy.
- Research is needed to assess the long-term effects of combination anti-HIV drug regimens.
- Studies are needed to identify effective HIV prevention interventions for MSM (only 11 of 98 rigorous intervention studies in the United States have included MSM).

Terminology

AIDS: Acquired immunodeficiency syndrome, the most severe phase of infection with human immunodeficiency virus (HIV). Persons infected with HIV are said to have AIDS when they get certain opportunistic infections or when their CD4+ cell count drops below 200.

CD4+ cell count: A measure of the number of CD4+ cells present in the blood. Because HIV infection kills CD4+ cells, the CD4+ cell count is used to track the progress of HIV infection.

Cost-effective: Indicates that the cost of a particular intervention compares favorably to lifesaving interventions associated with other diseases.

Cost-saving: Indicates that a particular intervention averts health care costs in excess of the cost of the intervention.

HAART (highly active antiretroviral therapy): Aggressive anti-HIV treatment usually including a combination of drugs called protease inhibitors and reverse transcriptase inhibitors whose purpose is to reduce viral load infection to undetectable levels.

HIV (human immunodeficiency virus): A virus that infects and takes over certain cells of the immune system that are important in fighting disease.

HIV antiretrovirals: Drugs, such as zidovudine (AZT) and saquinavir, designed to attack HIV and prevent it from multiplying.

Opportunistic infections: Infections that take advantage of the opportunity offered when a person's immune system has been weakened by HIV infection. At least 25 medical conditions, including bacterial, fungal, and viral infections and certain types of cancer, are associated with HIV infection.

Pandemic: An epidemic over a large area or country.

Prevalence: A proportion of persons in a population who are infected, at a specified point in time or over a specified period of time, with HIV.

Prophylaxis: Measures designed to prevent the spread of disease and preserve health; protective or preventive treatment.

Protease inhibitor: A drug that binds to and blocks HIV protease from working, thus preventing the production of new functional viral particles.

Serostatus: The result of a blood test for the antibodies that the immune system creates to fight specific diseases.

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Immunization and Infectious Diseases

Healthy People 2010 Goal

Prevent disease, disability, and death from infectious diseases, including vaccine-preventable diseases.

Overview

This chapter focuses on the vaccine-preventable diseases of primary concern to lesbian, gay, bisexual, and transgender (LGBT) populations: hepatitis A and hepatitis B. It highlights both the financial and preventive benefits of making vaccinations for hepatitis A and hepatitis B more readily available to LGBT populations—especially men who have sex with men (MSM) and transgender persons who have sex with men. The chapter also has a discussion of hepatitis C and tuberculosis transmission among MSM.

Issues and Trends

Between 1980 and 1992, the number of deaths from infectious diseases rose 58 percent in the United States.[1] Even when diagnoses associated with human immunodeficiency virus (HIV) and acquired immunodefiency syndrome (AIDS) are removed, deaths from infectious diseases still increased 22 percent during this period. (See HIV/AIDS focus area.) Considered as a group, three infectious diseases—pneumonia, influenza, and HIV infection—constituted the fifth leading cause of death in the United States in 1997.[2]

Infectious diseases also must be considered in a global context. Increases in international travel, importation of foods, inappropriate use of antibiotics on humans and animals, and environmental changes multiply the potential for worldwide epidemics of all types of infectious diseases. International cooperation and collaboration on disease surveillance, response, research, and training are essential to prevent or control these epidemics. Actions taken to improve health in one country affect the health of people worldwide.

Vaccines. Vaccines are biological substances that interact with a person's immune system to produce an immune response identical to that produced by the natural infection.

Vaccines can prevent the debilitating and, in some cases, fatal effects of infectious diseases. Vaccines help to eliminate the illness and disability of polio,[3] measles, and rubella.[4] However, the organisms that cause these diseases have not disappeared. Rather, they have receded and will reemerge if the vaccination coverage drops or if people are not reimmunized if their vaccine protection is outdated and no longer effective.

Vaccines can protect more than the vaccinated individual. They also can protect society. When vaccination levels in a community are high, the few who cannot be vaccinated—such as young children and persons with contraindications to vaccination—often are indirectly protected because of group immunity (in other words, they live among vaccinated persons who may offer protection from exposure to disease).

Significant progress has been made in reducing indigenous (not imported) cases of vaccine-preventable diseases (VPDs). The occurrence of many VPDs is at or near record-low levels. Most diseases have been reduced by more than 95 percent from peak prevaccine levels.[5] Although this is true for diseases routinely immunized in infancy (e.g., polio, diptheria, smallpox), it is not yet true for such diseases as varicella, hepatitis A, influenza, pneumonococcus, and nonneonatally transmitted hepatitis B.

In 1996, a vaccine against hepatitis A virus (HAV) was licensed that has the potential to reduce the health burden of this disease. The vaccine is now recommended primarily for high-risk groups. To decrease HAV transmission, universal vaccination was recommended in 1999 for children who lived in States where the rate of new cases was greater than two times the national average.[6]

Disparities

Among LGBT communities, men who have sex with men have been consistently identified for having elevated risks for viral hepatitis.[7] Since the 1980s, the Centers for Disease Control and Prevention (CDC) has recommended that all homosexually active men be immunized to prevent hepatitis B (HBV). In 1996, CDC extended this recommendation to include vaccination against HAV in gay and bisexual men as well as other high-risk groups.[8] Healthy People 2010 notes the significance of CDC's recommendations targeting MSM. Healthy People 2010 also points out the necessity for identifying missed opportunities for vaccinations and patient counseling by physicians, which also holds true for health providers serving MSM and transgender persons who have sex with men (TSM).

Opportunities

A coordinated strategy is necessary to understand, detect, control, and prevent infectious diseases, including those that disproportionately affect LGBT populations. The major strategies to protect people from vaccine-preventable diseases are:[9]

- Improving the quality of vaccines and the number of opportunities for immunization services
- Minimizing financial burdens for low income persons
- Increasing community participation, education, and partnership in immunization health education campaigns
- Improving surveillance and monitoring of diseases and immunization rates
- Continuing to develop new and improved vaccines, and improving the use of those new vaccines

Patients who are immunosuppressed, such as individuals living with HIV infection or people with certain chronic diseases, should be vaccinated against pneumococcal pneumonia and influenza. HIV-infected patients are at increased risk of invasive and noninvasive pneumonococcal disease (e.g., bacteremia, meningitis, pneumonia) and suffer more complications from influenza, such as secondary bacterial pneumonia. Culturally sensitive health prevention education programs are needed to enhance utilization of these highly effective vaccines. Although the exact number of LGBT individuals who need either vaccine is unknown, the assumption can be made that a proportion of LGBT people need these immunizations because of their high-risk status and the severity of the secondary conditions. All individuals, but particularly those with disabilities or suppressed immune systems and the elderly, should follow the recommended immunization schedules set forth by the U.S. Preventive Services Task Force in its Guidelines for Clinical Preventive Services.[10] Additional information on recommended clinical preventive services, including immunization schedules, is available online at the Agency for Healthcare Quality and Research's Web site at: www.ahrq.gov/clinic/prevenix.htm.

Summary of LGBT Research

For LGBT populations, and for MSM in particular, HAV and HBV education and prevention efforts must be designed in a way that is consistent with the social context of MSM and other high-risk LGBT populations. Nonetheless, young MSM and TSM, in particular, often are not engaged in health care or do not seek out health care on a timely basis, which severely limits opportunities for health promotion and disease prevention efforts as they relate to prevention of HAV and HBV. There is a dire need to help young MSM and TSM obtain information about vaccines and to increase access to affordable vaccination services.

Hepatitis C is the most common cause of chronic infectious liver disease in the United States, affecting more than 4 million Americans.[11] The virus establishes a persistent infection in the majority of infected persons, most of whom develop evidence of chronic inflammatory liver disease.[12] The morbidity and mortality of hepatitis C stems from its propensity for causing chronic inflammation, which can progress to cirrhosis and liver cancer.[13]

Data regarding the sexual transmission of hepatitis C virus (HCV) among MSM are limited and contradictory.[14] Hepatitis C has been most highly associated with blood-borne exposures. One study found that 4.6 percent of a cohort of 735 MSM had hepatitis C antibodies.[15] When percutaneous injection exposures were controlled for, the risk of HCV was marginally greater in men who had more than 50 sex partners per year, or more than 25 receptive anal or oral partners. In a Pittsburgh cohort of 1,058 MSM, the prevalence of HCV was 2.9 percent.[16] Multivariate analysis indicated that prior parenteral (intravenously or otherwise administered by injection) drug use was most highly associated with being infected with hepatitis C. However, in the Pittsburgh study, hepatitis C seropositivity was found to be associated with prior sexually transmitted diseases (STDs) and unprotected anal intercourse, but not with the number of sexual partners. In a San Francisco STD clinic study, 5 percent of non-injection-drug-using MSM and 25 percent of MSM who injected drugs had hepatitis C antibodies, but there was no association between hepatitis C and specific sexual behaviors.[17] In a study from Sydney, 7.6 percent of MSM were found to have evidence of hepatitis C infection. Multivariate analysis indicated that injection drug use (IDU) history and coinfection with HIV were associated with hepatitis C but did not reveal specific sexual practices associated with this infection.[18] The aggregate data suggest that hepatitis C may be sexually transmitted, but further studies are needed to better define the epidemiology and specific practices that may increase the potential for its transmission (e.g., the role of traumatic sex). There are no prospective studies that identify the prevalence or incidence of hepatitis C infection among lesbians, transgender, and bisexual people.

HIV-infected people are more susceptible to becoming infected with tuberculosis (TB) and developing related conditions. Because almost half of the people living with HIV in the United States are MSM, culturally specific programs may be needed to enhance access to appropriate TB screening services, such as subcutaneous tests and chest x rays, particularly if they may have been exposed to TB. Transmission of TB is facilitated by malnutrition and crowding, and epidemics have been described in prisons and homeless shelters. Research is needed to determine if LGBT community members are at risk for acquiring TB apart from the previously mentioned situations. For example, research has shown that LGBT youth who are rejected by their parents are at increased risk for homelessness,[19] prostitution,[20] HIV infection,[21] and stress.[22, 23] Youth who identify as lesbian, gay, or bisexual at an early age are also at increased risk of becoming victims of violence,[24] even within their families,[25] and of abusing substances.[26] Many of these factors increase their risk for acquiring TB and other diseases.

Discussion of Healthy People 2010 Objectives

14-3. Reduce hepatitis B.

Unsafe sexual practices and drug use (especially sharing needles) promote the spread of HBV.[27] [28] Based on a 1996 study of 385 MSM aged 17 to 22 in San Francisco and Berkeley, California, CDC in 1996 reported that 20 percent of the men had previously been exposed to HBV (lifetime), whereas 3 percent had an active infection at the time of the study. In addition, 80 percent of the participants reported having had anal sex or injecting drugs in the 6 months preceding the study,[29] supporting earlier findings.

Data from the Netherlands suggest that male-to-female transsexuals, many of whom have sex with men, were significantly more likely to be HBV-infected than controls.[30]

14-6. Reduce hepatitis A.

Healthy People 2010 recognizes that MSM are at high risk for HAV infection. This is likely true for TSM as well. However, additional data are needed to document the incidence and prevalence of HAV and vaccination rates among LGBT groups other than MSM, such as TSM. Vaccination for HAV is available, and in 1996 the Advisory Committee on Immunization Practices[31] began recommending HAV vaccinations for gay and bisexual men and other high-risk groups. Yet, numerous barriers often inhibit vaccination rates, including lack of awareness among patients and providers, limited or no access to a reliable source of health care, provider discomfort with talking about intimate issues related to sexuality or sexual practices, restricted access to counseling and services, and the ability of MSM and TSM (especially younger persons) to afford the cost of vaccination.

14-28. Increase hepatitis B vaccine coverage among high-risk groups.

Healthy People 2010 specifically identifies MSM as a high-risk group for HBV infection. TSM are plausibly at high risk as well. There is a significant chasm between the scientific community's understanding of the benefits of HBV vaccination and the use of the vaccine, especially among high-risk groups. Although vaccination for HBV was first recommended in the 1980s, there are several barriers that often prevent LGBT populations from being vaccinated, including the lack of awareness of LGBT health needs among health care providers, limited access to counseling and services, and affordability. Therefore, increasing vaccination rates for hepatitis B, particularly among the MSM and TSM populations, should be a public health priority.

The same CDC study referenced above found that only 3 percent of its sample of young MSM were vaccinated against HBV.[32] Additional data are needed to increase the Nation's understanding of HBV prevalence and incidence as well as vaccination rates among MSM populations. Without standard prevalence rates for HBV vaccinations, education and prevention programs have not been able to develop and implement targeted, evidence-based vaccination campaigns that could play a powerful role in preventing HBV transmission among MSM and other high-risk LGBT populations.

Services—RECOMMENDATIONS

- Public health, private health care providers, and STD clinics must all participate in programs to identify at-risk persons for HAV and HBV infection, including MSM and TSM, and to encourage vaccination.
- Providers should be expected to ask nonthreatening questions that identify individuals at risk, not just MSM and TSM, and they should offer the vaccine when they determine the individual is at risk.
- Individuals who are aware that they are at risk should be educated to understand that they share responsibility for requesting HAV and HBV vaccines.
- Providers and health plans should ensure that high-risk populations (e.g., persons over aged 65, persons with compromised immune systems due to chronic disease or disability or medications) receive the appropriate immunizations for pneumonia and influenza.

Education and Training—RECOMMENDATIONS

- New efforts are needed to reach physicians and other health care practitioners in all health care settings who provide health care to MSM and transgender persons so they can play an active role in educating patients about the risks of HAV and HBV infection as well as the availability of vaccinations.
- Curricula should be developed for physicians and other health care providers, as well as in health education and health promotion programs, on how to prevent, recognize, and treat HAV and HBV infection in high school and college students.

Policy—RECOMMENDATIONS

- Managed care organizations, insurance companies, and other health plans should provide insurance coverage or reimbursement for needed vaccines for high-risk populations, without cancellation penalties.
- Efforts must be made to ensure that LGBT individuals—including elders, children, and youth—who cannot afford to pay for needed vaccines have access to publicly funded services or affordable HAV and HBV vaccinations.

Research—RECOMMENDATIONS

- Additional research is needed to gain a better understanding of the risk and prevalence of HAV and HBV—not only among MSM and TSM but also among other LGBT populations.
- New studies are needed to explain why HAV and HBV vaccination rates among MSM and TSM are low.

Terminology

Advisory Committee on Immunization Practices (ACIP): Federally chartered advisory committee with the goals of providing advice to the CDC Director on decreasing disease through the use of vaccines and other biological products and on improving the safety of their use.

Group immunity: The immunity of a group or community; immunity based on the resistance to infection among a high proportion of individual members of the group.

Hospital-acquired infection: Any infection that a patient acquires as a result of medical treatment while in the hospital.

Vaccines: Biological substances used to stimulate the development of antibodies and thus confer active immunity against a specific disease or number of diseases.

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Mental Health and Mental Disorders

Healthy People 2010 Goal

Improve mental health and ensure access to appropriate, quality mental health services.

Overview

Evidence suggests that lesbian, gay, bisexual, and transgender (LGBT) people may disproportionately utilize mental health services.[1] However, there are serious concerns about the quality of mental health care that LGBT people receive. The well-documented history of having "homosexuality" classified as a mental disorder[2] may lead to iatrogenic problems—disorders induced in a patient by a physician's actions or words. In addition, there are four specific diagnoses within the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition,[3] that are potentially applicable to transgender persons.

Children and adolescents may be most vulnerable. Within the developmental life cycle, most children and youth feel awkward and embarrassed by sexual conflicts. Sexually diverse youth may have an even more difficult time in that their sexuality is not adequately acknowledged. The societal assumption is that sexual orientation and gender identity is something identified or chosen in adulthood. Although the coming-out process can occur in adulthood, most LGBT youth have an awareness of being different. Many LGBT youth experience feelings of self-hatred, depression, and anxiety as a result of being raised in a society that is condemning and rejecting of morés different from the majority. Children who admit their sexual orientation or gender identity to their family risk ostracism from the one societal unit always expected to unconditional care, love, and support.[4] For many such youth, coming out to their families has led to physical and verbal abuse or their running away from home.[5]

Some families have sought mental health professionals to use "reparative therapy," also known as conversion therapy, to change their child's sexual orientation from homosexual to heterosexual. According to the American Psychiatric Association (APA), there is "no published scientific evidence supporting the efficacy of reparative therapy as treatment to change one's sexual orientation."[6] In addition, reparative therapy is not included in the APA's Treatments of Mental Disorders.[7] Nonetheless, nearly 10 percent of respondents in one study reported that their therapist suggested or attempted to change their sexual orientation from homosexual to

heterosexual, although no consumers had expressed this desire.[8] Some psychiatrists have urged that gender identity disorder in children be removed from the next edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), which implicitly labels homosexual boys as mentally disordered[9] and may perpetuate the demand for conversion therapy.

LGBT people who also have a mental disorder must cope with more than one stigma. The belief persists among some segments of society that LGBT people are "mentally ill" because they self-identify as LGBT. Evidence that mental disorders are of a different nature in origin and highly responsive to appropriate treatment promises to be a potent antidote to the stigma related to mental disorders, which should encourage more individuals to seek needed mental health care. However, LGBT people may still be reluctant to seek needed mental health services because of the negative attitudes associated with their sexual orientation and gender identity.

No Federal surveys of mental health and mental disorders currently ask sexual orientation and gender identity questions, so discussing differences in the rates of mental disorders among LGBT people must be approached with sensitivity and caution.

Issues and Trends

Mental health is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and cope with adversity. Mental health is indispensable to personal well-being, family and interpersonal relationships, and contribution to community or society. *Mental disorders* are health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof). Mental disorders also are associated with distress or impaired functioning, and they spawn a host of human problems that may include disability, pain, or death. Mental disorders generate an immense public health burden of disability, varying in their severity and in their impact on people's lives. More severe disorders—such as schizophrenia, major depression, manic depressive or bipolar illness, obsessive-compulsive disorder, and panic disorder—can be enormously disabling.

The World Health Organization, in collaboration with the World Bank and Harvard University, has determined the "burden of disability" associated with the whole range of diseases and health conditions suffered by people throughout the world. A striking finding of the landmark Global Burden of Disease Study is that the impact of mental illness on overall health and productivity in the United States and throughout the world often is profoundly underrecognized. In established market economies such as the United States, mental illness is on a par with heart disease and cancer as a cause of disability.[10] Suicide—a major public health problem in the United States—occurs most frequently as a consequence of a mental disorder.

Mental disorders occur across the lifespan, affecting persons of all racial and ethnic groups, both genders, all educational and socioeconomic groups, and others, including lesbian, gay, bisexual, and transgender people. Approximately 40 million people in the United States aged 18 to 64, or 22 percent of the population, had a diagnosis of mental disorder alone

(19 percent) or of a co-occurring mental and addictive disorder in the past year.[11, 12, 13] At least one in five children and adolescents between the ages of 9 and 17 has a diagnosable mental disorder in a given year.[14] Mental and behavioral disorders and serious emotional disturbances (SEDs) in children and adolescents can lead to school failure, alcohol or illicit drug use, violence, or suicide.[15, 16, 17] About 5 percent of children and adolescents are extremely impaired by mental, behavioral, and emotional disorders.[18]

In later life, the majority of people aged 65 and older cope constructively with the changes associated with aging and maintain mental health. Yet an estimated 25 percent of older people (8.6 million) experience specific mental disorders—such as depression, anxiety, substance abuse, and dementia—that are not part of normal aging. Alzheimer's disease strikes 8 to 15 percent of people aged 65 and older,[19] with the number of cases in the population doubling every 5 years of age after age 60. Alzheimer's disease is thought to be responsible for 60 to 70 percent of all cases of dementia and is one of the leading causes of nursing home placements.[20]

Modern treatments for mental disorders are highly effective, with a variety of treatment options available for most disorders. There is no "one size fits all" in treatment. Similarly, there exists today a diverse array of treatment settings, and a person may have the option of selecting a setting based on health care coverage, the clinical needs associated with a particular type or stage of illness, and personal preference. Despite the effectiveness of treatment and the many paths to obtaining treatment, only 25 percent of persons with a mental disorder obtain help for their disorder in the health care system. In comparison, 60 to 80 percent of persons with heart disease seek and receive care.[21]

More critically, 40 percent of all people who have a severe mental disorder do not seek treatment from either general medical services providers or specialty mental health providers. Indeed, the majority of persons with mental disorders do not receive mental health services. Of those aged 18 and older who seek help, about 15 percent turn to mental health specialists.[22] Of young people aged 9 to 17 who have a mental disorder, 27 percent receive treatment in the health sector.[23] However, an additional 20 percent of children and adolescents with mental disorders use only school-based mental health services.[24]

The direct costs of diagnosing and treating mental disorders totaled approximately $69 billion in 1996. Lost productivity and disability insurance payments due to illness or premature death accounted for an additional $74.9 billion.[25] Crime, criminal justice costs, and property loss contributed another $6 billion to the total cost of mental illness. People with mental disorders are overrepresented in jail populations, where many do not receive treatment.[26] Of the $69 billion spent for diagnosing and treating mental disorders, nearly 70 percent was spent on the services of mental health specialty providers, with most of the remainder for general medical services providers. The majority—53 percent—of treatment for mental disorders was paid for by public-sector sources, including the States and local governments as well as Medicaid, Medicare, and other Federal programs. Some 47 percent of expenditures were from private sources, and of these, almost 60 percent were from

private insurance.[27] The remainder came from out-of-pocket payments, including insurance copayments, with a small amount from other sources, such as foundations.

Programs and services that prevent mental disorders and mental health problems have the potential to lessen an enormous burden of suffering and to reduce the cost of future treatment and lost productivity at home, at school, and at work. When applied faithfully, preventive interventions can decrease the risk of onset or delay onset of a disorder.[28] The availability and accessibility of these interventions to the millions of people whose health care is provided by managed care organizations (MCOs) depend upon whether or not mental health services are covered among the benefits offered. Only gradually are health plans adding coverage for preventive interventions for mental health problems to their benefit packages.

Public Law 102-321, also known as the Alcohol, Drug Abuse, and Mental Health Administration Reorganization Action of 1992, requires States to include estimates of serious mental illness in their applications for State Block Grant Funds. The State-level estimates developed are based on a synthetic estimation method.[29] This method begins with direct national estimates of serious mental illness based on survey data within a series of subsamples, defined on the basis of census variables (e.g., age, sex, race), and then weights the class means by the proportion of people in each State in each class to arrive at State-level estimates. There are also two surveys to obtain direct estimates. The Epidemiologic Catchment Area Study was carried out in the 1980s,[30] and the National Comorbidity Study was carried out in the early 1990s.[31] The National Household Survey on Drug Abuse contains a series of questionnaire items that can be used to determine diagnoses of substance dependence and screening questions indicating a high probability that respondents have one of more mental syndromes—that is, major depressive episode, general anxiety disorder, agoraphobia, and panic attacks.[32]

Research on the brain and behavior in mental health and mental disorders is moving at a rapid pace. An increasingly strong consumers' movement in the mental health field is adding urgency to the tasks of translating new knowledge into clinical practices and refining service delivery systems to maximize the use of new and emerging information for consumer needs. Consumer and family organizations, which formed out of concern over the frequent fragmentation of mental health services and the inaccessibility of such services, have assumed a substantial role in supporting development of mental health services. Diverse groups share overlapping goals, including overcoming stigma and preventing discrimination toward persons with mental disorders, supporting self-help groups, and promoting recovery from mental disorders.[33]

The co-occurrence of addictive disorders among persons with mental disorders is gaining increasing attention from health care professionals, especially professionals working in the mental health and substance abuse fields. Among adults aged 18 and older with a lifetime history of any mental disorder, 29 percent have a history of an addictive disease. Of those with a diagnosis of alcohol disorder, 37 percent have had a mental disorder. Among those with other drug disorders, 53 percent have had a mental disorder.[34] When looking at specific

populations, the prevalence can be even much greater. For example, co-occurring mental and addictive disorders are estimated to affect 50 to 60 percent of homeless persons.[35]

Children and adolescents also experience co-occurring disorders.[36] Especially at risk for alcohol use problems are boys diagnosed with so-called externalizing disorders, such as conduct problems, oppositional-defiant disorder, and attention deficit/hyperactivity disorder.[37] From public health promotion and disease prevention perspectives, children and adolescents with mental disorders often do not become substance abusers until after the mental disorder is apparent.[38] This time lag creates a "window of opportunity" when prevention of substance abuse may be possible.[39]

As the life expectancy of individuals continues to increase, the sheer number—although not necessarily the proportion—of persons experiencing mental disorders in later life also will increase. This trend presents society with unprecedented challenges in organizing, financing, and delivering effective preventive and treatment services in the aging population. As recognition continues to grow that depression and certain cognitive losses are treatable disorders and not inevitable concomitants of aging, diagnostic precision in later life and provision of targeted treatment are increasingly urgent.

Health care in the United States continues to undergo fundamental structural changes that require creative and flexible responses from service providers, administrators, researchers, and policymakers alike. Two prominent forces of change are Federal and State efforts to improve access to health care, including treatment of mental disorders, and the rapid growth and impact of managed care organizations. In 1998, the Mental Health Parity Act (P.L. 104-204) was implemented to help increase access to care. (The term "parity" or "mental health parity" refers generally to insurance coverage for mental health services that includes the same benefits and restrictions as coverage for other physical health services.) Although the Federal Mental Health Parity Act is quite limited in reducing insurance coverage discrepancies between physical and mental disorders, 53 percent of the U.S. population is now covered by State mental health parity laws.[40]

Consumers, providers, insurers, and purchasers are all stakeholders in decisions about which services will be included in MCO contracts and how those services will be delivered. Other stakeholders include constituency groups, accrediting organizations, and business groups on health.[41] Several compelling reasons motivate these stakeholders to support the incorporation of proven, effective preventive behavioral health programs and services into MCO systems of care. It is in the public interest to prevent mental disorders rather than to wait until disease and disability impose their burdens. A substantial and growing body of research provides evidence that certain preventive behavioral health interventions are effective and efficacious. A small, but developing, body of multidisciplinary research demonstrates that certain preventive behavioral health interventions can produce cost savings or a cost offset. And MCO accreditation standards include requirements for some preventive behavioral health interventions.[42]

Disparities

Although mental disorders, for the most part, are equal opportunity disorders, there are some marked differences in how they present themselves and how they are prevented, diagnosed, and treated by gender, racial and ethnic group, sexual orientation, gender identity, and age.[43, 44, 45, 46] Mental disorders are not only the cause of limitations of various life activities but also can be a secondary problem among people with other disabilities. Depression and anxiety, for example, are seen more frequently among people with disabilities than among those without disabilities.[47]

Studies of the number of cases of mental health problems among different populations, although increasing in number, remain limited and often inconclusive. Discussion of the rates of existing cases must consider variations in how persons of different cultures and racial and ethnic groups perceive mental health and mental disorders. Behavioral problems that Western medicine views as signs of mental illness may be assessed differently by non-Western individuals. With this in mind, along with the recognition that sample sizes for racial and ethnic groups and the elderly may be limited, examination of studies for mental health trends among all people, including LGBT people, remains important.

Opportunities

Social and behavioral research is beginning to explore the concept of *resilience* to identify strengths that may promote health and healing. Resilience involves the interaction of biological, psychological, and environmental processes. LGBT people are enmeshed in stressful situations throughout their lives. Yet, most LGBT people survive and might be viewed as prototypes for resiliency. In the discussion of the Boston Lesbian Health Project, Sorensen and Roberts noted that attempts of suicide decreased considerably after adolescence and "coming out."[48] Increased understanding of how to identify and promote resilience will assist all health planners in designing effective programs that foster and draw on innate internal capacity.

Consumers are the ultimate end users of the health care system, including the mental health system. Mental health consumers, their families, and advocates have had an important impact on the organization, financing, and delivery of managed care services. Mental health consumers are working as active partners with practitioners to ensure that their causes are addressed at State and national levels.[49] In 1996, the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, released a consumer-oriented report card for mental health services in a collaborative effort with many consumers and consumer groups.[50]

Managed care is challenging the interrelationship between behavioral health and physical health that has existed for quite some time. Evidence has been presented that the provision of behavioral interventions, especially preventive interventions, can be effective and reduce medical costs. Preventive behavioral interventions can shift much responsibility for health care from providers to consumers. Placing the onus for health and well-being back into the hands of individuals should increase more direct responsibility of health care status, and

ultimately, reduce the demand for service utilization. These actions are not meant to obviate the responsibilities of providers, especially physicians. However, at the present time, many individuals view behavioral disorders as something beyond their control. Thus, the role of patients with behavioral disorders is characterized as a passive, sometimes negative role that, when accompanied by stigma, strips individuals of their dignity and results in resentment against the providers and systems whose true aim is to help. Vigorous, well-designed programs of health promotion and prevention of behavioral disorders require a therapeutic alliance and active participation by all parties. If the objective of an integrated delivery system is to both increase the quality of life and reduce the financial burden, then behavioral medicine is the vanguard. The measurement of ultimate success is the transformation of the current health care system from a focus on sickness to wellness.[51]

Summary of LGBT Research

Mental health, mental disorders, and the LGBT population. The relationship between sexual orientation and gender identity and mental health or mental disorders has evolved through four phases.[52, 53] First, "homosexuality" was classified as a mental disorder.[54] Then, beginning in the late 1950s, with psychologist Evelyn Hooker's groundbreaking research funded by the National Institute of Mental Health[55] and continuing with a number of studies in the 1960s and early 1970s,[56] the validity of the mental disorder classification of homosexuality was directly assessed and found invalid. In the context of wider social changes that increased lesbian, gay, and bisexual people's power and visibility in society, such studies led the American Psychiatric Association to declassify homosexuality as a mental disorder in 1973.[57, 58] Specific attention to mental health issues in transgender-identified individuals developed late in this second phase, in part because such individuals were encountered more rarely and because homosexuality and gender identity were often conflated.

Once homosexuality was declassified as a mental disorder, subsequent research focused on understanding the mental health needs of the LGBT population. At the same time, LGBT-focused community-based organizations began to develop basic mental health services outside the mainstream health and mental health service delivery systems. The prevalence of social prejudice, however, severely limited the scope of both research and services. In this phase, the results of studies on convenience samples of LGBT people, coupled with the professional judgment of clinicians in the community, generated widespread concern that mental health problems arising in reaction to social stigmatization might be elevated in the LGBT population. However, sample limitations made it difficult to know whether such elevated risks could be generalized to the population.[59]

The widespread prejudice, discrimination, and violence to which LGBT people are often subjected is a major mental health concern. Sexual prejudice, sexual orientation discrimination, and antigay violence are stressors.[60, 61, 62] Furthermore, resilience in the face of such stress and coping skills for adapting to it are complicated by the internalization of negative social attitudes.[63, 64] Because of sociocultural attitudes and discrimination,

finding appropriate and affirming social support may be a crucial and difficult process for LGBT people.

As society has begun to acknowledge that the health needs of LGBT people are legitimate and merit additional study, a fourth phase is beginning. Population-level information on mental health and mental disorders is beginning to be published.[65, 66, 67, 68, 69, 70, 71, 72, 73] However, additional research is needed. The issue of whether and how to include sexual orientation questions in general population research and surveillance is being addressed more widely,[74] although this has not yet occurred for gender identity issues. Large-scale studies targeting LGBT samples are beginning to receive funding and to produce information about the moderating and mediating factors related to mental health and mental disorders—not just rates of mental illness.[75]

LGBT patients may not disclose their sexual orientation out of fear that their care may be adversely affected.[76] Why have gay and lesbian health care consumers been relatively silent as our health care system is rapidly changing and becoming very consumer-oriented? Social and legal sanctions, as well as hate crimes, against individuals whose sexual orientation is either primarily or partly homosexual are enough to precipitate silence. Any disclosure connected with sexual behavior that is incongruent with the societal norm is risky because of possible harmful consequences to the individual.

Homosexually active men have reported higher rates of major depression and panic attack syndromes than males who reported no same-sex sexual partners in the past year. Likewise, homosexually active women have reported higher rates of alcohol and drug dependence than their female counterparts who reported no same-sex sexual partners in the past year.[77] Another study found that LGBT young people in New Zealand were at higher risk for major depression, generalized anxiety disorder, and conduct disorders than were non-LGBT youth.[78]

Young homosexually active men may be at greater risk for depression than exclusively heterosexually active young men.[79] Pillard found elevated rates of bipolar disorders among gay men,[80] and Atkinson and colleagues found elevated rates for most mental disorders among gay men.[81] In samples of gay men, compared with estimates of U.S. rates of disorders reported by the Epidemiologic Catchment Area Study,[82] Williams and colleagues found a high lifetime prevalence of affective disorders, but no elevated prevalence of current disorders.[83] Tross and colleagues found a slightly elevated prevalence for current major depressive disorder.[84]

The National Lesbian Health Care Survey[85] found that symptoms of depression among lesbians were roughly equivalent to those in studies among heterosexual women.[86] Oetjen and Rothblum used a standardized measure to examine the effect among lesbians of factors consistently cited in the women and depression literature (relationship status, relationship satisfaction, social support from friends, and social support from family) and two unique factors (outness and relationship status satisfaction) to determine their ability to predict depression among lesbians. Perceived social support from friends, relationship status

satisfaction, and perceived social support from family were found to be significant predictors.[87] A similarly designed study among Canadian lesbians found lower depression rates among women in relationships, lesbians who had more social support from friends and family, and those who were more open about their sexual orientation.[88]

Another study reported higher levels of depressive symptoms among homosexually active African American men and women than those found in studies of the general population of African Americans.[89]

Although research is inadequate, some studies have suggested that there may be an increased incidence of severe personality disorders, psychoses, and other severe mental illnesses in clinical samples of transgender persons,[90, 91, 92, 93] but more recent studies have found no relationship between gender dysphoria and other psychiatric diagnoses.[94, 95] More rigorous research will be required to determine the actual incidence of mental disorders in transgender persons.[96] Two studies have found that psychological function, as measured by the Minnesota Multiphasic Personality Inventory and by clinical measures, improves after sex-reassignment surgery.[97, 98]

Mental health and older LGBT persons. Although there is some evidence that older gay men usually have a higher measure of psychological well-being than younger gay men,[99] there are still numerous, profound mental health issues that affect older LGBT populations. Older LGBT individuals who seek social support services do so usually because of a crisis in their lives, such as failing health, death of a partner or lover, personal care needs, isolation, difficulty in applying for benefits and other financial concerns, couples counseling, or lack of an existing support system.[100, 101] Other potential concerns that may affect older LGBT individuals include hostility they have experienced, social emphasis on youthful attractiveness, loneliness during holidays, a tendency to withdraw into a relatively closed circle of friends that may not provide adequate social support,[102] and regrets that they did not have children.[103]

Mental health issues for intersex individuals. The traditional model for medical management of intersexuality (congenital sexual ambiguity) has been in place since the 1950s but lacks long-term outcome studies or scientific justification.[104] The traditional model is based upon the notion that "reconstructive" genital surgeries can make parents forget that their child was born with a sexual difference and eliminate parental confusion, shame, guilt, and fear. Numerous reports of negative outcomes indicate that this model is flawed.[105, 106, 107] The emerging model of care—which centers on open disclosure, counseling, and patient autonomy—may reduce long-term negative consequences, including reduced psychosocial function, sexual dysfunction, and damage to fertility.

Use of mental health services. Understanding patterns of and risk factors for mental disorders in LGBT individuals is important for tailoring proper mental health treatment and for designing effective public health intervention and prevention programs.[108] Like members of other minority groups, LGBT populations are not passive recipients of stigma and discrimination but engage in active coping to counter the ill effects of negative social

stressors. Such positive coping has been shown to be beneficial to members of minority groups.[109]

Prejudice against transgender individuals is pervasive within American medicine.[110] Most U.S. medical providers and researchers, as well as the public at large, believe that transgender behavior is pathological. A survey of transgender men and women in San Francisco found that many are chronically underserved with regard to basic medical and psychological support services.[111]

There is evidence that transgender people often avoid seeking treatment for depression out of concern that their gender issues will be assumed to be the cause of their symptoms and that they will be judged negatively.[112] Because of these and other factors, depression associated with gender transition may be underdiagnosed.

Transgenderism as a mental disorder. The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)[113] offers four specific diagnoses that are potentially applicable to transgendered persons:

- Gender identity disorder (GID) in adolescents and adults (302.85)
- Gender identity disorder in children (302.6)
- Gender identity disorder not otherwise specified (GIDNOS; 302.6)
- Transvestic fetishism (302.3)

(*Note:* The numbers in parentheses represent the numerical nomenclature of the International Classification of Diseases, which is the basis for classifying mental disorders within DSM-IV and used by clinicians, medical record librarians, administrators, benefit claims representatives, researchers, epidemiologists, and program planners.)

Under DSM-IV, any of these diagnoses requires evidence of distress or impairment in functioning. Functional impairment that is solely due to societal prejudice based on perceived social deviance does not meet this criterion.[114] Under DSM-IV, being transgender does not in itself constitute a mental disorder.

The diagnosis of GID is generally reserved for the most severely gender dysphoric adults and adolescents, persons who usually meet the criteria for transsexualism.[115] Transvestic fetishism, a paraphilia, could be the diagnosis given some cross-dressers. GIDNOS is the most general of the DSM-IV diagnoses and is potentially applicable to a wide variety of transgender persons.[116]

The diagnoses of GID and transvestic fetishism are considered pejorative by many in the transgender community. GID is often viewed as stigmatizing of nonnormative gender behavior, in much the same way that homosexuality was pathologized prior to its removal from the list of mental illnesses by the American Psychiatric Association in 1973.

Additional issues related to the relationship between mental health and Healthy People 2010 objectives not addressed in this chapter: HIV/AIDS and substance abuse. Stress and mental health raise important and practical public health issues related to HIV risk-taking behavior, particularly as prevention research has begun to move from purely cognitive explanatory models of risk-taking behavior to the consideration of affective and nonrational processes among gay men.[117, 118, 119] Mental health problems, including substance use and personality and psychological constructs (e.g., low self-esteem, sensation seeking), have been associated with HIV-related risk-taking behavior.[120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130] Research has also described high-risk behavior as an emotion-focused coping strategy to reduce stress.[131]

The convergence of internalized homophobia, drug problems, and AIDS-related traumatic stresses are related to increased risk-taking.[132] In addition, in the context of reports of increased risk for suicide among gay and bisexual men, the relationship of mental health and HIV risk-taking is of particular concern. Some researchers have suggested that high-risk sexual behavior among young gay and bisexual men may be related to a sense of hopelessness and suicidal tendencies.[133, 134]

Discussion of Healthy People 2010 Objectives

18-1: Reduce the suicide rate.

Research has not demonstrated any higher risk of completed suicide associated with same-gender sexual orientation for either adults or adolescents.[135, 136] An association between same-gender sexual orientation and elevated lifetime prevalence of suicide ideation and attempts has been reported in several studies of general population probability samples of adolescents and adults.[137, 138, 139, 140, 141, 142, 143] In addition, research studies on convenience samples of LGBT people have commonly found higher rates of reported suicide attempts and ideation than general population research would lead one to expect.[144, 145, 146, 147, 148, 149, 150, 151] For example, the results of the National Lesbian Health Care Study found that more than half the sample had experienced thoughts of suicide at some time, and 18 percent had attempted suicide.[152] This compares to 33 percent and 4 percent, respectively, for women in the United States as reported in the Epidemiologic Catchment Area Study.[153]

The biggest challenge in studies of completed suicide is obtaining an accurate post mortem classification of sexual orientation. It is reasonable to assume that post mortem estimates are underestimated. Furthermore, judging whether rates of completed suicide are elevated in such studies requires making assumptions about the base rate of same-gender sexual orientation—estimates of which vary from population to population and across different definitions of same-gender sexual orientation.

Van Kesteren and colleagues reported a disproportionately high number of deaths due to suicide in male-to-female (MTF) transsexuals compared to the general population.[154]

However, after reviewing more than 2,000 cases, Pfafflin and Junge found reports of only 16 possible suicide deaths following surgical sex reassignment.[155]

Dixen and colleagues found that, among 479 MTF and 285 female-to-male (FTM) transsexuals seen in the Palo Alto program, about 25 percent and 19 percent, respectively, had attempted suicide prior to transition.[156] Most other studies report a pretransition suicide attempt rate of 20 percent or more, with MTFs relatively more suicide-prone than FTMs.[157] In the Washington Transgender Needs Assessment Survey, the suicidal ideation rate was 35 percent, and the attempt rate was 16 percent.[158]

Another form of self-harm in transgender persons is attempted or completed autocastration, or genital mutilation. A study of a cohort of transgender individuals who applied for services at gender identity clinics reported that genital mutilation was attempted by 9 percent of males and breast mutilation was attempted by 2 percent of females.[159]

18-2: Reduce the rate of suicide attempts by adolescents.

Several recent population studies have reported alarmingly high rates of suicide ideation and attempts among young people who identify themselves as homosexual or report same-sex sexual partners. For example, six studies found that rates of various measures of suicide ideation and attempts were three to seven times higher among gay and lesbian youth than heterosexual youth.[160, 161, 162, 163, 164, 165] Mediating factors for suicidal ideation among LGBT youth include depression, substance abuse, and victimization.[166, 167, 168, 169, 170] The suicidal ideation rate in one needs assessment of young transgender people was 28 percent, with 17 percent reporting actual suicide attempts.[171]

18-5: (Developmental) Reduce the relapse rates of persons with eating disorders including anorexia nervosa and bulimia nervosa.

Some studies of clinical samples have found sexual orientation to be a significant predictor of eating disorders among men, though not among women.[172, 173, 174, 175, 176] Other studies have found no such association.[177, 178, 179]

Community studies—which have typically sampled college students or participants in gay and lesbian organizations—have often found a significant association between sexual orientation and negative body image among gay men.[180, 181, 182] Among women, while being female was related to concerns about dieting and being fat, lesbians were less likely to be preoccupied with weight and body image than heterosexual women.[183, 184]

In the Minnesota Adolescent Health Survey,[185] homosexual boys were more likely than heterosexual boys to report a poor body image (28 percent vs. 12 percent), frequent dieting (9 percent vs. 6 percent), binge eating (25 percent vs. 11 percent), and purging behaviors (12 percent vs. 4 percent).[186] In contrast, homosexual girls were more likely than heterosexual girls to report a positive body image (42 percent vs. 21 percent). However, they were no less likely to report disordered eating behaviors, such as binge eating or purging.[187]

Significant gender differences that relate to eating problems hold true for gay and lesbian populations. In the Minnesota sample, young boys (15 percent) were less likely than young girls (27 percent) to rate themselves low on body image. A greater proportion of older females (38 percent) than males (22 percent) considered themselves to be overweight. In each group, more girls than boys reported dieting in the last year, at all levels of frequency. Despite increased risk among homosexual men compared with heterosexual men, women (both lesbian and heterosexual) are at greater risk for body dissatisfaction and disordered eating.[188]

18-6: Increase the number of persons seen in primary health care who receive mental health screening and assessment.

The Institute of Medicine (IOM) defines primary care as "the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of perceived health care needs, developing a sustained partnership with patients, and practicing in the context of family and community health."[189]

Primary care providers (PCPs) are now the gatekeepers of the managed care system. These services should meet the health needs of most people and be the entry point into the medical care system. In a primary care medical practice, approximately 10 to 20 percent of presenting patients have a diagnosable psychiatric disorder. Many of the remaining presenting patients also have significant psychological distress.[190, 191] More than a dozen studies have looked at the rate of recognition of mental health and substance abuse problems in a primary care setting.[192] Most often, a person will present with a physical complaint, and about half the time the PCP will recognize the underlying behavioral health issues.[193, 194] In the small number of cases in which the presenting problem is emotional or psychological, the mental health or substance abuse diagnosis is correctly determined about 90 percent of the time.[195] The IOM report on the future of primary care has called for the development of models of coordinated, integrated care, including better integration among mental health and primary health care professionals.[196] Studies of existing, working models would help to identify best practices in the coordination of all care, particularly primary care and behavioral health care. Carved-out behavioral health services do not necessarily lead to poor coordination of care or to coordination poorer than that in a fee-for-service system. However, the separation of primary care and behavioral health care systems brings risks to coordination and integration that may not be in the best interest of consumers.[197]

The challenge for health care providers—regardless of discipline—is to ensure access. The IOM committee defines access as "the extent to which those in need of mental health and substance abuse care receive services that are appropriate to the severity of their illness and the complexity of their needs."[198] Too often, indicators of access reflect merely the availability of services or the delivery of any service rather than the delivery of services that respond effectively to consumer needs. Considering the fit between service need and access also means taking into account variations in need among special populations, such as LGBT persons.

Some PCPs have reported an unwillingness to treat lesbian and gay consumers, as well as a negative bias against other providers who themselves are lesbian and gay.[199] Although the target population for this objective is PCPs, another study showed that mental health providers are not invulnerable to having their perceptions of consumers affect the therapeutic alliance. This study examined the hypothesis that clinicians' perception of psychological maladjustment is related to the deviations of symptoms from prevailing role stereotypes. In a study by Waisberg and Page, practicing psychologists viewed female patients with masculine symptoms (e.g., alcoholism, antisocial behavior) as more psychologically disturbed than males with the same symptoms. Similarly, psychologists also perceived male patients with feminine symptoms (e.g., depression, anxiety) as more psychologically disturbed than their female counterparts.[200]

Almost 20 years after APA's removal of homosexuality from DSM, one-fourth of psychiatric faculty admit their homophobia. In a 1991 survey of 4-year U.S. medical schools, the mean amount of course time devoted to the topic of homosexuality was 3 hours, 26 minutes.[201] More than half of nurses teaching in nursing schools think being a lesbian is unnatural. In a 1986 study of more than 1,000 physicians in San Diego, 40 percent were uncomfortable treating lesbians and gay men, 30 percent opposed admitting lesbians and gay men into medical school, and 40 percent would not refer patients to a lesbian or gay colleague.[202]

According to a study of gay men, almost half did not reveal their sexual orientation to their PCPs. That same percentage applied to gay men with HIV. A 1988 study of 529 African American lesbians and bisexual women found that only 33 percent had disclosed their sexual orientation to their health care providers.[203] In a 1989 health care study of 1,681 lesbians in Michigan, 6 percent had a health care provider who was lesbian or gay, 61 percent felt that they were unable to come out to their provider, and 6 percent of their providers tried to "cure" their patients' lesbianism.[204]

18-7: Increase the proportion of children with mental health problems who receive treatment.

LGBT adolescents face unique difficulties and risks.[205] LGBT youth may experience estrangement from their parents when they reveal their sexual orientation.[206, 207] When parents reject their LGBT children, these young people are at increased risk for homelessness,[208] prostitution,[209] HIV infection,[210] and stress.[211, 212] Youth who identify as lesbian, gay, or bisexual at an early age are also at increased risk of becoming victims of violence,[213] even within their families;[214] of abusing substances;[215] and of attempting suicide.[216] The social stigma associated with LGBT identity also may complicate career choice and development.[217] Perceived parental and peer acceptance has an important impact on the social adjustment of LGBT youth.[218] Although peers and educators may be helpful in improving the psychosocial environment for these youth,[219, 220, 221, 222] they may lack the information and experience necessary to be effective. When these potential sources of support are heterosexist, they may cause additional conflict and distress.[223, 224]

In recent years, there has been an upsurge in publicity for the idea that homosexuality is a mental disorder and that adolescents should be encouraged to seek psychotherapeutic treatment to change their sexual orientation. The concept of "reparative therapy" is based on an understanding of homosexuality that has been rejected by most major health and mental health professions. These professions have all taken the position that homosexuality is not a mental disorder and thus there is no need for a cure.[225]

Almost all research on transgender youth combines them with gay and lesbian youth in the catchall "LGBT" category. Moreover, many youth who appear transgender, and who may later identify as transgender, initially identify as gay or lesbian. Consequently, little is known about the prevalence of mental disorders among transgender youth. One study of psychological functioning in 29 adolescent transsexuals in the Netherlands found little evidence of more frequent mental disorders than in nontranssexual youth.[226]

For the most severely gender-dysphoric youth, early intervention with puberty-delaying hormones has been used to allow the adolescent time to explore gender issues in therapy, while preventing the irreversible hormone-induced physical changes that make passing in the desired gender so difficult for most adult transsexuals.[227, 228, 229] Transsexuals who have been treated early at the Amsterdam Gender Clinic pass very easily as members of the opposite gender.[230] As a result, these individuals may suffer less stress as adults.

18-9: Increase the proportion of adults with mental disorders who receive treatment.

Prejudice, discrimination, and violence pose risks to the mental health and well-being of LGBT people.[231] Membership in a stigmatized group increases the risk for stress related to chronic daily hassles (e.g., hearing antigay jokes, always being on guard) to more serious negative life events (e.g., loss of employment, home, or custody of children; antigay violence; discrimination due to sexual orientation).[232, 233] Research has shown that gay men are at risk for mental health problems[234] and emotional distress [235] as a direct result of discrimination and negative experiences in society. Social stressors affecting LGBT older adults—such as a lack of legal rights and protection in medical emergencies and a lack of acknowledgment of couples' relationships, particularly following the loss of a partner—have been associated with feelings of helplessness, depression, and disruption of normative grief processes.[236, 237, 238]

LGBT people who live in rural communities may experience stress related to the risk of disclosure because anonymity about their sexual orientation or gender identity may be more difficult to maintain. Fears about the loss of employment and housing may be more significant because of the limited opportunities within a small community. Less visibility and fewer LGBT support organizations may intensify feelings of social isolation. Furthermore, LGBT people may feel more vulnerable to acts of violence and harassment because rural communities may provide fewer legal protections.[239, 240]

Given the real and perceived social and physical dangers many LGBT consumers face, developing a sense of safety is of primary importance. Societal stigmatization, prejudice,

and discrimination (e.g., antigay ballot initiatives, murders of LGBT individuals) can be sources of stress and create concerns about workplace and personal security.[241, 242, 243] Physical safety and social and emotional support have been identified as central to reducing stress among LGBT people.[244, 245, 246]

In addition to external stressors, negative societal attitudes may result in self-image problems ranging from a lack of self-confidence to overt self-hatred,[247] depression,[248, 249] or alcoholism and other substance abuse.[250] Meyer and Dean showed that gay men scoring high on a measure of internalized homophobia were significantly more likely than less homophobic gay men to experience sexual dysfunction and relationship instability, and to blame themselves for antigay victimization.[251]

Because of the stigmatization of homosexuality and bisexuality, it is to be expected that many lesbian, gay, and bisexual people feel conflicted or have significant questions about aspects or consequences of their sexual orientation.[252] Fear of multiple personal losses—including family, friends, career, and spiritual community—and vulnerability to harassment, discrimination, and violence may contribute to an individual's fear of self-identifying as lesbian, gay, or bisexual. Many consumers who are conflicted about or are questioning the implications of their sexual orientation seek psychotherapy to resolve their concerns. Some LGBT adults may seek reparative therapy in an attempt to change their sexual orientation, even though all major health and mental health professions have rejected it. In addition, mental health service providers who harbor prejudice or are misinformed about sexual orientation may offer responses to the questioning or conflicted client that may exacerbate the client's distress.[253]

Transgender people are likely to experience some form of victimization as a direct result of his or her transgender identity or gender expression. A link between these experiences and mental health disorders such as posttraumatic stress disorder is widely suspected, but has not been adequately documented. Victimization includes subtle forms of harassment and discrimination, as well as blatant verbal, physical, and sexual assault. The last may include physical and sexual assault—and even homicide.

The majority of assaults against transgender persons are never reported to the police. This situation exists because transgender individuals have little social support and limited or no access to legal recourse. Sexual violence against MTF transsexuals is common, but such incidents are rarely prosecuted in the criminal justice system.[254] Of the transgender individuals sampled in the Washington Transgender Needs Assessment Survey, 13.5 percent reported having been the victims of sexual assault.[255]

There is evidence that changes related to gender identity significantly affect partners and could unsettle relationships, causing significant emotional stress to both individuals.[256] When initially introduced to their partner's transgender status, spouses, partners, and significant others often question their own and their partners' sexual orientation. Partners' symptoms can be severe and sometimes resemble those of posttraumatic stress disorder.[257]

18-10: Increase the proportion of persons with co-occurring substance abuse and mental disorders who receive treatment for both.

Although no research on co-occurring disorders has focused on LGBT populations, some evidence suggests that LGBT persons may be at heightened risk for some substance abuse or mental disorders.[258, 259] Furthermore, limited data suggest that the prevalence and patterns of some substance abuse and mental disorders may differ for LGBT persons and those in the general population. For example, studies that have compared lesbians and gay men have found much smaller gender differences in problems related to substance use or substance abuse than is typically reported in studies of women and men in the general population.[260, 261] In addition, in a recent study comparing 1-year prevalence of several psychiatric syndromes using data from the HIV/AIDS questions appearing in the 1996 National Household Survey of Drug Abuse, patterns of gender differences in disorders were found that are opposite of those typically reported in the general population.[262] In this study, homosexually active men reported higher rates of major depression and panic attack syndromes, whereas homosexually active women reported higher rates of alcohol and drug dependence than did their male and female counterparts who reported no same-sex partners in the past year.

18-12: Increase the number of States and the District of Columbia that track consumers' satisfaction with the mental health services they receive.

Gay, lesbian, and bisexual consumers form a significant percentage of consumers in mental health treatment, perhaps greater than their percentage in the U.S. population.[263] Nevertheless, no large, cross-national studies have been sponsored to determine LGBT consumer satisfaction with existing services. Existing research has suggested that many LGBT consumers are dissatisfied with current treatment practices.[264, 265]

18-13: Increase the number of States, Territories, and the District of Columbia with an operational mental health plan that addresses cultural competence.

When a client presents with discomfort about his or her sexual orientation or gender identity, it is important for providers to assess the psychological and social context in which this discomfort occurs. Such an assessment might include an examination of internal and external pressures on consumers to change their sexual orientation or gender expression; the presence or absence of social support and models of positive LGBT life; and the extent to which consumers associate homosexuality, bisexuality, or gender variance with negative stereotypes and experiences. The role of providers, regardless of therapeutic orientation, is not to impose their beliefs on consumers, but to examine thoughtfully the consumers' experiences and motives. They may also serve as a resource for accurate information about sexual orientation (e.g., by providing consumers with access to empirical data on such

questions as the development of sexual orientation or gender identity or the relationship between mental health and sexual orientation or gender identity).[266]

Racial/ethnic minority LGBT people must negotiate the norms, values, and beliefs regarding homosexuality, bisexuality, and gender expression of both mainstream and minority cultures.[267, 268, 269, 270, 271] Cultural variation in these norms, values, and beliefs can be a major source of psychological stress. There may be no one group or community to whom a racial/ethnic minority LGBT person can anchor his or her identity and receive full acceptance. This problem may be an even greater challenge for racial/ethnic minority youth that are exploring their sexual identity and orientation.[272]

Bisexual adults and youth may experience a variety of stressors in addition to the social prejudice resulting from same-sex attractions. One such stressor is that the polarization of sexual orientation into heterosexual and homosexual categories invalidates bisexuality.[273, 274, 275, 276, 277, 278, 279] This view has influenced psychological theory and practice as well as social attitudes and institutions. Consequently, bisexuality may be inaccurately represented as a transitional state. Although no evidence of psychological maladjustment or psychopathology has been found, bisexual individuals who do not adopt an exclusively heterosexual or homosexual identity may nevertheless be viewed as developmentally arrested or in other ways psychologically impaired.[280]

Negative individual and societal attitudes toward bisexuality in both heterosexual and homosexual communities adversely affect bisexual individuals.[281, 282] Such attitudes may be associated with the lack of information about, or limited access to, a visible and supportive community of other bisexuals.[283] Providing information on community resources can help facilitate the development and maintenance of positive bisexual identities.[284, 285]

Services—RECOMMENDATIONS

- Mental health and substance abuse services for LGBT consumers should be culturally competent and consumer-based to reflect the diversity of LGBT people.
- Effective services should be available for LGBT people who are in the process of acknowledging sexual orientation and gender identity. If age-appropriate, services are also needed for families and other significant individuals.
- Social, mental health, and substance abuse service providers should be sensitive to issues such as homophobia and internalized homophobia.
- A culturally appropriate and linguistically suitable hotline should be available, 24 hours a day, 7 days a week, to assist LGBT people and families who need assistance with mental health problems.

In addition to involving traditional child- and adolescent-serving agencies (e.g., mental health, substance abuse, education, child welfare, juvenile justice), an LGBT-competent system of care should involve community organizations, advocacy groups, and other programs that specialize in providing access to LGBT-focused community supports.

- Public-sector systems serving LGBT youth, including schools, should implement a comprehensive, wraparound approach to providing services.
- Given that mental health problems in children and adolescents generally precede the onset of substance abuse problems by approximately 6 to 8 years, policymakers and community leaders should support and establish substance abuse prevention activities that specifically target LGBT youth.

Education and Training—RECOMMENDATIONS

- Providers need to acquire basic knowledge of LGBT people (through curricula, inservice programs, or other educational opportunities) and their mental health needs. This understanding should reflect the diversity of different populations and the availability of community resources and referrals.
- Mental health care providers of all disciplines who serve children and adolescents and their families should be adequately trained to address sexual orientation and gender identity in clinical practice.
- Training programs for mental health, substance abuse, social service, and health care providers on LGBT issues should be developed and evaluated for effectiveness.

Policy—RECOMMENDATIONS

- Sexual orientation and gender identity information should be included as components of cultural competency training for managed care, Medicaid, Medicare, and Children's Health Insurance Program providers.
- Sexual orientation and gender identity should be included, whenever appropriate, in national surveys, evaluation studies, and surveillance systems.
- Licensing bodies for medicine, nursing, psychology, social work, and other health and mental health professions should include guidelines that prohibit discrimination based on sexual orientation and gender identity.
- Specific regulations should be developed to cease involuntary hospitalization of LGBT youth by parents and removal of LGBT youth from parent or guardian custody by child welfare agencies.
- The existing mental health consumer groups—such as On Our Own, the National Empowerment Center, the Consumer Managed Care Network, the Mental Health Consumers Association, United Seniors Health Cooperative, and the Information Exchange—should include sexual orientation and gender identity within their special populations of concern.
- Existing accreditation organizations—such as the National Committee for Quality Assurance, the Council on Accreditation of Services for Families and Children, the Joint

Commission on Accreditation of Healthcare Organizations, the Rehabilitation Accreditation Committee, and the Utilization Review Accreditation Commission—should include sexual orientation and gender identity as one of the cultural competence-related areas for accreditation.

- As most businesses and industries purchase health care benefits for their employees, groups such as the Washington Business Group on Health, the Pacific Business Group on Health, and the Employee Assistance Professionals' Association should sponsor regional meetings to discuss the mental health concerns of their LGBT employees.

Research—RECOMMENDATIONS

- New studies are needed to assess whether an elevated risk of suicide exists for LGBT populations.
- Research is needed to develop better screening tools to assess patients' sexual orientation, gender identity, and mental health needs.
- Additional research is necessary to generate new knowledge about LGBT youth and mental health services, including access to mental health services in comparison to non-LGBT youth and mental health services, specific mental health disparities, service utilization patterns, and outcomes.
- Research is needed to understand the healthy development of LGBT persons at all stages of life, including studies of how sexual orientation and gender identity develop. Such research should reflect the diversity of the LGBT community.
- Clinical and intervention research is needed to identify mental disorders that may be more prevalent among LGBT persons and to identify the most appropriate prevention and treatment strategies.
- Studies are needed that focus on comparisons *within* LGBT samples, such as similarities and differences based on sexual orientation, gender, gender identity, age, race/ethnicity, socioeconomic status, and geographic location.
- More clinical research focusing on the transgender population is needed, including followup psychosocial assessments for long-term outcomes for treatment of gender dysphoria, for gender reassignment, and for the relationship between the age at which an individual receives sex reassignment and long-term outcomes.

Terminology

Anxiety disorders: Anxiety disorders have multiple physical and psychological symptoms, but all have in common feelings of apprehension, tension, or uneasiness. Among the anxiety disorders are panic disorder, agoraphobia, obsessive-compulsive disorder, posttraumatic stress disorder, and generalized anxiety disorder.

Case management: Practice in which the service recipient is a partner in his or her recovery and self-management of mental illness and life.

Co-occurring/comorbidity: In general, the existence of two or more illnesses—whether physical or mental—at the same time in a single individual. In this chapter, comorbidity specifically means the existence of a mental illness and a substance abuse disorder or a mental illness and a physical illness in the same person at the same time.

Consumer: In this chapter, any person using mental health services.

Cultural competence: In this chapter, a group of skills, attitudes, and knowledge that allows persons, organizations, and systems to work effectively with diverse racial, ethnic, and social groups.

Depression: A state of low mood that is described differently by people who experience it. Commonly described are feelings of sadness, despair, emptiness, or loss of interest or pleasure in nearly all things. Depression also can be experienced in other disorders such as bipolar disorder (manic-depressive disorder).

Diagnosable mental illness: Includes all people with a mental illness in a specified population group, whether or not they have received a formal diagnosis from a medical or mental health professional.

Homeless person: A person who lacks housing. The definition also includes a person living in transitional housing or a person who spends most nights in a supervised public or private facility providing temporary living quarters.

Juvenile justice facility: Includes detention centers, shelters, reception or diagnostic centers, training schools, ranches, forestry camps or farms, halfway houses and group homes, and residential treatment centers for young offenders.

Mental health services: Diagnostic, treatment, and preventive care that helps improve how persons with mental illness feel both physically and emotionally as well as how they interact with other persons. These services also help persons who have a strong risk of developing a mental illness.

Mental illness: The term that refers collectively to all diagnosable mental disorders. *Mental disorders* are health conditions characterized by alterations in thinking, mood, or behavior (or some combination thereof) that are all mediated by the brain and associated with distress or impaired functioning or both. Mental disorders spawn a host of human problems that may include personal distress, impaired functioning and disability, pain, or death. These disorders can occur in men and women of any age and in all racial and ethnic groups. They can be the result of family history, genetics, or other biological, environmental, social, or behavioral factors that occur alone or in combination.

Parity, mental health parity: Equivalent benefits and restrictions in insurance coverage for mental health services and for other health services.

Resilience: Manifested competence in the context of significant challenges to adaptation or development.

Schizophrenia: A mental disorder lasting for at least 6 months, including at least 1 month with two or more active-phase symptoms. Active-phase symptoms include delusions, hallucinations, disorganized speech, and grossly disorganized or catatonic behavior. Schizophrenia is accompanied by marked impairment in social or occupational functioning.

Screening for mental health problems: A brief formal or informal assessment to identify persons who have mental health problems or are likely to develop such problems. The screening process helps determine whether a person has a problem and, if so, the most appropriate mental health services for that person.

Serious emotional disturbance (SED): A diagnosable mental disorder found in persons from birth to aged 18 that is so severe and long-lasting that it seriously interferes with functioning in family, school, community, or other major life activities.

Serious mental illness (SMI): A diagnosable mental disorder found in persons aged 18 and older that is so long lasting and severe that it seriously interferes with a person's ability to take part in major life activities.

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Nutrition and Weight

Healthy People 2010 Goal

Promote health and reduce chronic disease associated with diet and weight.

Overview

Nutrition is essential for physical growth, development, health, and well-being. Many dietary components are involved in the relationship between nutrition and health. This chapter explores what little is known about the nutritional, dietary, and related physical activity habits of lesbian, gay, bisexual, and transgender (LGBT) populations. There is a growing body of evidence to suggest that some portions of the LGBT population may be at increased risk for a range of negative health outcomes associated with poor nutrition, weight, and disordered eating behaviors. Special consideration must be given to lesbians with a high body mass index, certain groups of gay and bisexual men, persons living with human immunodeficiency virus (HIV) infection, and LGBT or questioning adolescents. Finally, recommendations for action in the areas of nutrition services, education and training, policy, and research are discussed.

Issues and Trends

Nutritional or dietary factors contribute substantially to the burden of preventable illnesses and premature deaths in the United States.[1] Indeed, dietary factors are associated with 4 of the 10 leading causes of death: coronary heart disease, some types of cancer, stroke, and type 2 diabetes.[2] These health conditions are estimated to cost society more than $200 billion each year in medical expenses and lost productivity.[3] Dietary factors also are associated with osteoporosis, which affects more than 25 million persons in the United States and is the major underlying cause of bone fractures in postmenopausal women and elderly persons.[4]

The 2000 Dietary Guidelines for Americans recommend that, to stay healthy, persons aged 2 and older should follow these ABCs for good health: **A**im for fitness, **B**uild a healthy base, and **C**hoose sensibly. [Note: In text that follows in this chapter, Dietary Guidelines for Americans will refer to the 2000 Dietary Guidelines for Americans unless otherwise noted.]

The Food Guide Pyramid, introduced in 1992, is an educational tool that conveys recommendations about the number of servings from different food groups each day and other principles of the Dietary Guidelines for Americans.[5] The degree to which LGBT populations understand these recommendations and incorporate them into their day-to-day lifestyles remains unknown.

In addition to including whole grains, fruits, and vegetables and limiting saturated fat, cholesterol, total fat, sugar, salt, prepared food, and alcoholic beverages, the Dietary Guidelines for Americans also emphasize the need for adequate consumption of iron-rich and calcium-rich foods.[6] Although some progress has been made since the 1970s in reducing the prevalence of iron deficiency among low-income children,[7] much more is needed to improve the health of children of all ages and of women who are pregnant or of childbearing age, including lesbian and bisexual women who are pregnant or contemplating pregnancy. Since the start of this decade, consumption of calcium-rich foods, such as milk products, has generally decreased and is especially low among teenage girls and young women.[8]

In general, however, excesses and imbalances of some food components in the diet have replaced once commonplace nutrient deficiencies. Yet there has been a marked increase in the number of overweight and obese persons.[9, 10] Overweight results when a person eats more calories from food (energy) than he or she expends, for example, through physical activity. This balance between energy intake and output is influenced by metabolic and genetic factors as well as behaviors affecting dietary intake and physical activity. Environmental, cultural, and socioeconomic components also play a role.

When a body mass index (BMI) cut-point of 25 is used, nearly 55 percent of the U.S. adult population was defined as overweight or obese in 1988–94, compared to 46 percent in 1976–80.[11, 12] In particular, the proportion of adults defined as obese by a BMI of 30 or greater has increased from 14.5 to 22.5 percent.[13] A similar increase in overweight and obesity also has been observed in children over aged 6 in both genders and in all population groups.[14]

Many diseases are associated with overweight and obesity, even though weight is hard to alter and much of the research has not controlled for income or dieting history. Persons who are overweight or obese are at increased risk for high blood pressure, type 2 diabetes, coronary heart disease, stroke, gallbladder disease, osteoarthritis, sleep apnea, respiratory problems, and some types of cancer. Total costs (medical costs and lost productivity) attributable to obesity alone amounted to an estimated $99 billion in 1995.[15]

Disparities

Disparities in health status indicators and risk factors for diet-related disease are evident in many segments of the population based on gender, age, race and ethnicity, and income. For example, overweight and obesity are observed in all population groups, but obesity is particularly common among Hispanic, African American, Native American, and Pacific Islander women. Portions of LGBT communities also appear to be at risk for overweight or obesity. Several nonrandom studies suggest that lesbians are more likely to be overweight or

obese than heterosexual women,[16, 17, 18] including their heterosexual sisters.[19] Although undetermined, it is possible that lesbians who are Hispanic, African American, Native American, or Pacific Islander may be at higher risk for obesity.

Although sexual orientation has not been identified as a risk factor for the general population of gay men, there is some evidence that a certain segment of gay men that celebrate their larger girth—commonly referred to as "bears"—report high levels of compulsive eating.[20]

Furthermore, despite concerns about the increase in overweight and certain excesses in U.S. diets, segments of the population suffer from undernutrition, including persons who are socially isolated and poor. Many LGBT adolescents, particularly males, may experience high levels of undernutrition associated with body dissatisfaction and eating disorders,[21] and there is some evidence to suggest that this problem may extend into adulthood.[22, 23, 24, 25, 26, 27, 28, 29]

Moreover, malnutrition, protein depletion, weight loss—and more recently body fat distribution and metabolic alternations in the United States—have been common complications of HIV infection for gay and bisexual men and others[30, 31, 32] Initial research with respect to nutritional therapy to address these issues have shown that although weight gain does occur through such methods as appetite stimulants, the new weight is composed primarily of fat.[33] Physical activity and exercise also have been examined as a means for increasing muscle strength for even critically ill patients, with some success.[34, 35]

There are also concerns about the nutritional status of persons in hospitals, nursing homes, convalescent centers, and institutions; persons with disabilities, including physically, mentally, and developmentally disabled persons in community settings; children in childcare facilities; persons living on reservations; persons in correctional facilities; and persons who are homeless. National data about these population groups are currently unavailable or limited, especially for LGBT individuals. Data also are insufficient to target the fastest-growing segment of the population, old and very old persons who live independently, including older LGBT persons.

Opportunities

Healthy People 2010 places strong emphasis on establishing healthy dietary and physical activity behaviors in childhood—largely through education, curricula development, and parental influence. However, additional efforts may be necessary to ensure that LGBT communities understand the importance of sound nutritional and dietary habits as part of preventive healthy behavior and disease prevention. For example, LGBT youth are at risk for dropping out of school because of harassment and violence,[36, 37] and they may miss out on education-based efforts to promote healthier nutritional, dietary, and physical activity behaviors. Curricula for students will need to provide an LGBT-competent response to the concerns of LGBT adolescents who may be at risk for eating disorders because of negative body image. Teachers may need training in how to identify LGBT and questioning youth

who may be exhibiting signs of eating disorders and how to respond in a way that is culturally appropriate and respects the individual's right to confidentiality and privacy.

Healthy People 2010 also recognizes that although nutrition promotion efforts should begin in childhood, they need to continue throughout the lifespan. In particular, public education about the long-term health consequences and risks associated with yo-yo dieting and lack of exercise are necessary. Although many persons attempt to lose weight, studies show that within 5 years the majority regain the weight.[38]

Policymakers and program planners at the national, State, and community levels can and should provide important leadership in fostering healthful diets and physical activity patterns among all people in the United States, including LGBT youth and adults. The family and others, such as health care practitioners, schools, worksites, institutional food services, and the media, can play a key role in this process. For example, registered dietitians and other qualified health care practitioners can improve health outcomes among LGBT populations by increasing health professionals' knowledge of LGBT health, seeking training in LGBT competency, and applying what they learn to nutrition screening, assessment, and primary and secondary prevention.

Many of the Healthy People 2010 objectives that address nutrition and overweight in the United States measure in some way the Nation's progress toward implementing the recommendations of the Dietary Guidelines for Americans. However, none of these tracking measures use sexual orientation or gender identity as demographic variables. Although the data for the Healthy People 2010 dietary intake objectives measure the consumption of specified levels of certain foods or nutrients by populations, it is important to track and report on the levels consumed by currently unmeasured population groups, including LGBT people, to broaden the scope of progress on these objectives.

In summary, several actions are recognized as fundamental in achieving this focus area's objectives:

- Improving accessibility of nutrition information, nutrition education, nutrition counseling and related services, and healthful foods in a variety of settings and for all population groups, including LGBT communities
- Focusing on preventing chronic disease associated with diet and weight, beginning in youth, but continuing into adulthood
- Strengthening the link between nutrition and physical activity in health promotion
- Maintaining a strong national program for basic and applied nutrition research, including population-based nutrition research on LGBT populations, to provide a sound science base for dietary recommendations and effective interventions
- Maintaining a strong national nutrition monitoring program to provide accurate, reliable, timely, and comparable data to assess status and progress and to be responsive to unmet

data needs and emerging issues, including tracking of sexual orientation and gender identity as they relate to nutrition

- Strengthening State and community data systems to provide new information about the nutritional habits of LGBT populations and to be responsive to the data users at these levels
- Working in close partnership with LGBT organizations at the national, State, and local levels to build and sustain broad-based nutrition education initiatives targeting LGBT youth and adults

Summary of LGBT Research

Very little research has been done on the nutritional habits of LGBT individuals. Healthy People 2010 recognizes that there are disparities in health status indicators and risk factors for diet-related disease in certain segments of the U.S. population, based on gender, age, race and ethnicity, and income. Sexual orientation and gender identity are not identified in Healthy People 2010 as potential risk factors for poor nutrition and obesity, even though there is a growing body of evidence to suggest that sexual minorities in the United States may be at increased risk for negative health outcomes associated with poor nutrition and obesity.

Lesbians. Several nonrandom studies suggest that lesbians are more likely to be overweight or obese than heterosexual women,[39, 40, 41] including their heterosexual sisters.[42] Other nonrandom studies suggest that lesbians may have a higher BMI and smoke more than heterosexual women, which may increase their risk for cardiovascular disease and cancer.[43, 44, 45] However, although being female has been related to concerns about dieting and being fat, lesbians tend to be less preoccupied with weight and body image than heterosexual women.[46, 47]

Although a higher body mass may be associated with genetic factors, it may also be attributed to poor nutrition or behaviors linked to eating disorders. Lesbians have been found to consume fewer vegetables and fruits than heterosexual women.[48] Additional studies are needed, however, to determine to what degree having a higher BMI can be attributed to poor nutrition or eating disorders among lesbians. Research also is needed to determine at what point in the lifespan lesbians gain weight compared to nonlesbians who have been found to gain weight in adolescence or during pregnancy. More information is needed on the prevalence of obesity among bisexual women compared to lesbians and heterosexual women.

Gay and bisexual men. Very little is known about the nutritional habits of gay and bisexual men, and there appears to be significant variation within gay and bisexual male populations in their nutritional and weight management practices. Some studies of clinical samples have found sexual orientation to be a significant predictor of eating disorders among men, though not among women.[49, 50, 51, 52, 53] Other studies have found no such association.[54, 55, 56] Community studies—which have typically sampled college students or participants in gay

and lesbian organizations—have often found a significant association between sexual orientation and negative body image among gay men.[57, 58, 59] There is a theory that "gay male gym culture" is a current phenomenon that prescribes a sort of gay beauty requirement and narrow norm for gay male attractiveness to which some men desperately try to conform. More information is needed about this theory and its potential impact on eating disorders among gay men.[60]

Gay and bisexual men, and others infected with HIV, often experience nutritional and weight problems. Despite a decreased incidence in malnutrition in the United States with persons taking active antiretroviral therapy, individuals infected with HIV have developed problems in the areas of body fat distribution and metabolic alterations including hyperlipidimia and insulin resistance.[61] Additional research is needed as well as provider education and standards that will ensure individuals with HIV receive LGBT-competent, HIV-sensitive, and individualized information with respect to nutritional therapy and physical activity.

One population of gay and bisexual men, known as "bears," may be at significant risk for adverse health outcomes associated with poor nutrition and being overweight. "Bears" typically celebrate large bodies as more masculine and generally identify a sexual attraction to other large men. A newsletter-based survey of members of New York City's Metrobear Club asked, "What are your five greatest health concerns?" Compulsive overeating was identified as the top health concern of "bears," especially those aged 35 to 49, followed by depression, HIV/AIDS, lack of health insurance, and stress.[62] Although the sample was small and represented only 18 percent of the Metrobear Club's membership, its findings clearly indicate an important public health concern and a need for additional research.

Additional research is needed to examine for both "bears" and lesbians the unique cultural ways in which weight and body image are viewed, including the rejection of heterosexual norms. Such research could lead to improved LGBT competency by providers and educators in the areas of nutrition, eating disorders, body image, and sexuality.[63, 64]

Lesbian, gay, and bisexual adolescents. In the Minnesota Adolescent Health Survey,[65] homosexual boys were more likely than heterosexual boys to report a poor body image (28 percent compared to 12 percent), frequent dieting (9 percent compared to 6 percent), binge eating (25 percent compared to 11 percent), and purging behaviors (12 percent compared to 4 percent).[66] In contrast, homosexual girls were more likely than heterosexual girls to report a positive body image (42 percent compared to 21 percent). However, they were no less likely to report negative eating behaviors, such as binge eating or purging.[67]

It is important to note that significant gender differences related to eating problems and body image appear to hold true for gay and lesbian populations. Young boys (15 percent) in the Minnesota sample were less likely than young girls (27 percent) to rate themselves low on body image. A greater proportion of older females (38 percent) than males (22 percent) considered themselves to be overweight. In each group, more girls than boys reported dieting in the last year, at all levels of frequency. Despite increased risk among homosexual

men compared with heterosexual men, women (both lesbian and heterosexual) are at greater risk for body dissatisfaction and eating disorders.[68]

Transgender persons. No empirical studies on the nutritional and weight management practices of transgender persons have been conducted. However, it is reasonable to expect individuals who are transitioning to the opposite gender may modify their diet, eating behaviors, or perception of weight to appear more like the desired gender. For example, female-to-male (FTM) transgender persons may be more likely to accept or attempt to achieve a higher BMI because it may seem more masculine in appearance. Likewise, male-to-female transgender persons may be more likely to diet or have higher rates of eating disorders to attain a more feminine appearance. These behaviors to modify body image merit further study.

Additionally, cross-gender hormone therapy with either androgens or estrogens may predispose to weight gain;[69] and androgen therapy in FTM transgender persons causes a shift in lipid profiles to male patterns, which increases the risk of cardiovascular diseases.[70] Additional studies are needed to better understand the long-term health risks associated with cross-gender hormone therapy and how modifying one's diet might help reduce these risks.

LGBT populations and issues related to physical activity, heart disease, and stroke. The fact that lesbians may have a higher BMI than women in the general population is interesting in that lesbians also report more frequent episodes of regular, vigorous physical activity[71] and weight-bearing exercise.[72] Together, these findings may justify concerns that some lesbians may be experiencing an imbalance between energy intake and output, although there also may be a correlation between increased muscle mass due to physical activity and a higher BMI. Additional research is needed to give health providers better information on nutrition, diet, and physical activity among lesbians. Both the National Health and Nutrition Examination Survey (NHANES) and the Behavioral Risk Factor Surveillance System (BRFSS) collect national data on physical activity. Adding sexual orientation as a demographic variable or additional population group in these national data sets would yield information on the physical activity, nutritional, and dietary habits of LGBT populations and allow for comparisons across multiple populations and with the general population. Such data may be critical in defining risk profiles for cardiovascular disease, breast cancer, and other diseases related to inactivity or poor nutrition as well as in developing culturally competent interventions.

Although there is a lack of data specific to lesbians, coronary heart disease is the leading cause of death among women,[73] and there is no evidence that lesbians are at less risk among women. Lesbian-specific interventions are needed to combat additional risk factors, such as smoking, hypertension, abnormal lipid profiles, diabetes, obesity, and inactivity.[74] Another study which compared lesbians, bisexual women, heterosexual women, and asexual women found that two groups of lesbians—lifetime lesbians and adult lesbians—had the highest rates of myocardial infarction and slightly lower prevalences of stroke and hypertension.[75]

It is also known that psychosocial factors—particularly low socioeconomic status, gender-specific stress, racial/ethnic differences, and discrimination can contribute to elevated blood pressure. A few studies have investigated whether or not stress or discrimination due to sexual orientation is elevated in LGBT individuals and the degree to which this may elevate blood pressure in the population.[76, 77, 78] By inference, if stress due to sexual orientation-based discrimination is high, then LGBT persons who also have low income or are members of racial or ethnic minority groups may have even greater levels of stress and elevated blood pressure.

Discussion of Healthy People 2010 Objectives

19-1: Increase the proportion of adults who are at a healthy weight.

See discussion under objective 19-2.

19-2: Reduce the proportion of adults who are obese.

As noted earlier in this chapter, several studies suggest that lesbians are more likely to be overweight or obese than heterosexual women.[79, 80, 81] Additional studies are needed to determine the specific causes of increased rates of obesity among lesbians and to determine if the long-term, potential health consequences of obesity in lesbians differ from women in the general population.

Few data are available on obesity among gay and bisexual men, bisexual women, and transgender persons. National data sets, such as NHANES, and other data surveys conducted by the Centers for Disease Control and Prevention (CDC) and the National Center for Health Statistics (NCHS/CDC) could provide vehicles through which to collect data on LGBT populations using both sexual orientation and gender identity as demographic variables.

Health care providers can play an important role in counseling LGBT patients on how to modify eating patterns and improve nutrition. However, there is evidence that many health care providers fail to establish rapport and communicate effectively with patients, which can lead to decreased levels of adherence to physician advice and treatment plans and decreased rates of satisfaction.[82] Many clinicians are unaware of their patients' sexual orientation, and as a result, they may fail to accurately diagnose, treat, or recommend appropriate preventive measures, including recommendations for achieving and maintaining a healthy weight and eating a balanced diet. However, when patients have difficulty communicating with a primary care provider, they may be more likely to delay seeking health care.[83] (See Health Communication focus area.)

One of the barriers to patient education for transgender persons is that most health professionals lack knowledge about transgender identity, sexuality, and health care issues and are unable to respond appropriately to their transgender patients. As a consequence, responsibility for educating health care providers about transgender issues far too often falls on the patient.[84, 85] Providing the needed information presents a formidable challenge for

transgender persons who also are subject to discrimination from health care professionals based on their gender-variant physical and social presentations.[86]

19-5: Increase the proportion of persons aged 2 and older who consume at least two daily servings of fruit.

See discussion under objective 19-10.

19-6: Increase the proportion of persons aged 2 and older who consume at least three daily servings of vegetables, with at least one-third being dark green or deep yellow vegetables.

See discussion under objective 19-10.

19-7: Increase the proportion of persons aged 2 and older who consume at least six daily servings of grain products, with at least three being whole grains.

See discussion under objective 19-10.

19-8: Increase the proportion of persons aged 2 and older who consume less than 10 percent of calories from saturated fat.

See discussion under objective 19-10.

19-9: Increase the proportion of persons aged 2 and older who consume no more than 30 percent of calories from total fat.

See discussion under objective 19-10.

19-10: Increase the proportion of persons aged 2 and older who consume 2,400 mg or less of sodium daily.

Healthy People 2010 states that consuming a healthy diet of fruits, vegetables, and grains that is low in calories, saturated fat, and sodium is essential to good nutrition. Good nutritional habits should be developed in childhood and adolescence. However, there is evidence that LGBT youth may be at risk for developing poor nutritional habits at an early age. In 1986-87, more than 30,000 adolescents completed the Minnesota Adolescent Health Survey, a comprehensive assessment of adolescent health status, health behaviors, and psychosocial factors. Although the survey included relatively few items on nutrition-related issues, it found that homosexual orientation among adolescent males was a risk factor for inadequate food intake patterns or unhealthy weight-control practices. Other risk factors included low socioeconomic status, chronic illness, poor school achievement, low family connectedness, weight dissatisfaction, being overweight, and other health-compromising behaviors[87]—many of which may be experienced by gay or bisexual adolescent males. Ethnicity was also found to be a risk factor, further increasing the likelihood of poor food intake or weight control practices by ethnic gay or bisexual adolescent males.[88]

Good nutrition is important for all populations within the LGBT community. For example, LGBT individuals with a high BMI, such as lesbians or "bears," need to work in close partnership with health care providers to develop a healthy nutritional routine. Similarly, LGBT persons living with HIV infection also need sound nutritional assistance tailored to their needs.

Due to a combination of factors—such as body image disorders, related and unrelated chronic dieting, eating disorders, single lifestyle causing a likely increase in eating outside of the home or eating prepared foods, and high prevalence of certain illnesses in LGBT communities (e.g., HIV infection)[89, 90, 91, 92]—many LGBT individuals may be more likely to fail to meet the nutritional goals outlined in Healthy People 2010. Additional efforts are needed to ensure that LGBT populations understand the basic components of good nutrition. Although efforts have been made to educate school-aged children, parents, elderly persons, racial/ethnic minorities, and other segments of the U.S. population about good nutrition habits, LGBT people have not been targeted for LGBT-specific and basic nutritional education.

19-16: Increase the proportion of worksites that offer nutrition or weight management classes or counseling.

See discussion under objective 19-17.

19-17: Increase the proportion of physician office visits made by patients with a diagnosis of cardiovascular disease, diabetes, or hyperlipidemia that include counseling or education related to diet and nutrition.

Worksites have demonstrated their value in reaching large numbers of employees with information, activities, and services that promote healthy dietary and physical activity behaviors.[93] They have also demonstrated success in helping employees make healthier dietary decisions.[94] Examples of such programs include weight management classes, physical activity programs, lunchtime seminars, self-help programs, cooking demonstrations and classes, healthy food service and vending machine selections, nutrition information, and offering flexible benefits that include nutrition-related education and services.

It is critical that employer-sponsored programs be available and accessible to LGBT employees. LGBT persons may be less likely to access employee-sponsored nutrition and weight management programs because of high levels of uninsurance and underinsurance.[95, 96] They are also unlikely to have access to LGBT-competent educators and providers[97] and may be less likely to participate in such programs because of perceived or actual discrimination or heterosexism.[98]

Additional research is needed to shed new light on the incidence and prevalence of hyperlipidemia, type 2 diabetes mellitus, and cardiovascular disease in LGBT populations. Healthy People 2010 states that primary care providers are well positioned to provide a range of preventive services, including nutrition screening and assessment, referral, and counseling. However, there is evidence that numerous barriers experienced by LGBT

persons within the health care system often result in LGBT persons avoiding prevention services.[99] (See Access to Quality Health Services focus area.) Although referring LGBT clients who need nutritional assessment, education, counseling on behavior change, diet modification, and specialized nutrition therapies to a qualified nutrition professional may constitute appropriate clinical practice, it is critical that nutrition professionals provide their services in an LGBT-competent manner.

Services—RECOMMENDATIONS

- New efforts are needed to address body dissatisfaction and eating disorders among LGBT populations, with a strong emphasis on gay male and transgender adolescents. Specifically, school-based nutrition education programs must be LGBT-competent and relevant to LGBT youth who may be experiencing body dissatisfaction and eating disorders.
- LGBT-competent health care and support services must be made available to address nutrition, physical activity, and weight for lesbians with a high BMI, gay and bisexual men with weight or body image concerns, transgender individuals, persons living with HIV infection, and LGBT or questioning adolescents.

Education and Training—RECOMMENDATIONS

- Health care providers of all disciplines—but especially primary health care providers, dietitians, and nutritionists—need training on the specific nutritional needs of LGBT populations, such as lesbians with a high BMI, certain groups of gay and bisexual men, persons living with HIV infection, and LGBT or questioning adolescents. Such training should include a strong emphasis on delivering culturally competent and sensitive care.

Policy—RECOMMENDATIONS

- The U.S. Department of Health and Human Services and the U.S. Department of Agriculture should collaborate in designing, supporting, and evaluating a public health education campaign designed to increase awareness among LGBT populations about the Food Guide Pyramid and the recommendations of the Dietary Guidelines for Americans.

Research—RECOMMENDATIONS

- Sexual orientation and gender identity should be included as demographic variables in all relevant Federal and national data sets, including NHANES, BRFSS, the Continuing Survey of Food Intakes by Individuals, and the National Worksite Health Promotion Survey, as well as data sets administered by CDC and NCHS.
- Research is needed to examine the impact of self-esteem and body image, and their relationship to eating disorders within LGBT populations, especially among gay and bisexual males and MTF transgender individuals. Research also should look at the

extent to which alienation, discrimination, and resultant stress may increase any propensity to eating disorders among all LGBT populations.

- Additional studies are needed to determine the specific causes of increased rates of obesity among lesbians and to determine if the long-term, potential health consequences of obesity in lesbians differ from women in the general population.
- Once sexual orientation and gender identity are added as demographic variables in national data sets, additional analyses will be needed to estimate the prevalence of poor nutrition and diet, obesity, physical inactivity, smoking, alcohol and drug use, and other risk factors commonly observed in LGBT populations as well as their association with heart disease, stroke, diabetes, and other negative health outcomes.
- Additional research is needed on the nutritional status of LGBT persons in hospitals, nursing homes, convalescent centers, and institutions; LGBT persons with physical, mental, and developmental disabilities in community settings; LGBT persons living on reservations and in correctional facilities; and LGBT youth and adults who are homeless. Data also are insufficient to develop targeted interventions for older LGBT persons who live independently.
- Research on the nutritional and dietary habits of transgender populations are needed to better understand the appropriate role of nutrition and diet in gender expression and reassignment.

Terminology

Body mass index (BMI): Weight (in kilograms) divided by the square of height (in meters), or weight (in pounds) divided by the square of height (in inches) times 704.5. Because it is readily calculated, BMI is the measurement of choice as an indicator of healthy weight, overweight, and obesity.

Calorie: Unit used for measuring the energy produced by food when metabolized in the body.

Cholesterol: A waxy substance that circulates in the bloodstream. When the level of cholesterol in the blood is too high, some of the cholesterol is deposited in the walls of the blood vessels. Over time, these deposits can build up until they narrow the blood vessels, causing arteriosclerosis, which reduces the blood flow. The higher the blood cholesterol level, the greater is the risk of getting heart disease. Blood cholesterol levels of below 200 mg/dL are considered desirable. Levels of 240 mg/dL or greater are considered high and require further testing and possible intervention. Levels of 200-239 mg/dL are considered borderline. Lowering blood cholesterol reduces the risk of heart disease.

Coronary heart disease: The type of heart disease due to narrowing of the coronary arteries.

Dietary Guidelines for Americans: A report published by the U.S. Department of Agriculture and U.S. Department of Health and Human Services that explains how to eat to maintain health. The guidelines form the basis of national nutrition policy and are revised every 5 years. This chapter refers mostly to the 2000 guidelines.

Fats and fatty acids: Hydrocarbon chains ending in a carboxyl group at one end that bond to glycerol to form fat. Fatty acids are characterized as saturated, monounsaturated, or polyunsaturated depending on how many double bonds are between the carbon atoms. Fatty acids supply energy and promote absorption of fat-soluble vitamins. Some fatty acids are "essential" because the body cannot make them.

Food Guide Pyramid: A graphic depiction of the U.S. Department of Agriculture's current food guide that includes five major food groups in its "base" (grains, vegetables, fruits, milk products, and meats and meat substitutes) and a "tip" depicting the relatively small contribution that discretionary fat and added sugars should make in U.S. diets. The Food Guide Pyramid provides information on the choices within each group and the recommended number of servings.

Hypertension: High blood pressure.

Hypertriglyceridemia: Elevated levels of triglycerides in the blood.

Iron deficiency: Lack of adequate iron in the body to support and maintain functioning. It can lead to iron deficiency anemia, a reduction in the concentration of hemoglobin in the red blood cells due to a lack of iron supply to the bone marrow.

Nutrition: The set of processes by which nutrients and other food components are taken in by the body and used.

Obesity: A condition characterized by excessive body fat.

Osteoporosis: A bone disease characterized by a reduction in bone mass and a deterioration of the bone structure leading to bone fragility.

Overweight: Excess body weight.

Physical activity: Bodily movement that substantially increases energy expenditure.

Registered dietitian: A food and nutrition expert who has met the minimum academic and professional requirements to receive the credential "R.D." Many States and Commonwealths also have licensing laws for dietitians and nutrition practitioners.

Type 2 diabetes: The most common form of diabetes, which results from insulin resistance and abnormal insulin action. Type 2 diabetes was previously referred to as noninsulin-dependent diabetes mellitus or adult-onset diabetes.

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Public Health Infrastructure

Healthy People 2010 Goal

Ensure that Federal, tribal, State, and local health agencies have the infrastructure to provide essential public health services effectively.

Overview

The mission of public health is to fulfill "society's interest in assuring conditions in which persons can be healthy."[1] Public health engages both private and public organizations as well as individuals in accomplishing this mission. Responsibilities encompass preventing epidemics and the spread of disease, protecting against environmental hazards, preventing injuries, encouraging healthy behavior, helping communities to recover from disasters, and ensuring the quality and accessibility of health services to individuals who otherwise cannot access or afford needed health care and related services.

The Nation's public health infrastructure consists of the resources needed to deliver the essential public health services to every community—people and health professionals who work in the field of public health; information and communication systems used to collect and disseminate accurate data; and public health organizations at the Federal, State, and local levels in the front lines of public health. The public health infrastructure is a complex web of practices and organizations that has been characterized as in "disarray."[2,3] Public health encompasses three core functions: assessment of information on the health of the community, comprehensive public health policy development, and assurance that public health services are provided to the community.[4] These functions have been defined further and expanded into 10 essential public health services.[5] (See Figure 1 for a full list of functions.) The totality of the public health infrastructure includes all governmental and nongovernmental entities or organizations that provide any of these services. Environmental health, occupational health and safety, mental health, and substance abuse are integral parts of public health. Service providers, such as managed care organizations, hospitals, nonprofit corporations, schools, faith organizations, businesses, and consumer organizations also are an integral part of the public health infrastructure in many communities. They are among the stakeholders who should be at the public health planning table at the State level and in the community.

Issues and Trends

Various reports and evaluations have described the continuing deterioration of the national public health system. Health departments are closing, technology and information systems evaluated have been found to be outmoded, newly emerging and drug-resistant diseases threaten to overwhelm resources, and serious inadequacies in health professions training weaken the capacity of the public health workforce to address new threats and adapt to changes in the health care market.[6, 7] Conversely, interest in public health has led to the development of public health improvement plans in many States, such as Illinois and Washington. In addition, private foundations have funded major national programs to improve health.

Figure 1. Essential Public Health Services

- Monitor health status to identify community health problems
- Diagnose and investigate health problems and health hazards in the community
- Inform, educate, and empower people about health issues
- Mobilize community partnerships to identify and solve health problems
- Develop policies and plans that support individual and community health efforts
- Enforce laws and regulations that protect health and ensure safety
- Link people to needed personal health services and assure the provision of health care when otherwise unavailable
- Assure a competent public health and personal health care workforce
- Evaluate effectiveness, accessibility, and quality of personal and population-based health services
- Research for new insights and innovative solutions to health problems

Source: Public Health Functions Steering Committee. Public Health in America, Fall 1994. Available online at www.health.gov/phfunctions/public.htm.

All public health services depend on the presence of basic infrastructure. Every categorical public health program—childhood immunizations, infectious disease monitoring, cancer and asthma prevention, drinking water quality, injury prevention, and many others—requires health professionals who are competent in cross-cutting and technical skills, public health agencies with the capacity to assess and respond to community health needs, and up-to-date information systems. Federal public health agencies rely on the presence of adequate infrastructure systems at the local and State levels to support the implementation of their programs.

Turning Point: Collaborating for a New Century of Public Health Initiatives, supported by the Robert Wood Johnson Foundation and the W.K. Kellogg Foundation, helps develop more effective public health infrastructure by providing technical assistance to health departments at State and local levels.

Source: www.turningpointprogram.org.

In public health, a strong infrastructure provides the capacity to prepare for and respond to both acute and chronic threats to the Nation's health, whether they are bioterrorism or weapons of mass destruction attacks, emerging infections, disparities in health status, or increases in chronic disease and injury rates. Such an infrastructure serves as the foundation for planning, delivering, and evaluating public health. The public health infrastructure comprises the workforce, data and information systems, and public health organizations. Research also is a key activity of public health infrastructure in identifying opportunities to improve health, strengthen information systems and organizations, and make more effective and efficient use of resources.

Health data and surveillance systems provide information on illness, disability, and death from acute and chronic conditions; injuries; personal, environmental, and occupational risk factors; preventive and treatment services; and costs. To be most useful, public health data must be accessible, accurate, timely, clearly stated, and adherent to strict confidentiality standards. The system must be linked with other data systems and linked with and integrated at the Federal, tribal, State, and local levels. The systematic collection, analysis, interpretation, dissemination, and use of health data drive efforts to determine the health status of a population, plan prevention programs, and evaluate program effectiveness. Healthy People activities during the 1980s and 1990s have demonstrated the central role of data, focused attention on what is important to measure, and stimulated the expansion and improvement of existing national-level surveys and the development of new data systems.

Although Federal agencies take the lead in collecting national public health data, these agencies are only some of the many necessary partners that collect, analyze, and use public health data. Surveillance often involves active cooperation among Federal, tribal, State, and local agencies. For example, the Vital Statistics Cooperative Program obtains information on births, deaths, marriages, and divorces from all 50 States, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and Guam. Programs in each area collect vital information from many sources in local communities, including funeral directors, medical examiners, coroners, hospitals, religious authorities, and justices of the peace. Other data collection systems, based on sample surveys rather than reports, depend on the participation of thousands of private citizens nationwide. And still other systems rely on the administrative records of public and private health care organizations.

If data are unavailable or missing, problems can arise, especially for State and local health agencies. In particular, health problems may not be identified in high-risk populations, such as lesbian, gay, bisexual, and transgender (LGBT) populations, or the public intervention may not be timely enough. Information enables public health to direct preventive services and health promotion activities toward select populations.

Caitlin Ryan and Donna Futterman wrote their book, Lesbian and Gay Youth: Care and Counseling as a followup document to a national working conference sponsored by the Health Resources and Services Administration to address the full range of primary health care and preventive needs for these underserved adolescents.[8]

The public health workforce must have up-to-date knowledge, skills, and abilities to deliver services effectively and carry out the core functions of assessment, policy development, and assurance of services to all populations. The importance of organizations in making a system effective may be overlooked. Yet, tribal, State, and local public health agencies, in partnership with other community organizations, are essential to creating an effective public health system.

Today's fiscal restraints and increasing social problems increase the challenge to maintain a proactive, effective, and culturally responsive public health infrastructure. In addition, this difficult task is made more complicated by an increasingly diverse, multicultural society. People in the public health work force now must provide services for people whose cultural orientation, view of life, and living circumstances may differ significantly from the providers. LGBT people, for example, often have different social systems and social interactions than those of health planners and other individuals responsible for strengthening the public health infrastructure.

Disparities

One of the overarching goals of Healthy People 2010 is to eliminate health disparities. These disparities exist at all State and local levels but are not well delineated because of differences in public health systems between States. A better trained public health workforce, improved data and information systems, and more effective public health organizations will strengthen the public health infrastructure at all levels and help identify where disparities exist so that targeted, more effective interventions and programs to eliminate the disparities can be developed.

Disparities among public health organizations and between the public and private health sectors also are of concern. For example, a diverse, highly skilled workforce must be recruited and trained to meet the challenges expected to emerge during the 21st century. These challenges include the changing racial and ethnic demographics of the country; immigration trends and the overall health of new immigrants; an increase in the older population; the identification of other sicker and higher-risk populations as well as populations in disparity in access to needed health care and related services; the emergence of epidemic or pandemic diseases; changes in cost-containment strategies by health plans and health insurance companies; and gaps in the types of health care providers needed to serve the changing population of health care consumers. Salary structures and the differences in staffing patterns across public health jurisdictions, as well as disparities between workers in the public and private sectors, will affect the ability of public health agencies to recruit and retain a high-quality workforce.

Among the populations more recently recognized as in disparity in access to needed services are LGBT people who often remain invisible and "in the closet" or who never identified as LGBT even though they may seek public health services or are entitled to receive such services.[9, 10] The invisibility of LGBT people also means that heterosexuals may assume that LGBT people seeking services are heterosexual. The heterosexual

provider, who also may be homophobic, then may fail to modify or alter the services so they are appropriate to the sexual orientation of the person being served.[11] Over the last 25 years, researchers have found evidence of homophobia among a variety of health care professionals, including psychologists, nurses, social workers, counselors, and physicians.[12]

Opportunities

Several developments suggest opportunities to improve public health capacity nationwide. The Public Health Workforce: An Agenda for the 21st Century, published by the Public Health Service in 1997, recognized the need for the public health system to assure a stronger public health workforce.[13] The report identified five areas to be strengthened: national leadership, State and local leadership, workforce composition, health professions curriculum development, and distance learning. Data systems are needed to track the extent to which the workforce has the knowledge, skills, and abilities to carry out its evolving functions. With wide input from the public health community, the Standard Occupational Classification system was updated in 1997 and 1998 to include an array of public health professions.[14] This classification system will continue to be used in a number of national population- and employer-based surveys by the Bureau of Labor Statistics (U.S. Department of Labor), the Bureau of the Census (U.S. Department of Commerce), and the Bureau of Health Professions (Health Resources and Services Administration, U.S. Department of Health and Human Services). A standard classification may be useful in determining minimum levels of competency for each classification.

Part of the effort to better understand the effectiveness of public health interventions and to make Healthy People 2000 more understandable and useful to the States and localities was release of a set of 18 Health Status Indicators and Priority Data Needs in July 1991 by the Centers for Disease Control and Prevention (CDC). The indicators were developed in response to one of the Healthy People 2000 objectives that focused on obtaining data for racial and ethnic groups, and their use by Federal, State, and local health agencies was encouraged. Data on the Health Status Indicators and Priority Data Needs are reported on in the Healthy People 2000 Reviews published at regular intervals, the most recently published being Healthy People 2000, 1998-99.[15] State data are available for both the Health Status Indicators and Priority Data Needs at www.cdc.gov/nchswww/datawh/datawh.htm. Data on the health indicators have been an important step in monitoring progress toward the second goal of Healthy People 2010: to eliminate health disparities among population groups, particularly at the State and local levels. Additional steps need to be taken to produce relevant health status data for all populations at the national, State, tribal, and local levels.

The greatest opportunity for obtaining health-related data for LGBT people has been a greater acceptance of LGBT people over the past 40 years.[16] A cursory review of key health care stakeholders was conducted to identify professional associations, provider groups, private and public purchasers, accrediting groups, and other major policies that specifically addressed sexual orientation or sexual identity relative to clients and providers. The following groups have such policies. The date reflects when the policies were written.

- Academy of Managed Care Pharmacy (1998)
- Addiction Prevention and Recovery Administration (1997)
- American Academy of Pediatrics (1996)
- American Counseling Association (1992)
- American Medical Association Council on Scientific Affairs (1996)
- Council for Accreditation of Counseling and Related Educational Programs (1998)
- Employee Assistance Professional Association (1996)

The American Federation of State, County, and Municipal Employees (AFSCME) continues to work to promote the rights of their lesbian and gay union members via the promotion of legislation that affects domestic partner benefits and discrimination based on human immunodeficiency virus (HIV) status. AFSCME also issued a 1994 report resulting from their Presidential Advisory Commission that clearly states consumer rights issues within health care.[17] More than 100 LGBT-community based programs are located throughout the United States, offering not only medical care but also public health services to many recipients. (More information about the LGBT community health centers can be found online at www.gaycenter.org.) Finally, in several communities, such as Seattle, networks of youth service agencies, public health departments, schools, and religious-affiliated groups have been developed to conduct needs assessments and coordinate communitywide program development for both "visible" and "invisible" gay and lesbian youth.[18]

Summary of LGBT Research

This chapter addresses the need to ensure that the public health system infrastructure has the capacity to carry for LGBT people the three core functions of public health as set forth in the Public Health Infrastructure focus area of Healthy People 2010:

- Assessing the health status of LGBT populations (including ensuring adequate data and information, monitoring trends, and informing and educating decisionmakers and the general population)
- Developing comprehensive public health policies (including programs, plans, laws, and regulations) that are based on adequate health status and health services data and are supportive of individual and community health efforts
- Assuring the availability of quality personal and public health services.

These core functions exist in the context of the broad-based public health infrastructure. and relate to all aspects of health care, including primary health care, mental health, and substance abuse. Although there are increasing efforts among some Federal, State, and local agencies to address LGBT health concerns in the context of these core functions, outside of

HIV and acquired immunodeficiency syndrome (AIDS), the health of LGBT people is largely invisible to the public health system.

The White House Office of National AIDS Policy, created by President Clinton and Vice President Gore, is the only Federal organization that provides broad policy guidance and works closely with community-based and national organizations. There is, however, no single office or agency within the U.S. Department of Health and Human Services charged with the coordination of public health infrastructure issues for LGBT people. Similarly, no one Federal agency has the responsibility for maintaining linkages among the various Federal agencies that address some aspect of LGBT public health (e.g., breast cancer, substance abuse treatment services, access to health services).

There is a lack of data about health status and access to and utilization of health services among LGBT populations. Resolving that lack of data would be a significant contribution toward ensuring a public health infrastructure that meets the needs of all people. One of the challenges is that national-level health data for the LGBT population are limited because of the methodological challenges in researching LGBT health issues, due to limitations in the infrastructure and a lack of funding to support such research.[19, 20] In Healthy People 2010, the availability of consistent and uniformly reliable data for the U.S. population is recognized as a cornerstone of a sound public health infrastructure. The document also recognizes that the current collection of health data and surveillance systems do not meet all current data needs. However, for the total population the existing data systems provide a level of reliable and valid data, based, for example, on periodic national surveys, sample surveys, and public and private administrative health records of individual practitioners and provider institutions.

Reliable data about LGBT health, then, serve as an essential starting point for building the capacity of the public health system to maintain and improve the health of LGBT people. A number of researchers, health planners, and providers are either not culturally competent or uninterested in addressing LGBT health concerns. This, in combination with the lack of data, affects the ability of the public health system to eliminate disparities against one group that also is diverse with respect to age, race/ethnicity, socioeconomic status, and educational level. For example, a rural public health agency may be challenged to plan substance abuse services for LGBT people. However, the agency or the State may not collect information about the local LGBT youth, adults, and families and may find that few, if any, of the local substance abuse staff have expertise in this area. A first step for this hypothetical agency might be to build its own capacity to identify and respond to the needs of local LGBT residents, with the support and leadership of State, Federal and local community-based agencies. To assist in this effort, this chapter is organized into three categories that relate to public health infrastructure: data and information systems, core workforce and organizational competency, and the law and public health.

Data and Information Systems

The lack of data on smaller populations, usually those people who are vulnerable or at higher risk, presents a conundrum for the American public health system. Healthy People 2010, a statement of national health and prevention priorities, is based on the goal of eliminating health disparities. However, without methodologically sound data on the health status and health needs of LGBT populations, public health agencies cannot accurately document the health status of this population, identify disparities, and address emerging health conditions and issues. For example, because HIV/AIDS surveillance includes men who have sex with men, data indicate that the highest number of new AIDS cases in 1996-98 was among African American men in the Southern United States who have sex with men. Nearly one-quarter of those men live in the rural South—outside of major metropolitan areas.[21] This is critical information for HIV prevention and AIDS treatment planning. However, current public health documents are only slowly addressing other health issues for LGBT populations that are beginning to reveal comparable critical epidemiologic information that identifies disparities or disease trends and informs public health policy.

The collection of accurate data is especially important for LGBT people of color and all transgender individuals, who suffer a disproportionate burden of discrimination and associated health risks.[22, 23, 24] Without accurate data, health planners at the Federal and local levels are limited in their ability to organize, finance, and deliver meaningful health promotion, health education, disease prevention, and treatment services. Knowledge and understanding of health-related information (e.g., health status, services access and utilization) on any population can inform public health policy in general as well as policies and plans related to targeted prevention and treatment efforts. This, in turn, lays the foundation for the more effective allocation of limited Federal, State, and local public health resources, including financial, health workforce, and physical infrastructure.

In addition to methodological and other challenges that relate generically to public health data and information, three that relate specifically to LGBT people are increasingly recognized within broad public health policy forums as urgently in need of resolution. These are:

- *Methodological issues related to collection of data by sexual orientation and gender identity.* This challenge underscores the need for expert discussions on the appropriate way to collect information on sexual orientation and gender identity as demographic variables in national data collection efforts. Specifically, how should questions about sexual orientation or gender identity be framed in the public health and other service delivery settings? Can specific terminology be agreed upon? How will issues related to data reliability and validity be addressed? When sexual orientation or gender identity are assessed, what precisely will be measured? How does asking questions affect response rates? Information about each of these issues currently is limited at best.

- *Ethical issues related to data collection.* This issue relates to both the general population (e.g., protection of confidentiality in national data collection projects) and sensitivity on the part of subpopulations within the LGBT community. For example, closeted lesbians

and gay men will be reluctant to declare their sexual orientation if they are not assured of anonymity. How will national surveys capture accurate data from individuals living in a heterosexual marriage or relationship, given that these individuals may be reluctant to divulge same-sex sexual behavior? How will the findings be reported without compromising confidentiality?

- *Consistency and accuracy in terminology*. Ensuring accurate and culturally neutral terminology that is used across national and other data sets will be critical, as it is for all data and information systems on which the public health infrastructure depends. In the case of the LGBT populations, policymakers and researchers must address cultural differences within different constructs of sexuality and gender. The terms "gay," "lesbian," "homosexual," "bisexual," and "transgender" are relatively new and often are considered to be referring to people among the "mainstream" or "Northern European American" populations. Communities of color, rural communities, and immigrant populations may not understand the terms, or may not associate their sexual behavior, sexual orientation, or gender variance with the terms. The full understanding of these definitions culturally or the impact of that understanding on attempts to measure sexual orientation or gender identity is unknown.

In spite of these challenges, there is an urgent need to collect, analyze, and disseminate data on LGBT communities—even as the methodological questions concerning the best way to do so are being discussed. It is common practice for the U.S. census to change how questions about race, ethnicity, or occupation are asked from one census to the next—apparently without a broad understanding of or consensus on the best way for such questions to be asked. Like race, ethnicity, or occupation, survey questions about self-identification of sexual orientation and gender identity may evolve over time as communities change the way they define and identify themselves or as research identifies more reliable and valid ways to obtain desired information.

The collection and dissemination of data are essential building blocks in the effort to address health disparities among LGBT communities. Many chapters in this companion document present known data regarding health disparities—and address specific needs for data and information related to the health issues addressed in those chapters. This section addresses the overall need for improved data and information systems related to LGBT people and issues related to the following six objectives:

23-2: (Developmental) Increase the proportion of Federal, tribal, State, and local health agencies that have made information available to the public in the past year on the Leading Health Indicators, Health Status Indicators, and Priority Data Needs.

23-3: Increase the proportion of all major national, State, and local health data systems that use geocoding to promote nationwide use of geographic information systems at all levels.

23-4: Increase the proportion of population-based Healthy People 2010 objectives for which national data are available for all population groups identified for the objective.

23-5: (Developmental) Increase the proportion of Leading Health Indicators, Health Status Indicators, and Priority Data Needs for which data—especially for select populations—are available at the tribal, State, and local levels.

23-6: Increase the proportion of Healthy People 2010 objectives that are tracked regularly at the national level.

23-7: Increase the proportion of Healthy People 2010 objectives for which national data are released within 1 year of the end of data collection.

Including sexual orientation and gender identity measures in population-based studies is essential to accurately identify health disparities in LGBT communities as well as the nature and extent of those disparities. Such studies should include Federal population and health-related data collection surveys; State, tribal, and local government data collection activities; studies and research undertaken by private foundations (e.g., Robert Wood Johnson Foundation, Kaiser Family Foundation); and publicly funded research studies (e.g., those performed by the National Academy of Sciences).

The issues concerning data systems are primarily issues of data collection and the escalating cost of collecting data, particularly for smaller populations. Objective 23-6 speaks to the need to maintain data collection efforts on an ongoing basis, and objectives 23-2 and 23-7 speak to the importance of disseminating research findings. However, it is the lack of data on the health status of LGBT communities that is the focus of this discussion. The lack of needed data is not surprising, given the overall lack of population-based surveys of sexual behavior[25] and the lack of resources for research on lesbian and gay health.[26]

Emerging communities. In the past three decades, LGBT communities have become less of a "hidden" population. The ability of these communities, or of public health planners, to evaluate or know the health status of LGBT communities is hindered by a lack of questions about sexual orientation or gender identity in health-related surveys. At the same time, there is growing evidence that it is not difficult or problematic to ask these questions in surveys that ask respondents to self-identify gender, race, ethnicity, age, or other personal characteristics.

For example, in 1997, it was found that 488 of 520 (94 percent) of women responded to a question about sexual orientation in a random-digit-dial telephone survey.[27] Those who refused to answer the question about sexual orientation differed from those who did answer the question in that they were less willing to answer other personal questions, such as their race, age, and income. In general, willingness to disclose was greater among younger, highly educated, and higher income women.

In Massachusetts, questions have been added to the Federal Youth Risk Behavior Study, which asks students in grades 9 through 12 to answer questions about sexual identity and same-sex sexual behavior. Data from this random sample of school-based youth have provided valuable information about disparities in risk behavior and response rates. In the 1997 survey, 3,982 Massachusetts public high school students in grades 9 through 12 were surveyed on a total of 94 items. The sexual identity question was included in the upfront demographics section, which may account, in part, for the low non-response rate. Sexual behavior items were grouped later in the survey. Of the 3,982 respondents, only 36 individuals (0.9 percent) did not respond to the sexual identity item. Only 13 other items had a better response rate, putting this item in the top 20 percent of all items on the survey in this regard.[28] The non-response rate for "sex of sexual partner(s)" was 1.6 percent.

In comparison, other items and their non-response rates included "ever had intercourse," 8.0 percent; "ever drank alcohol," 6.9 percent; "trying to lose weight," 1.8 percent; and "rode a bicycle in the past year," 3.1 percent. Questions about sexual identity and same-sex sexual behavior have been asked biannually from 1993 through 1999. These comparisons regarding response rates generally hold true for the 1993, 1995, 1997, and 1999 surveys.

With the HIV/AIDS epidemic, the Federal Government, for the first time, realized that a lack of information on the gay and bisexual male community made it difficult to understand the path and extent of the epidemic. Information about male-to-male sexual activity was included in AIDS surveillance forms completed across the country. However, even this information did not fully provide information about the impact of HIV/AIDS on the LGBT communities, as lesbians and transgender persons were still excluded from the surveys. The Centers for Disease Control and Prevention has recognized that information about same-sex sexual behavior is an important part of data collection in following certain diseases. For example, new surveillance forms drafted by CDC for hepatitis C include questions about sexual activity with both male and female partners that will be asked of all respondents, regardless of gender.

Geographic-based data. There is a need to understand more about the relationship between sexual orientation, gender identity, and the geographical distributions of populations. Currently, there are very limited data that are population-based or based on a large enough sample to convincingly demonstrate whether LGBT communities are geographically homogenous or, as often suspected, concentrated in urban areas. Some urban centers have been considered to be "gay ghettos," but sufficient information has not been collected through research or population-based studies to confirm those patterns or to allow comparisons between and among lesbians, gay men, bisexuals, and transgender persons.

Because neither sexual orientation nor gender identity have been included in the largest Federal databases, such as the census, there is not information that could be used for geocoding (coding by ZIP Code) and mapping information about health status indicators based on the geographical distribution of populations identified by selected characteristics. Some Federal databases include measures of sexual orientation (see below), but HIV/AIDS

is the only area in which information about sexual orientation has been collected sufficiently to analyze some data geographically.

AIDS incidence trends vary greatly among geographic areas in the United States. Areas in which AIDS incidence trends are similar are defined as clusters. Areas within a cluster may have similar HIV epidemic patterns and thus may lead to similar prevention and intervention strategies.[29] Geographic and racial/ethnic variations in the AIDS incidence among homosexual and bisexual men in the United States not using injection drugs has been measured over time. Incidence increased much less rapidly after 1986 in the three metropolitan statistical areas (MSAs) with the most AIDS cases—New York City, Los Angeles, and San Francisco—and may have reached a plateau in these areas. This change in incidence occurred in non-Hispanic Black and Hispanic gay and bisexual men, as well as in non-Hispanic Whites in these MSAs, but earlier in Whites. There have been similar changes in incidence (but later in time) in all other MSAs with a population of at least 1 million combined, with more of a tendency toward a plateau in Whites than in non-Whites. In contrast, incidence increased linearly through 1989 in MSAs with a population of fewer than 1 million and in rural areas, with no change in trend after 1986.[30]

However, rates of HIV/AIDS incidence among gay and bisexual men may reflect differences in risk behavior as much as the actual location of gay men. It could be misleading to assume that incidence or prevalence rates of HIV/AIDS among gay or bisexual men are identical in urban, suburban, and rural areas. However, work within the LGBT communities in urban, small town, and rural areas may provide some health-related information about the presence or absence of LGBT persons in various geographic locations.

In urban areas, one of the few population-based studies of gay and bisexual men, the Urban Men's Study, used random-digit dialing within selected zip code areas in Chicago, Los Angeles, New York, and San Francisco. The study provides information on the percent of households in which the person answering the telephone identified as either a gay or bisexual male. ZIP Codes were selected based on information indicating that many gay or bisexual men lived in this area. Given limited resources, it was cost-effective to derive a population-based sample by specifically targeting certain neighborhoods perceived as having a higher density of gay or bisexual men.[31, 32]

Studies of transgender populations, although not population-based, have focused exclusively on urban areas. Studies in San Francisco[33] and Washington, D.C.,[34] used convenience sampling to identify significant numbers of transgender individuals (515 in San Francisco and 252 in Washington D.C.). The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, (1987) estimates the prevalence of transsexual persons to be 1 in 30,000 for male-to-female transsexuals and 1 in 100,000 for female-to-male transsexuals. As with cities with fewer than 1 million people, either there is substantial, disproportionate representation of transgender individuals in urban centers, or estimates on the prevalence of the transgender population need to be revisited.

Not all studies of LGBT communities have occurred in major metropolitan areas. The Trilogy Project is a longitudinal study of lesbian and gay people living in and around two smaller metropolitan areas in a southern State. The study was specifically designed to provide epidemiological data on the lifetime, past-year, and past-month prevalence rates for the use of six illicit, four psychotherapeutic, and two licit drugs, as well as comparative data to the National Household Survey on Drug Abuse (NHSDA).[35]

Although not population-based, exit polling data collected by the Voter News Service between 1990 and 1998 asked whether voters identified with any of several minority groups, including "gay, lesbian, or bisexual." (Bisexual was added in 1992.) In 1996, 5 percent of polled voters identified as gay, lesbian, or bisexual. When examined by type of location, data averaged for 1996 and 1998 found approximately 8 percent of voters in large and medium-sized cities, 4 percent of voters in suburban or small towns, and 2 percent of rural voters identified as gay, lesbian, or bisexual.[36] The question remains whether these differences are due to residential preferences, differences in voting patterns, or differences in willingness to disclose this information. Yet another study estimated gay and bisexual men to constitute 9.2 percent of the population in the centers of the 12 largest SMAs; 3.4 percent of their suburbs; 4.2 percent of the centers of the 13th to 100th largest SMAs; 1.3 percent of their suburbs; 1.9 percent of smaller cities and towns; and 1.2 percent of rural areas.[37]

To some extent, the door has been opened for Federal data systems to monitor health disparities based on sexual orientation. A review of the Healthy People 2010 objectives identified 18 objectives that could be tracked using four data systems: the National Health and Nutrition Examination Survey, the National Survey of Family Growth, NHSDA, and the Youth Risk Behavior Survey. An additional 21 objectives could be tracked if sexual orientation were added to the National Health Information Survey, the National Vital Statistics System, the STD Case Surveillance System, the National Notifiable Disease Surveillance System, the National Crime Victimization Survey, the HIV/AIDS Case Surveillance System, and the Behavioral Risk Factor Surveillance System.[38]

Attachment 1 reproduces and adds to Table 2 from that report indicating the readiness of these systems to address questions of sexual orientation. Gender identity questions are not currently addressed through these systems, but a column has been added to the table to promote discussion of this issue.

A model program for collection of a population-based sample of women is the 1997 Los Angeles County Health Survey. Participants reported their sexual orientation; the respondents included 4,697 women of which 4,610 were heterosexual, 51 were lesbians, and 36 were bisexual. With this sample, analysts adjusted relative risks to assess the effect of sexual orientation on important health issues.[39]

Defining LGBT communities. A substantial amount of work by LGBT community researchers has focused on clarifying definitional issues. Specifically, research has attempted to define what constitutes a same-sex or homosexual orientation. Although a variety of hypotheses have been proposed and studied, a general consensus has emerged

that same-sex sexuality may be measured in terms of three concepts: identity, behavior, and attraction/desire.[40, 41]

Researchers have expressed the challenge of definition as follows:

> "How to define and identify sexual orientations for the purpose of constructing representative samples of homosexuals, bisexuals, and heterosexuals is unclear and confusing to researchers. Different definitions and measures have been proposed and used to develop samples since the 1860s when sexual orientations first gained widespread research interest. Unfortunately, the definitions and measurement tools used since then result in the selection of divergent and incomparable samples. If advances in the understanding of sexual orientations are to be made, it is critical that definitions and measures of sexual orientation be standardized." [42]

Thus, it is important that standardization take place—particularly at the national level—to create comparable survey questions on sexual orientation and gender identity. However, it is equally important that research move forward at all levels and not wait for universal consensus, which most agree is unlikely to be achieved.

Some of the more recent discussions on issues of identity for bisexual men have occurred in the context of HIV/AIDS. One researcher addresses the issue of bisexual identity versus bisexual behavior among men. Cultural differences around gender roles and norms in the African American and Hispanic communities may influence identity versus behaviors.[43] Indeed, cultural differences in the definition of homosexuality, bisexuality, and transgender identity are likely to have an effect on the response rate and validity of questions in these areas.[44, 45]

Questions about behavior are more frequently being included in surveys specifically looking at risk behavior around HIV/AIDS and other sexually transmitted diseases (STDs). The 2000 Massachusetts Adult Behavioral Risk Factor Surveillance System asks about same-sex activity as it attempts to measure condom use in a population-based survey of the State. Attachment 2 highlights the specific way in which respondents are asked to identify the gender of their most recent sexual partner.

Researchers have conducted meta-analyses of research methods. One paper looked at the representativeness of samples of homosexuals, bisexuals, gays, and lesbians obtained for public health research. It identified journal articles cited in Medline, that were published between 1990 and 1992, that sampled individuals and classified them as homosexual, bisexual, gay, or lesbian. Information was abstracted from these articles to evaluate four components of sample selection affecting the representativeness of samples: (1) how the population is conceptually defined, (2) how the sampled population is operationally identified, (3) the setting from which samples are selected, and (4) the use of probability sampling to select subjects. [46]

Race and ethnicity will affect the ability of surveys to reflect the LGBT communities accurately. In one case, members of a minority community disproportionately and

inaccurately selected "lesbian" when given the choice of "heterosexual," "homosexual," "bisexual," and "lesbian" because it was the only choice without "sex" in it and, therefore, was assumed to be the least threatening. Many gay or bisexual Hispanic males who only engage in insertive homosexual sex do not consider themselves homosexual or bisexual; only the recipient is perceived to be homosexual. Similarly, lesbians from ethnic minority groups may not identify in the same way as lesbians generally.[47] Some of this may be related to immigration and the degree of acculturation.[48]

With respect to the transgender community, a Native American researcher describes use of the term "two-spirit" by Native populations, which refers to a person who may exhibit some characteristics of a trangender or gay person but does not overlap precisely with either identity.[49]

Recommendations

- Establish guidelines within the Federal Government that recommend the collection of sexual orientation and gender identity data in all Federal, State, tribal, and local surveys that routinely collect population-based information regarding health, violence, or social issues.
- Support should be fostered for research to study how different ways of asking questions about sexual orientation, same-sex sexual behavior, attraction, and gender identity affect response rates and the validity of responses. Questions about methodology will continue to be discussed and should not be seen as a barrier to the immediate collection of data on sexual orientation and gender identity in population-based surveys.
- Methodological studies should ensure that racial, ethnic, and geographic differences in terminology and the definitions of sexual orientation and gender identity are accounted for when measuring health status indicators in LGBT communities.
- Demographic questions about sexual orientation and gender identity should be framed in national studies and surveys so as to provide widespread geographic and population-based information about prevalence of LGBT communities and their health status. Findings should be widely disseminated through all appropriate distribution methods, including through State, tribal, and local public health agencies.

23-17: (Developmental) Increase the proportion of Federal, tribal, State, and local public health agencies that conduct or collaborate on population-based prevention research.

The purpose of this objective is to increase collaboration between Federal, tribal, State, and local public health agencies and the communities they serve. LGBT communities are stakeholders in the health of the community, and representatives should be included in all broad public health planning. Ways to increase inclusiveness include supporting LGBT research projects and ensuring that LGBT communities are active and visible participants in research studies. LGBT experts also should be involved in study sections, grant review

committees, advisory boards, and other groups that help determine public health data collection priorities, research, needs assessment, and information dissemination.

To date, this high level of involvement has occurred only in a handful of cases. In 2000, the Office of the U.S. Surgeon General in the U.S. Department of Health and Human Services (DHHS) convened a cross-agency Steering Committee on Health Disparities Related to Sexual Orientation. Within DHHS, the Substance Abuse and Mental Health Services Administration (SAMHSA) has created an advisory board on LGBT issues. The Health Resources and Services Administration (HRSA) routinely includes representatives from the LGBT community in planning to increase access to health care and related services for LGBT and other unserved or vulnerable populations served by its grantees. (More information is available at www.hrsa.gov and in HRSA's strategic plan, Eliminating Health Disparities in the United States, released in December 2000 and available online at www.hrsa.gov/OMH/OMH/OMH.HTM). A handful of local health departments also have created an office or appointed an individual to coordinate gay and lesbian health issues.

LGBT communities need ongoing Federal, State, and local support in organizing and mobilizing their resources to address health issues of mutual concern, including setting research agendas, identifying high-priority local health concerns, and advocating for additional health services resources. In October 2000, the National Coalition for LGBT Health was formed to serve this function at the national level. However, organizations at the State and local level need to partner both with each other and with organizations at the national level to support ongoing health improvement efforts.

Recommendations

- Federal, tribal, State, and local public health agencies must involve representatives from LGBT communities at all levels of decisionmaking, including soliciting input and participation of LGBT academics and other expertise in study sections, grant review committees, and advisory boards. The curriculum vitae of LGBT persons with specific areas of expertise should be provided to the organizations reviewing grant proposals and involved in other health planning and research activities.
- LGBT researchers should be encouraged to participate in extramural research programs.

Core Workforce and Organizational Competency

To reduce and eliminate health disparities experienced by LGBT persons in the United States, public health agencies need the capacity to provide culturally competent and nondiscriminatory public health services to these populations. "Homophobia in Health Care is Unhealthy" is the central message of a campaign supported by the Gay, Lesbian, Bisexual, and Transgender Health Access Project of JRI [Justice Research Institute] Health and the Massachusetts Department of Public Health. Homophobia and heterosexism—both of which continue to exist among many individuals and institutions within the health care system—must be addressed to ensure that LGBT people have an equal opportunity to

achieve optimal health status.[50, 51, 52, 53] Therefore, both individual and organizational cultural competency is required at all levels of the public health system to provide appropriate services to LGBT people. Cultural competency training, which includes competencies for health providers serving LGBT communities, should be provided in the health professions schools, as a component of continuing education and graduate medical education, and in advanced training courses and workshops. Resources for cultural competency materials, training modules, and best practices for addressing the health care needs of LGBT populations should be made available online as well as in printed materials that are widely disseminated through the national health professions organizations.

The next section of this chapter focuses on three Healthy People 2010 objectives that address issues related to core workforce and organizational competency:

23-8: (Developmental) Increase the proportion of Federal, tribal, State, and local agencies that incorporate specific competencies in the essential public health services into personnel systems.

23-11: (Developmental) Increase the proportion of State and local public health agencies that meet national performance standards for essential public health services.

23-12: Increase the proportion of tribes, States, and the District of Columbia that have a health improvement plan and increase the proportion of local jurisdictions that have a health improvement plan linked with their State plan.

All three of these objectives relate to the elements of true LGBT competency, which encompasses both personnel and organizational cultural competency. "Public health agency LGBT competency" means that an organization is a nondiscriminatory workplace that includes LGBT health needs in its program-specific and agency-level planning. "LGBT-competent personnel" includes direct service providers, policy and program developers, and researchers, whose ranks should include LGBT people as well as people sensitive to and skilled in understanding the needs, demographic characteristics, and behaviors of these populations. "LGBT-competent human resource policies," such as domestic partner benefits, domestic partner and transgender options on forms, sensitivity to the needs of different kinds of families, and nondiscrimination policies help to foster a nondiscriminatory workplace. An "LGBT-competent public health plan" should assess need, ensure access, promote policies designed to address disparities, and incorporate LGBT health into existing programs and services.

LGBT competency in data collection, service delivery, research, needs assessment, and program planning. Data collection can and should be a process that emphasizes sensitivity to LGBT health concerns. To collect and analyze meaningful data on this population, researchers and analysts need an understanding of the methodology of researching LGBT health and the need to ask specific questions regarding sexual orientation, behavior, and gender identity. Researchers also should recognize the importance of asking questions in a sensitive and skillful way that will elicit the most accurate response.

Research has shown that when studies are crafted and administered appropriately, people will disclose their sexual orientation. Inappropriately crafted and administered studies miss this information and provide invalid data. In addition, researchers need skills and understanding about racial and ethnic differences to gain a better understanding of LGBT subpopulations. Because diverse racial and cultural groups define sexuality and gender in different ways (and some of the definitions concerning sexuality and gender identity are themselves evolving and different across locales), questions about same-sex behavior and sexual orientation should be culturally specific to obtain complete and accurate information.[54, 55]

A positive example of LGBT-competent program planning is evident in the Seattle-King County Department of Public Health's "Hep Squad," which targets bus signs and outreach materials to diverse gay and bisexual men. It also offers provider training and free vaccinations for uninsured or low-income gay and bisexual men.

Positions for health care workers who will be providing direct services or working at the point of service (e.g., health centers, mental health centers, clinics) should have specific competencies incorporated into their job descriptions, especially in service areas in high demand by LGBT people. Experience with HIV counseling and testing has demonstrated that expertise in research, and understanding LGBT communities is needed to provide adequate services. Understanding and skill are needed for providers and public health workers to create a safe space for disclosure of sexual orientation and gender identity and to communicate effectively with LGBT clients. In another example, a health care worker unaware that domestic violence occurs nearly as frequently among LGBT communities as in the general population is unlikely to ask important questions, provide outreach, or recommend appropriate referrals to LGBT clients. Nursing home staff that either refuse or fail to recognize clients' same-sex relationships cause great suffering by limiting their clients' access to their life partners, thus eliminating an important source of support.

The issue of disclosure is a critical one for providers to understand, and LGBT people are not likely to reveal their sexual orientation or gender identity to, or even seek services from, providers who are not LGBT-friendly or do not demonstrate an adequate understanding of LGBT issues. Specific skills and strategies are required to make LGBT clients comfortable enough to "come out." Such strategies may include displaying welcoming materials, making LGBT-affirmative statements, and asking appropriate interview questions. One small study found that disclosure of sexual orientation is correlated with more frequent use of health care services.[56] However, according to a 1995 study, 60 percent of young LGBT people do not disclose their sexual orientation to providers, and more than half of these young respondents explained that the reason they do not "come out" to providers is fear or embarrassment.[57] Similarly, studies of gay, lesbian, and bisexual adults show that a significant percentage—and in some cases, a majority—does not disclose sexual orientation to providers.[58, 59, 60] Transgender persons in particular face ignorance, hostility, and discrimination from providers unskilled in serving this population.[61] Such experiences,

coupled with a fear of provider hostility, lead to a low use of health services for transgender individuals.[62]

Planners and program developers need a comprehensive understanding of LGBT health issues to ensure that agencies carry out their missions effectively and do not unwittingly contribute to health outcome disparities. For example, in the face of widespread misunderstanding and ignorance regarding transgender individuals, residential detoxification programs that segregate clients by gender usually assign transgender people by their biological birth gender, not their gender identity. As a result, many transgender people do not seek services, while others quit detoxification programs.

An example of the successful inclusion of LGBT health needs in health improvement planning is the health and social service needs assessment conducted by John Snow, Inc., on behalf of the Board of Supervisors in California's Santa Clara County. The recommendations from the needs assessment were presented to the Board of Supervisors, and a plan for their implementation has begun. Several city health departments—such as the District of Columbia, New York City, and San Francisco—have undertaken similar needs assessments of the transgender community to ensure that the unique needs of transgender people in those localities are addressed and to generate much-needed data on the health needs of transgender individuals.

Healthy People 2010 recognizes the importance of conducting State and local needs assessments and developing health improvement plans that are responsive to those needs. It is critical that the health priorities of LGBT populations are reflected in needs assessments and that those needs are reflected in State and local health planning. The participation of the LGBT community in such needs assessment and research planning will help ensure that the needs assessment and research agenda are appropriate to all members of the community.

Public health planning and organizational competency. An informal survey of major urban health departments across the Nation revealed that fewer than 10 had or were in the process of creating a plan, position, programs, or services to address LGBT health concerns other than HIV/AIDS. Several cities, such as Chicago and New York City, have offices of lesbian and gay health charged with ensuring that their city health departments address lesbian and gay health issues. The Boston Public Health Commission, which serves as the city's board of health, has created a new position of LGBT health coordinator to implement a series of commission-wide policy recommendations approved by the board. (The commission's recommendations can be found in Attachment 3). Similarly, the public health departments of San Francisco and Seattle-King County integrate LGBT health concerns into the programming and services throughout the departments.

When agencies make plans to address LGBT health, such as designating a liaison or creating an office to coordinate LGBT health efforts, it is important that competency training be provided to all relevant staff within the agency so that the burden of organizational competency does not fall upon the liaison or the designated office.

The Massachusetts Department of Public Health funds the Gay, Lesbian, Bisexual, and Transgender (GLBT) Health Access Project, which operates out of JRI Health in Boston. Working with community partners, such as John Snow, Inc., and Fenway Community Health Center, the project trains providers on LGBT health and cultural competency issues, disseminates reports and information on LGBT health, supports research, maintains a Web site at www.glbthealth.org, and sponsors an annual meeting focusing on LGBT health and best practices.

Federal agencies like HRSA have focused their efforts on capacity-building by establishing lesbian and gay health advisory committees that make recommendations regarding LGBT health, access, and research issues. Most recently, HRSA created a new position within the Office of the Administrator to serve as a liaison to the LGBT community and other DHHS agencies. Other agencies in DHHS also have designated an LGBT liaison to coordinate information within each agency.

Standards of practice. A 1997 report by the GLBT Health Access Project identified the need for community standards of care because of the proven lack of LGBT awareness and understanding on the part of providers as well as the poor communication, discrimination, and barriers to care often reported by LGBT individuals. Working from the premise that LGBT people seek health care and prevention services in every community throughout Massachusetts, the project worked with consumers and advocates to develop Community Standards of Practice for the Provision of Quality Health Care Service for Gay, Lesbian, Bisexual, and Transgendered Clients. The standards (see figure 5, page 45) address a wide range of concerns, including personnel, clients' rights, intake and assessment, service planning and delivery, confidentiality, community outreach, and health promotion.

The Harry Benjamin International Gender Dysphoria Association, an international body of professionals who care for transsexual patients, developed standards of care for providers working in this field. Only 9 out of 19 European and North American clinics responding to a recent survey reported that they completely follow these standards.[63] Although there is some disagreement about certain aspects of these standards, the fact that fewer than half of surveyed clinics reported following these standards points to possible gaps in care for transsexual patients.

It is also important to note that some practices commonly used in various health disciplines may be culturally incompetent—or even harmful—for LGBT individuals. For example, it has been argued that reparative therapy to alter a young person's sexual orientation and gender expression may constitute child abuse,[64] which raises serious questions about the appropriateness of reparative therapy under standards of mental health care for LGBT people.

Promising approaches to LGBT-competent service delivery. The San Francisco Public Health Department developed a gay health specialist waiver process for positions determined as requiring this cultural competency. Similar waivers used by the department include an African American health specialist and various bilingual waiver requirements. The waiver program is administered by the department's Equal Employment/Affirmative

Action and Cultural Competency Office and must be approved by the lesbian/gay health services coordinator. The waiver requires 500 hours or more of service to lesbian and gay clients and an accredited course in human sexuality that focuses on lesbian and gay life. The department also offers periodic training to assist employees in meeting the waiver requirements. In addition, San Francisco requires all contractors that provide direct services to clients to "demonstrate their ability to provide culturally competent and nondiscriminatory services," including competency in serving the sexual population to be served under the contract. The department is currently incorporating new standards of care for services to LGBT clients into existing cultural competency and nondiscrimination contract requirements. (See Attachment 4.)

The Mary-Helen Mautner Project for Lesbians with Cancer, a nonprofit organization based in the District of Columbia, offers an array of services and programs aimed at both cancer prevention and the specific issues faced by lesbians with cancer. Services offered include education, smoking cessation, support groups, referrals to lesbian-competent caregivers, and assignment of volunteers to assist lesbians and their families. The Mautner Project strengthens provider and organizational competency and removes access barriers to care through a special project designed to enhance the skills of health care providers and to promote organizational change through training and technical assistance. The Mautner Project also participates in research on lesbians and cancer and advocates for legislation that affects women's health.

Recommendations

- DHHS should develop an office of LGBT health to provide overarching guidance and planning on LGBT health policy.
- DHHS should support further study of effective models of building institutional and specific personnel LGBT competency, including support for agencies working together across local and regional boundaries to develop effective models and to share knowledge and best practices. For example, the Massachusetts Department of Public Health supported the May 2000 Boston meeting of urban health officials addressing LGBT health.
- DHHS should encourage State, tribal, and local health agencies to implement standards of care for LGBT health consumers. The standards should be developed by a panel of experts that also includes appropriate stakeholders representing the diversity within LGBT populations.
- The Agency for Healthcare Research and Quality (AHRQ) should support research designed to improve the outcomes and quality of health care and broaden access to effective services for LGBT health care consumers.
- Public health agencies should develop appropriate policies, procedures, and requirements for contractors to ensure that services and products purchased are organized and delivered in a nondiscriminatory manner.

- Accrediting organizations such as the Joint Commission on Accreditation of Healthcare Organizations and the National Committee for Quality Assurance, along with such entities as Federal agencies involved in the delivery of publicly funded health care and related services (HRSA, SAMHSA, the Health Care Financing Administration, the Administration for Children and Families, and the U.S. Department of Housing and Urban Development), the American Public Health Association, and the National Association of County and City Health Officials should collaborate to develop cultural competency standards for organizational and personnel competencies that may be adopted by State, local, and tribal health agencies nationwide.
- The National Institute of Mental Health (part of the National Institutes of Health), the Center for Mental Health Services (part of SAMHSA), and AHRQ should fund research into standards and best practices of mental health care for LGBT people, including research on the impact of reparative therapy. SAMHSA with HRSA should review the need for developing a collaborative mental wellness initiative that includes all populations in disparity.
- Technical assistance in grant writing should be made available to all interested applicants. Such assistance could be made available through the Internet, the use of tutorials on CD-ROM, and other workshops organized at the regional level.
- All legally prohibited discrimination should include discrimination on the basis of sexual orientation or gender identity.
- State agencies charged with the regulation and oversight of nursing homes and long-term care facilities should develop and enforce compliance with standards of care for LGBT clients, including policies that recognize and affirm same-sex partners.
- Federal agencies providing publicly funded services to unserved populations and conducting data surveillance activities should communicate regularly with the field and

As part of a Macy Foundation initiative on physician communication, the University of Massachusetts Worcester Medical School is training physicians in how to communicate more effectively about sexuality and sexual orientation. The school is developing a curriculum to incorporate the teaching of appropriate care for LGBT people and their families into the education of physicians, pediatricians, psychiatrists, family practitioners, and obstetricians/gynecologists. The Massachusetts Medical Society—in conjunction with the Massachusetts Department of Public Health, the GLBT Health Access Project, Beth-Israel Deaconess Medical Center, and the Fenway Community Health Center—is engaged in an initiative to raise awareness of LGBT health issues among practicing clinicians in Massachusetts, including working with the deans of local schools of medicine and developing a curriculum for the State to use in ongoing provider training. In addition, Kaiser Permanente's National Diversity Council has recently published a handbook on culturally competent care for LGBT

regional offices regarding cultural competencies for all populations in disparity in access to needed services. For example, the agencies could disseminate an article on the importance and availability of LGBT competencies and guidelines, along with resources for additional information, technical assistance, and implementation strategies.

23-9: (Developmental) Increase the proportion of schools for public health workers that integrate into their curricula specific content to develop competency in the essential public health services.

Training and education for health workers of all kinds—including nurses, physicians, dentists, paramedics, emergency medical technicians, and other allied health workers—should incorporate cultural competency training as part of the curricula. Few health professions programs currently devote a significant amount of attention to cultural competency. The provision of culturally competent care can make the difference in whether people in need seek out services; whether individuals receive the appropriate screening, preventive, and primary care services; and for many, such as transgender individuals in particular, whether services are received at all.

In one study of gay and bisexual young men, their ability to "discuss same-sex feelings or experiences with a physician or counselor" was a significant predictor of whether they had undergone HIV testing.[65] A study of lesbians demonstrated that women who reported that their health care providers were more knowledgeable and sensitive to lesbian issues were significantly more likely to have had a Pap test in the last year.[66] Another study reported that transgender people avoid mental health care for depression because they expect that mental health providers will assume that gender identity is the primary cause of their depression.[67] For reasons such as these, the American Medical Association's Council on Scientific Affairs recommended that the "physician's nonjudgmental recognition of sexual orientation and behavior enhances his or her ability to render optimal patient care in health as well as illness."[68]

Without specific training, health providers of all disciplines often fail to provide needed services, whether deliberately because of discomfort with their patient's sexual orientation or unintentionally because of a lack of knowledge. One survey found that 40 percent of physicians "sometimes" or "often" are uncomfortable caring for lesbian and gay patients.[69] As a result of widespread provider ignorance and discrimination against transgender individuals,[70] many transgender men and women are medically and psychologically "chronically underserved."[71] In a Gay and Lesbian Medical Association study, 67 percent of the respondents reported witnessing gay and lesbian patients receiving substandard care because of their sexuality.[72] Mental health providers in a random-sample Virginia survey were aware that they served lesbians in their practices, but reported little or no training in what special needs lesbians might have.[73] LGBT individuals also report experiencing discrimination in paramedical and auxiliary care settings, such as nursing homes, domestic violence centers, and senior centers.[74]

Half of the respondents in one survey of medical school departments of family medicine said that they did not include LGBT health at all in their curricula. For those departments that covered the topic, they spent an average of only 2.5 hours of the entire 4-year education focused on lesbian, gay, and bisexual issues. Several studies show that when cultural sensitivity training is included in provider curricula, it can help reduce negative bias toward other groups, including lesbians.[75] Other research suggests that additional studies on effective models of incorporating LGBT competency into the medical curriculum are needed.[76]

Centers for research on sexuality, gender identity, and health have opened at several universities. They are working to address critical research needs and to offer opportunities for graduate students and faculty to increase their knowledge of LGBT health issues and develop LGBT-competent research skills. The Center for Lesbian, Gay, Bisexual, and Transgender Health and the Lesbian Health Research Institute at Columbia University's Joseph L. Mailman School of Public Health were created to "assure equal access to comprehensive, culturally competent, quality health care for all regardless of sexual orientation or gender identity/expression." In addition to supporting research and evaluation activities focusing on LGBT health, the center offers education and training opportunities and health care services. It also provides vital policy and advocacy work, including playing a critical role in the formation of the National Coalition for Lesbian, Gay, Bisexual, and Transgender Health.

Education and training about LGBT health and homophobia are needed in graduate programs in mental health.[77] Research on the services impact of LGBT competency in public health graduate education programs is needed.

Recommendations

- The Centers for Disease Control and Prevention should fund the Association of Schools of Public Health to develop model curricula for public health students. CDC also should fund demonstrations and evaluations of LGBT-competent curricula.
- Accreditation bodies such as the Liaison Committee on Medical Education, the National Library of Medicine, and the Council on Education of Public Health should issue recommendations that address LGBT competency. They also should conduct surveys of schools of public health, nursing, and medicine, as well as emergency medical technician training programs, to determine which include LGBT competency in their curricula and to highlight case studies for dissemination throughout the medical field.

23-10: (Developmental) Increase the proportion of Federal, tribal, State, and local public health agencies that provide continuing education to develop competency in essential public health services for their employees.

In a study of physicians participating in the Mary-Helen Mautner Project for Lesbians With Cancer to train providers serving lesbians with cancer, half of respondents assumed they served lesbians, but did not see a need to address this fact directly in their care. These same providers expressed an interest in learning more about the needs of lesbians and asserted that they would make changes if they knew what to do.[78]

The Gay and Lesbian Youth Support Project (GLYS), funded by the Massachusetts Department of Public Health, is a program based in Brockton, Massachusetts, to educate providers that serve GLBT youth. An evaluation of this program, conducted by JSI, Inc., revealed that individual respondents to pretests and posttests improved their scores significantly for knowledge, attitudes, and beliefs regarding LGBT people. To a lesser degree, posttests also revealed positive behavior change.[79] This evidence suggests that training providers can make a difference in provider attitudes and behaviors.

The Seattle-King County Department of Public Health developed a special campaign to promote Pap testing for lesbians called "Lesbian Health Matters." The initiative is based on data that show that human papillomavirus can be sexually transmitted between women. It also supports a major public information campaign and offers training for health care providers on how to serve lesbians effectively.

However, the one knowledge item on the evaluation that did not show significant improvement in its score was knowledge about transgender individuals. At least one study suggests that there may be additional barriers for individuals to learn about transgender issues than about lesbian, gay, and bisexual issues.[80] Because the need for competent transgender care is so acute, developing effective means of developing transgender competency and standards of care should be a top priority.

Assuring that the current public health workforce possesses the competencies necessary to provide appropriate services to all populations in need, including LGBT people, is part of having an effective national public health infrastructure. It is also a critical step toward meeting the Healthy People 2010 overarching goal of eliminating health disparities, also an overarching goal of the Health Resources and Services Administration. Continuing education is an important method of increasing competency in the public and private health care workforce. Evidence suggests that LGBT competency training can be effective in changing the knowledge and behavior of individual providers in different health settings.[81] Further research is needed to determine the effect of such training on institutional change.

Competency training should always incorporate an understanding of the diversity within LGBT communities. For example, provider training on health issues for lesbians and bisexual women may help caregivers create an environment in which clients feel safe to

disclose sexual orientation. Research suggests that African American lesbians are more likely to have more extensive heterosexual experience than White lesbians.[82] If cultural competency training does not help providers understand this difference, a gynecologist might not ask an African American lesbian about heterosexual intercourse, thus missing critical health information.

Recommendations

- DHHS should ensure that cultural sensitivity training is provided to all health care providers receiving Federal funds. Special attention should be given to identifying and evaluating studies that examine the effectiveness of training programs designed to promote transgender competencies, eliminate discrimination, and improve organizational competencies. Efforts to partner with the private sector and managed care plans should be an important part of this initiative.
- Existing cultural competency training modules should be reviewed by the Federal agencies, and a menu of appropriate technical assistance resources and training models should be made available to all publicly funded services programs, health departments, and health professionals to ensure that culturally competent care is provided for LGBT clients.
- Additional efforts are needed to increase the number of public health agencies that integrate LGBT-focused core competencies into orientation and inservice training.
- DHHS should provide incentives to increase the number of Federal, State, and local health departments that support community-based agencies providing LGBT competency training to the public health workforce.

The Massachusetts Department of Public Health funds several programs that provide ongoing training in reducing heterosexism and homophobia and appropriately serving LGBT clients. The GLBT Health Access Project of JRI Health worked with other agencies to develop and distribute standards of care for LGBT clients. (See Attachment 3.) Working with the Fenway Community Health Center, the Health Access Project also provides training for staff of the Massachusetts Department of Public Health as well as for health and human service agencies Statewide.

The Law and Public Health

The law and its ability to safeguard and improve the health of LGBT people is a fundamental aspect of the public health infrastructure. However, this area is seldom addressed in public health discussions. This is relevant when the health disparities experienced by LGBT people are the result of a lack of action or due to the attitudes and behaviors of people charged with serving high-risk populations in need of services through publicly funded programs. In most cases, discrimination or actions that negatively affect an individual's access to needed publicly funded services are prohibited by law. In most contexts, racial and ethnic populations, as well as people with disabilities, are protected by

law from discriminatory treatment, but people whose sexual orientation or gender identity is not heterosexual are not. This section of the Companion Document focuses on the one Healthy People 2010 objective that broadly addresses laws and regulations. The objective is viewed as a building block for achieving a public health infrastructure that serves all eligible recipients and works to achieve the Healthy People 2010 goal to eliminate disparities in access to care.

23-15: (Developmental) Increase the proportion of Federal, tribal, State, and local jurisdictions that review and evaluate the extent to which their statutes, ordinances, and bylaws assure the delivery of essential public health services.

For LGBT populations, the legislative mechanisms mentioned in the objective have less to do with statutes that govern the agency's actions and more to do with having the agencies look at any lack of antidiscrimination laws that negatively affects their ability to provide needed, appropriate services to eligible populations. Given that LGBT people are not, in most cases, among the populations defined in antidiscrimination laws, the effect of that omission on the health status of LGBT communities is an important concern that requires attention and further discussion. Public and private health agencies and organizations should assume a supportive role in calling for statutes and local regulations that will positively affect the health and social welfare of all persons receiving health care and related services. In short, public health agencies should work with the private sector to eliminate the adverse health effects of discrimination.

Many examples of a lack of legislation, statutes, or local ordinances that negatively affect the health and welfare of people exist. In 39 States it is still legal to fire a person because of his or her sexual orientation or gender identity.[83] Likewise, anti-LGBT discrimination in housing, public accommodations, or credit is still within the bounds of the law in 39 States. The absence of civil rights legislation means that LGBT people have no protection in more than three-quarters of the States. Sodomy laws are enforceable in 18 States.[84] In many instances, the Supreme Court's 1986 decision in *Bowers* v. *Hardwick*, which upheld the Georgia statute criminalizing sodomy, has been used to withhold civil rights from gay men and lesbians.[85] The lack of consistent legal recognition for same-sex partners results in reduced access to insurance and other health-related benefits as well as negative treatment in health care settings, such as when providers fail to treat same-sex relationships in the same manner as marriages or long-term heterosexual relationships.[86]

Discrimination against transgender people is widespread. Although "homosexuality" was removed from the catalog of mental disorders by the American Psychiatric Association in 1973, "Gender Identity Disorder" remains. Although the association's Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, asserts that transgender identity itself is not a disorder, the listing may be stigmatizing and has been used to justify discriminatory treatment.

Laws that do not prohibit stigmatizing people but allow discrimination against groups of people perpetuate a stressful and negative health care environment for LGBT persons. The experience of another form of discrimination, specifically racial discrimination, has been correlated with high blood pressure related to the stress response to discrimination. The same result would be expected to be true for other stigmatized groups experiencing discrimination, such as LGBT people. In addition, this research suggests that LGBT people who also are people of color face racism in addition to homophobia and are at greater risk for adverse health effects associated with discrimination.[87] In another study, African American lesbians and bisexual women reported higher levels of depressive distress than African American gay and bisexual men, except for those with HIV infection.[88] The authors of the study also inferred that carrying multiple lower social statuses increases the risk for depression caused by stress. Psychoneuroimmunologic research suggests that the psychological stress of not "coming out" suppresses the immune system and may lead to an increased risk for melanoma or other cancers among gay men and lesbians who do not disclose their sexual orientation.[89]

By sending the message that LGBT people are not treated as full and equal citizens, laws that do not prohibit discrimination also foster a climate in which homophobia and anti-LGBT hate can flourish—potentially leading to violent hate crimes. Lesbians and gay men are among the most frequent victims of hate crimes.[90] Transgender people, however, are particularly at risk for hate crime violence. The Washington Transgender Needs Assessment Survey showed that 13.5 percent of respondents had been victims of sexual assault.[91] In Seattle, 85 percent of high school respondents to the Youth Risk Behavior Survey reported that they had been a target of offensive comments or attacks because of their actual or perceived sexual orientation.[92]

Arguably, the most important piece of legislation—whether Federal, State, local, or tribal—is the funding received for programs. The funding received is based on a budget request, and not all budget requests are fully funded. The funding or financing received is allocated to programs or initiatives described in the budget proposal, and so the funding amount largely determines what programs or services are implemented or funded. Public health agencies can strengthen their capacity to deliver services or create initiatives to improve the health of LGBT people in their jurisdictions by becoming more actively involved in the process to develop the next budget proposal. In addition to funding legislation, supporting both antidiscriminatory and civil rights legislation can affect the ability of public health agencies to carry out the delivery of needed services to eligible population—an essential public health service.

Discrimination also creates barriers to gathering health data, as LGBT persons may fear adverse consequences if they answer questions honestly, a similar fear of immigrants in the United States who lack legal status. For example, the U.S. military's "Don't Ask, Don't Tell" policy institutionalizes nondisclosure of sexual orientation, which then can lead to inadequate health care and negative health outcomes for LGBT people. For these reasons, legislation that prohibits LGBT-affirming health education or restricts services to LGBT

people—such as the 1987 Helms Amendment, which barred funding any public health or educational materials that "promote or encourage, directly or indirectly, homosexual sexual activities"—should be opposed.[93]

The City and County of San Francisco adopted a law prohibiting discrimination based on gender identity. The San Francisco Human Rights Commission created Compliance Guidelines to Prohibit Gender Identity Discrimination.

Barriers to disclosure affect access to needed health and related services as well as the quality of care received. For example, LGBT parents may be afraid to disclose their sexual orientation or gender identity for fear of losing custody of their children. As a result, both parents and children may receive inadequate and inappropriate care. They also may endure added stress as a result of fear of the family unit being fragmented. This stress and family instability is not in the best interests of any family member. Laws barring LGBT people from serving as foster and adoptive parents mean that, in many cases, LGBT youth are placed in inappropriate foster care, possibly putting them at greater risk for adverse health conditions. State laws and court rulings allowing LGBT people to become adoptive or foster parents have a protective function for LGBT families and also for foster and adoptive LGBT youth who need appropriate parenting. In addition, laws and insurance regulations that require parental consent or notification for minors to access care have a chilling effect on LGBT youth seeking LGBT-focused services. Such regulations effectively limit access to needed and culturally appropriate care for LGBT youth.

Recommendations

- DHHS with other Federal departments and agencies (e.g., U.S. Department of Education, U.S. Department of Housing and Urban Development, U.S. Department of Labor) should collaborate to determine how best to eliminate the effects of discrimination based on sexual orientation and gender identity.
- DHHS should direct its operating divisions and staff offices to review their policies, procedures, and practices to ensure that publicly funded services are being provided in a nondiscriminatory and culturally competent manner.
- Public health agencies at the State and local levels should review policies, procedures, and practices to ensure that publicly funded services for which they are accountable are being provided in a nondiscriminatory and culturally competent manner.
- The DHHS Office of Civil Rights should increase its efforts to enforce nondiscrimination protections, including meeting the requirements of the Americans with Disabilities Act.
- DHHS should review existing research and support new studies on the effect of legislation failing to prohibit discrimination on public health outcomes.

- Federal, State, tribal, and local health departments should adopt domestic partner benefits policies for employees and promote such policies on a wider basis as an access-to-care issue.
- Health agencies should incorporate guidelines to ensure equal consideration of same-sex partners of clients receiving treatment in all health care settings as part of their standards of care for LGBT people.

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Attachment 1

Readiness of Federal Data Systems to Monitor Disparities of Persons Defined by Sexual Orientation

	Total Number of Objectives Tracked	Number of Objectives Identified in Table 1	Sexual Orientation 1= included 2= planned 3= included in past	Gender Identity	Data System Needs Immediate Attention
1. NHIS	73	8			X
2. NHANES	43	6	1		X
3. NVSS-M/N	39	4			X
4. SHPPS	16				
5. NSFG	16	5	2		X
6. NVSS-N (combined with 3)	15				
7. NHDS	13				
8. NHSDA	12	2	3		
9. NPLHD	12				
10. BRFSS	11	1			
11. HIV/AIDS Case Surveillance System	10	1			
12. YRBSS	10	5	1, 2, 3		
13. NAMCS	9				
14. NHAMCS	9				
15. CSFII	6				
16. NCVS	6	2			X
17. NNDSS	6	2			X
18. USRDS	5				
19. MEPS	5				
20. MTF	5				
21. NWHPS	5				
22. STD-CRSS	5	3			X

Attachment 2

The following questions were included in the 2000 Massachusetts Behavioral Risk Factor Surveillance Survey:

SEXUAL BEHAVIOR SERIES (to be asked of all 18-64 year olds)

The next questions are about your sexual behavior. By sex we mean oral, vaginal, or anal sex, but NOT masturbation. When we talk about condoms, we mean both male as well as female condoms.

1. During the past 12 months, have you had sex?

Yes	[1]
No	[2]SKIP to END
Refused	[9]SKIP to END

2. During the past 12 months, with how many people have you had sex?

Number	[...]
Don't know / Not sure	[enter 777]
Refused	[enter 999]

3. During the past 12 months, have you had sex with only males, only females, or with both males and females?

Only males	[1]
Only females	[2]
Both males and females	[3]
Refused	[9] SKIP to END

4. Now, thinking back about the last time you had sex, did you or your partner use a condom?

Yes	[1] SKIP to END
No	[2] SKIP to 5
Refused	[9] SKIP to END

5. The last time you had sex, was your partner male or female?

Male	[1] If male respondent SKIP to 6, if female respondent SKIP to 7
Female	[2] If female respondent SKIP to END, if male respondent SKIP to 7
Refused	[9] SKIP to END

Attachment 3

RECOMMENDATIONS APPROVED BY THE BOARD OF THE BOSTON PUBLIC HEALTH COMMISSION

Health of Gay, Lesbian, Bisexual and Transgender (GLBT) Residents
Presented by the Public Health Advisory Committee as part of its ongoing efforts to improve service to underserved populations.

1. **Increase the health data collection and analysis of GLBT residents** - In reviewing the available reports and hearing from the community, we observed that there is relatively little information collected on the health of GLBT residents. GLBT status is rarely collected and when it exists it is often not included in reports (with AIDS as the notable exception). The Commission should review existing studies and literature on GLBT health, explore ways to collect health data information on GLBT residents, include such information in regular, standard reports and publish a GLBT special report once sufficient information is collected.

2. **Investigate possible organizational responses to GLBT health and begin an alliance with other large city health departments that are also addressing this issue** - The Commission should convene a national meeting with other large urban health departments regarding the approaches they have taken to address GLBT health. The experiences of these other departments should be summarized and shared with the Advisory Committee and the Commission Board, for possible replication in Boston.

3. **Designate a person/s to represent the Commission internally and externally** - The Commission should have at least one staff person whose job includes overseeing the degree to which GLBT issues are adequately addressed throughout the organization. This person will oversee the implementation of these recommendations. In addition, a person should be assigned to pay particular ongoing attention/serve as a liaison with the GLBT community.

4. **Conduct an internal assessment and create a strategic plan for how the Commission can better serve GLBT people in its own programs and services.** Write a policy statement articulating the Commission's commitment to the health needs of diverse GLBT residents. Among other efforts, the Commission can support internal training to ensure that all program staff is aware of and sensitive to the needs of GLBT clients.

5. **Include awareness of GLBT health issues in promotion of cultural competency.** Support outreach to and external training of providers in hospitals, community health centers, mental health, and other settings.

6. **Speak out on GLBT health issues on an ongoing basis** - The Commission should become more vocal in addressing health issues as they affect the GLBT communities, in partnership with the Mayor's Office, and the Mayor's advocacy. This would include condemning GLBT violence, advocating for appropriate care in medical settings, and supporting specific services where the community is underserved.

7. **Highlight and promote the importance of Mayor Menino's domestic partner health insurance benefits policy** as it affects the health of LGBT Bostonians and their families.

8. **Seek funding for GLBT prevention and services activities** - The Commission should make an effort to seek funding to support prevention and services activities from a variety of sources, both public and private. Whenever possible, these should be sought in collaboration with community partners.

Attachment 4

City and County of San Francisco **Department of Public Health**

CRITERIA FOR GAY HEALTH SPECIALIST WAIVER

1. Candidate must submit verification that she/he has at least 500 hours of service to lesbian/gay people supervised by a Gay Health Specialist or equivalent. These hours may be earned as a volunteer, as an intern, or on a job site. The hours must have been accrued within the past ten years.

2. Candidate must take an accredited course in Human Sexuality that includes a focus on lesbian/gay/bisexual lifestyles prior to employment or within six months of hire date.

3. Candidate must demonstrate to the satisfaction of the Coordinator of Lesbian/Gay Health Services and/or members of the Lesbian/Gay Health Services Coordinating Committee familiarity with the lesbian/gay community and its health services. This includes political, social, religious organizations and community resources as well as other lesbian/gay identified and sensitive staff to be sued for referral. This criteria may be satisfied through an oral examination.

N.B. Certification of a Gay Health Specialist Waiver is made on the basis of the criteria stated above, regardless of the sexual orientation of the candidate.

Attachment 4

City and County of San Francisco **Department of Public Health**

DEPARTMENT OF PUBLIC HEALTH

REQUEST FOR GAY HEALTH SPECIALIST (GHS) WAIVER

Pursuant to Civil Service Commission Rule Section 11.05(B) page 31

TO BE COMPLETED BY CANDIDATE AND UNIT SUPERVISOR.

RETURN TO: Personnel Office, 101 Grove Street, Room 210 with copies to: Office of Lesbian/Gay Health Services, 101 Grove Street, Room 214

SECTION A

Title_____ Division_____

Unit_____

_____ _____

Address/Site Telephone Number

Classification # _____ Requisition # _____

_____

Vice: _____

SECTION B

Justification for Gay Health Specialist Waiver

Is this a new position? YES_____ NO_____

Estimate how often specialist designation is to be used.

_____ _____

Weekly No. of Hours Percentage of Total Hours

Estimate number of persons who currently visit this location and require the services of a Gay Health Specialist.

_____

Weekly

Indicate the number of Gay Health Specialist Waivered position currently in unit_____

_____ _____

Date Signature of Unit Supervisor

_____

_____ Approved by: _____

Date Personnel Officer

_____

LGHS Coordinator

Attachment 4

City and County of San Francisco **Department of Public Health**

REQUEST FOR CERTIFICATION OF GAY HEALTH SPECIALIST CANDIDATE
(Pursuant to Civil Service Commission Rule Section 11.05 (b) page 31)

TO BE COMPLETED BY CANDIDATE AND UNIT SUPERVISOR. RETURN TO: Personnel Office, 101 Grove Street, Room 210 with copies to: Office of Lesbian/Gay Health Services, 101 Grove Street, Room 204.

SECTION A: (Please fill in the following information about the candidate)

Name_____ Division_____

Class_____ Unit_____

Location/Address:_____

Telephone:_____

_____ _____
Signature of Supervisor Signature of Candidate

SECTION B: (Evidence of the following criteria for certification must be attached)

1. Written verification of 500 hours or more of service hours provided by candidate to lesbian/gay client.

2. Verification that candidate has taken an accredited course in Human Sexuality that includes a focus on lesbian/gay bisexual lifestyle prior to employment or a signed agreement from the candidate that she or he will complete such a course within six months of hire date.

SECTION C: (To be completed by Coordinator of Lesbian/Gay Health Services and Personnel Office)

This candidate has demonstrated to the satisfaction of the Coordinator of Lesbian/Gay Health Services and/or members of the Lesbian/Gay Health Services Coordinating Committee that she/he is knowledgeable about the lesbian/gay community and its available health services.

YES_____ NO_____

COMMENTS:

_____
_____
_____

_____ _____ _____
Date Coordinator Personnel Office
Lesbian/Gay Health Services

Sexually Transmitted Diseases (Infections)

Healthy People 2010 Goal

Promote responsible sexual behaviors, strengthen community capacity, and increase access to quality services to prevent sexually transmitted diseases and their complications.

Overview

This chapter discusses the issues and trends surrounding sexually transmitted diseases (STDs) on a national level and specific to lesbian, gay, bisexual, and transgender (LGBT) populations. STDs are common, costly, and preventable. More than 65 million people are currently living with an incurable STD. An additional 15 million people become infected with one or more STDs each year, roughly half of whom contract lifelong infections. Healthy People 2010 cites a 1997 Institute of Medicine report on STDs to prioritize preventing the disproportionate effect that STDs have on some population groups, including youth, some racial groups, and those who are economically or socially disenfranchised. Without question, LGBT communities have historically experienced social marginalization and are disproportionately at risk for STDs. Additional disparities as well as challenges and opportunities for prevention and treatment for LGBT populations are explored with respect to the Healthy People 2010 objectives for STDs. Finally, recommendations for action in the areas of services, education and training, policy, and research are discussed.

Issues and Trends

Sexually transmitted diseases refer to the more than 25 infectious organisms transmitted primarily through sexual activity. Despite the burdens, costs, complications, and preventable nature of STDs, they remain a significant public health problem, largely unrecognized by the public, policymakers, and public health and health care professionals in the United States.[1]

Despite the fact that STDs are extremely widespread, have severe and sometimes deadly consequences, and add billions of dollars to the Nation's health care costs each year, most people remain unaware of the risks and consequences of almost every STD but one—

human immunodefiency virus (HIV). Studies of the worldwide HIV pandemic link other STDs to a causal chain of events in the sexual transmission of HIV infection.[2] (See HIV/AIDS focus area.) Although extremely common, STDs are difficult to track. Many people with STDs do not have or recognize symptoms and remain undiagnosed. STDs that are diagnosed frequently are not reported and counted. Thus, a part of the overall epidemic remains hidden, the scope and extent may go unrecognized, and other people exposed to STDs do not receive treatment.

A 1997 Institute of Medicine (IOM) report characterized STDs as "hidden epidemics of tremendous health and economic consequence in the United States" and stated, "STDs represent a growing threat to the Nation's health and that national action is urgently needed."[3] The principal conclusions in the IOM report are that the United States needs to:

> Establish a much more effective national system for STD prevention, taking into account the complex interaction among biological and social factors that sustain STD transmission in populations
>
> Identify and address the disproportionate effect that STDs have on some population groups
>
> Apply proven, cost-effective behavioral and biomedical interventions
>
> Foster change in personal behaviors and in health care services through education, mass media, and organization and financing of health care services and health care infrastructure policies[4]

LGBT communities, without question, have historically experienced social and economic marginalization and are disproportionately at risk for STDs.[5, 6, 7] Particular segments of the LGBT community may be at even higher risk due to factors related to age and economic and racial status.[8, 9] Furthermore, sexual orientation and gender identity are not included as demographic variables in several data sources that could generate a wealth of new knowledge on STD research, prevention, education, and treatment.[10, 11]

STDs are common, costly, and preventable.[12, 13, 14] Worldwide, an estimated 333 million cases of curable STDs occur annually.[15] In 1995, STDs were the most common reportable diseases in the United States, accounting for 87 percent of the top 10 infections most frequently reported to the Centers for Disease Control and Prevention (CDC) from State health departments.[16] Of the top 10 infections, five were STDs—chlamydia, gonorrhea, acquired immunodeficiency syndrome (AIDS), syphilis, and hepatitis B. Each year an estimated 15 million new STD infections occur in the United States, and nearly 4 million teenagers are infected with a STD.[17] The direct and indirect costs of the major STDs and their complications, including sexually transmitted HIV infection, are conservatively estimated at $17 billion annually.[18] The 1997 IOM report concluded that, despite recent progress toward controlling some STDs, the United States has failed to go far enough or fast enough in its national attempt to contain acute STDs and STD-related complications.[19]

Whether STDs are increasing or decreasing depends on the specific disease being reviewed. The latest scientific data suggest that chlamydia, the most commonly reported infectious

disease in the United States, may be one of the most dangerous STDs among women. Although it has declined in areas with screening and treatment programs, the infection rate remains at very high levels.[20] For the first time in nearly two decades, gonorrhea is on the rise, increasing more than 9 percent from 1997 to 1999, after a 72-percent decline from 1975 to 1997.[21] Syphilis, in both adults and infants, has declined overall and is now at an all-time low, presenting CDC with an opportunity to attempt to eradicate the disease. In October 1999, CDC launched the National Plan to Eliminate Syphilis in the United States.[22] Chancroid also has declined steadily since 1987.[23] Genital herpes has continued to increase, spreading across all social, economic, racial, and ethnic boundaries, but most dramatically affecting adolescents and young adults.[24] With an estimated 20 million people in the United States currently infected with human papillovirus (HPV), this viral STD also continues to spread with an estimated 5.5 million people becoming newly infected each year.[25]

A summary of key issues surrounding STDs in the United States follows.

Biological factors. STDs are behavior-linked diseases that result from unprotected sex.[26] Several biological factors contribute to their rapid spread.[27, 28, 29]

Asymptomatic nature of STDs. The majority of STDs do not produce any symptoms or signs, or they produce symptoms so mild that they often are disregarded, resulting in a significant number of infected persons who should, but often do not, seek medical care. For example, as many as 85 percent of women and up to 50 percent of men with chlamydia have no symptoms.[30, 31, 32, 33] In the case of gonorrhea, women are more likely to be asymptomatic than men.[34] Most HPV infections appear to be temporary and are probably cleared up by the body's immune system. The study of college students conducted by Ho and colleagues showed that, in 91 percent of women with new HPV infections, those infections were undetectable 2 years later.[35] Most people with genital herpes have no symptoms and are unaware of their infection. In a national household survey, less than 10 percent of people who tested positive with herpes knew they were infected.[36]

Lag time between infection and complications. Often, a long interval—sometimes years—occurs between acquiring a sexually transmitted infection and recognizing a clinically significant symptom or health problem. Examples are cervical cancer caused by HPV, liver cancer caused by hepatitis B virus infection,[37] and infertility and ectopic pregnancy resulting from unrecognized or undiagnosed chlamydia or gonorrhea.[38]

Gender and age. Women are at higher risk than men for most STDs, and young women usually are more susceptible than older women to certain STDs.[39, 40] The higher risk is partly because the cervix of adolescent females is covered with cells that are especially susceptible to certain STDs, such as chlamydia.[41] In nonmenstruating women, the protective effects of estrogen in thickening mucosal layers is missing.

Social and behavioral factors. The spread of STDs, especially in certain vulnerable population groups, is directly affected by social and behavioral factors. For example, military populations are thought to have high rates of STDs. In 1999, nearly 10 percent of 17- to 37-year-old women screened for STDs during their induction tested positive for

chlamydia.[42] The results from a Fort Bragg, North Carolina, study revealed that chlamydia rates for male and female active-duty soldiers were threefold to sixfold higher than rates for males and females in North Carolina and in the United States as a whole.[43] Social and cultural factors may cause serious obstacles to STD prevention by adversely influencing social norms regarding sex and sexuality. The use of the Internet has created another environment for meeting people, and the resulting exposure increases the potential risk for acquiring or transmitting STDs.[44] Behavioral factors that can increase STD transmission in a community include increases in the exchange of sex for drugs, increases in the number of anonymous sex partners, decreases in motivation to use barrier protection, and decreases in attempts to seek medical treatment.[45, 46, 47]

Poverty and marginalization. STDs disproportionately affect disenfranchised persons and persons who are in social networks in which high-risk sexual behavior is common and either access to care or health-seeking behavior is compromised. Some disproportionately affected groups include sex workers (people who exchange sex for money, drugs, or other goods), adolescents, persons in detention, and migrant workers.[48, 49, 50] The historical social marginalization of the LGBT community also places many segments of this population disproportionately at risk for STDs.[51] Without publicly supported STD services, many people in these categories would lack access to STD health care services.

Access to health care. Access to quality health care is essential for early detection, treatment, and behavior-change counseling for STDs.[52] Often, groups with the highest rates of STDs are the same groups in which access to health services is most limited, such as substance abusers, sex workers, adolescents, incarcerated people, and LGBT individuals.[53, 54, 55, 56, 57, 58, 59] Only half of local public health departments in the United States provide STD preventive services, compared with 96 percent that provide vaccinations.[60] Even when STD services are provided, access to care is often restricted by limited hours of operation and the lack of timely services.[61] Nearly 40 percent of local health departments that provide STD services cannot see potentially infected new patients the same day they seek care, and 15 percent cannot see such patients for 3 days or more.[62]

As a result of the organization and financing of health care services, most patients with STDs, especially women, are not examined in public STD clinics. In managed care organizations, where primary care providers are the gatekeepers, most providers do not routinely obtain a sexual history or ask about or screen for STDs.[63] However, managed care organizations do acknowledge the importance of both preventing and treating STDs.[64] Both adolescents and adults frequently perceive that primary care providers are uncomfortable discussing sexuality and often lack adequate communication skills on this topic.[65] Although the majority of North American medical schools offer medical students curriculum material in sexuality, nearly one-third of the curricula does not address important topics such as taking a sexual history.[66]

Innovative approaches to delivering STD clinical care outside of both clinics that specialize in STD treatment and individual primary care provider offices are occurring. For example, integration of STD and family planning services within a broader reproductive health model

provides efficient health care for women and has been highly successful as a primary strategy for reducing chlamydia infections in the United States.[67] Similarly, prenatal and obstetrical care settings provide another setting for STD/HIV screening and prevention, while enhancing the potential for preventing the STD-related adverse outcomes of pregnancy.[68]

Community outreach for STD prevention is limited in many jurisdictions, particularly where populations may be at increased risk.[69] However, school-based health clinics are an excellent venue for receiving STD-related services.[70] Unfortunately, although U.S. prisons have expanded screening programs for HIV infection in recent years, other STD screening and prevention remain less common.[71]

Substance abuse. Many studies document the association of substance abuse, especially the abuse of alcohol and drugs, with STDs.[72, 73] At the population level, the introduction of new illicit substances into communities often can drastically alter sexual behavior in high-risk sexual networks, leading to an epidemic of STDs.[74] Other substances, including alcohol and club drugs, may affect an individual's cognitive and negotiating skills before and during sex, lowering the likelihood that protection against STD transmission and pregnancy will be used.[75, 76]

Sexuality and secrecy. Perhaps the most important social factor contributing to the spread of STDs in the United States and the factor that most significantly separates the United States from those industrialized countries with low rates of STDs is the stigma associated with STDs and the general discomfort of people in the United States with discussing intimate aspects of life, especially those related to sex.[77] Sixty-two percent of parents of 10- to 12-year-olds have not discussed how to prevent pregnancy and STDs.[78] Changing sexual behaviors and sexual norms will be an important part of any long-term strategy to develop a more effective national system of STD prevention in the United States. For example, the adult film industry now has a nonprofit organization dedicated to STD testing, tracking, and education. Because of the Adult Industry Medical Health Care Foundation, regulations are in place that require adult performers to be tested monthly for STDs.[79] A new sexual openness needs to become the norm to ensure that all sexual relationships are consensual, nonexploitive, and honest and to protect against disease and unintended pregnancy. This openness would allow:

- Opinion leaders and the media to promote safe sexual behavior, to acknowledge that sex and sexuality are part of our culture and should be responsibly but explicitly discussed, including that diverse sexual cultures are present throughout our society
- Parents to talk frankly, comfortably, and sensitively with their children, as well as teachers and counselors with their students, about responsible behavior and avoiding risks (e.g., abstaining from intercourse, delaying initiation of intercourse, reducing the number of sex partners, increasing the use of effective barrier contraception)
- Sex partners to talk openly with each other about their sexual histories, any risks, and safe sexual behaviors

Health care providers to talk comfortably and knowledgeably, with sensitivity and acceptance, with patients about sexuality and sexual risk, to counsel them about risk avoidance, and to screen them regularly for STDs when indicated

HIV and STDs. Compelling worldwide evidence indicates that the presence of other STDs increases the likelihood of both transmitting and acquiring HIV infection.[80, 81] (See HIV/AIDS focus area.) Prospective epidemiological studies from four continents, including North America, have repeatedly demonstrated that when other STDs are present, HIV transmission is at least two to five times higher than when other STDs are not present. Biological studies demonstrate that when other STDs are present, an individual's susceptibility to HIV infection is increased, and the likelihood of a dually infected person (someone with HIV infection and another STD) infecting other people with HIV is increased. Conversely, effective STD treatment can slow the spread of HIV at the individual and community levels.[82]

Disparities

STDs affect all racial, cultural, geographic, economic, and religious groups.[83] Nevertheless, some population groups are disproportionately affected by STDs and their complications.

Gender disparities. Women suffer more frequent and more serious STD complications than men do.[84] Among the most serious STD complications are pelvic inflammatory disease, ectopic pregnancy, infertility, and chronic pelvic pain.[85] Women are biologically more susceptible to infection when exposed to a sexually transmitted agent.[86] Acute STDs (and even some complications) often are very mild or are completely asymptomatic in women.[87] STDs are more difficult to diagnose in women due to the physiology and anatomy of the female reproductive tract. This combination of increased susceptibility and "silent" infection frequently can result in women being unaware of an STD, which may result in delayed diagnosis and treatment. STDs in pregnant women can cause serious health problems or death to the fetus or newborn.[88, 89]

Age disparities. For a variety of behavioral, social, and biological reasons, STDs also disproportionately affect adolescents and young adults.[90] In 1997, females aged 15 to 19 had the highest reported rates of both chlamydia and gonorrhea among women; males aged 20 to 24 years had the highest reported rates of both chlamydia and gonorrhea among men.[91] The herpes infection rate of white youth aged 12 to 19 years increased nearly fivefold from the period 1976-80 to the period 1988-94.[92] Because not all teenagers are sexually active, the actual rate of STDs in teens is probably higher than the observed rates suggest.[93] There are several contributing factors:

Data indicate teenagers are increasingly likely to have more sex partners at earlier ages. In 1971, 39 percent of sexually active adolescent females aged 15 to 19 had more than one sex partner. By 1988, the percentage had increased to 62 percent.[94]

Sexually active teenagers often are reluctant to obtain STD services, or they may face serious obstacles when trying to obtain them. In addition, health care providers often are

uncomfortable discussing sexuality and risk reduction with their patients, thus missing opportunities to counsel and screen young people for STDs.[95] These factors are exacerbated for sexually active LGBT youth.

Racial and ethnic disparities. Certain racial and ethnic groups (mainly African American and Hispanic populations) have high rates of STDs, compared with rates for Whites.[96] Race and ethnicity in the United States are risk markers that correlate with other fundamental determinants of health status, such as poverty, limited or no access to quality health care, and fewer attempts to obtain medical treatment. Thus, some of the noted disparity may be a statistical artifact as national surveillance data may overrepresent STDs in racial and ethnic groups that are more likely to receive STD services from publicly funded STD clinics that report the occurrence of such diseases.

Opportunities

Prevention opportunities increase with the understanding of STD transmission dynamics. The rate of STD infection in a population is determined by the interaction of three principal factors:[97, 98]

The rate at which uninfected individuals have sex with infected persons (rate of sex partner exchange or exposure)

The probability that a susceptible exposed person actually will acquire the infection (transmission)

The time period during which an infected person remains infectious and able to spread disease to others (duration)

Effective STD prevention requires effective population-level and individual-level interventions that can alter the natural course of these factors. IOM advised in its report:

"Use of available information and interventions could have a rapid and dramatic impact on the incidence and prevalence of STDs in the United States. Many effective and efficient behavioral and biomedical interventions are available." [99]

Biomedical interventions can affect aspects of transmission and duration factors. Vaccines minimize the probability of infection, disease, or both after exposure (transmission). Although vaccines for some STDs are in various stages of development, the only effective and widely available STD vaccine is for hepatitis B.[100, 101] Unfortunately, hepatitis B vaccine coverage remains minimal, especially in high-risk groups, mainly due to a lack of awareness of all high-risk groups on the part of health care providers, limited opportunities to reach high-risk youth in traditional health care settings, and limited financial support for wide-scale implementation of this effective intervention.

Correct and consistent condom use decreases STD transmission.[102] However, the message that condom usage equals safe sex may lead to a false sense of security, as condom usage

does not prevent the spread of hepatitis A and HPV, nor does it provide protection from diseases spread by anal-oral contact, such as HPV.

Screening and treatment of STDs affect both transmission and duration factors. For curable STDs, screening and treatment can be cost-effective by decreasing the period during which infected persons can transmit diseases to others. Screening for STDs clearly meets the criteria for an effective preventive intervention.[103] For STDs that frequently are asymptomatic, screening and treatment benefit those who are likely to suffer severe complications (especially women) if infections are not detected and treated early.[104]

When combined with a new generation of sensitive and rapid diagnostic tests, some of which can be performed on a urine specimen, STD screening of specific high-risk populations in nontraditional settings appears to be a promising control strategy that expands access to underserved groups.[105] The success of screening programs will depend on the availability of funds, the willingness communities and institutions to support them, their cultural competence for serving LGBT individuals, and the availability of well-trained health care providers and well-equipped and accessible laboratories.

Identifying and treating partners of persons with curable STDs to break the chain of transmission in a sexual network always have been integral aspects of organized control programs.[106] Early antimicrobial prophylaxis of the exposed partner reduces the likelihood of transmission and infection. With partner treatment, the initially infected person benefits from a reduced risk of reinfection from an untreated partner, and the partner avoids acute infection and its potential complications. Future sex partners are protected by treating infected individuals; thus, this treatment strategy also benefits the community.

Active partner notification and partner treatment generally have been the responsibility of personnel in publicly funded STD clinics. New approaches for having more partners treated are being assessed both in traditional and nontraditional STD treatment settings. One approach actively involves initially infected patients in the process of referring their partners for evaluation and treatment.[107] Another approach uses new techniques to assess sexual networks in outbreak situations in order to identify infected patients and their partners more quickly.[108] Because most STD care in the United States is delivered in the private sector, private health care providers, managed care organizations, and health departments need to work together to overcome barriers to rapid and effective treatment of the nonplan sex partners of health plan members, including those in same-sex relationships.

In no area does the potential for managed care to diminish, rather than strengthen, public health carry more significance than in the prevention, treatment, and control of STDs.[109] In many communities, STD rates are highly elevated, and new forms of old diseases are an emerging cause of public health concern.[110] In the context, treatment, and prevention of STDs, several basic and separate issues relate to the intersection of managed care, especially Medicaid managed care, and public health.[111] Those issues are:

- The consequences of managed care on the delivery of STD prevention, testing, and treatment services by local public health agencies

The effect of managed care on the ability of public health agencies to exercise their historic police powers to control the spread of STDs through the use of practice guidelines and treatment interventions

The impact of managed care on the communitywide surveillance activities of public health agencies as well as other health activities, such as partner notifications, that depend on access to data

All three issues are embodied in the contextual relationships between managed care organizations (MCOs) and public health agencies, as exemplified by the written agreements—i.e., memoranda of understanding (MOU)—that codify the roles and responsibilities of each entity. In 2000, Rosenbaum and associates did a content analysis of MOUs as well as interviews of MCOs, State and local public health agencies, and Medicaid officials in 10 communities. The findings varied greatly. An earlier study for the Kaiser Family Foundation by the same investigators found that Medicaid agencies classify STD testing as a family planning service; however, the MOUs were silent on how people who tested positive would be referred back to health care plans for treatment. This finding is puzzling as the MOUs were drafted not by the MCOs but rather by public health and Medicaid agencies. According to the report, "Public health and MCO interviewees in several sites acknowledged that STDs are not even 'blips on the radar screen' in discussions concerning priorities for developing the public health/managed care relationship."[112] Obviously, more communication and collaborative efforts are needed in the relationship between managed care and public health to increase access to quality services to prevent and treat STDs.

Strong leadership in STD prevention by health agencies and health plans that is backed by appropriate rules and standards is critical.[113] Public health officials can demonstrate leadership by promoting and supporting consensus development around national standards, collaborating on priority setting, and simplifying interventions for clinicians. MCOs and other health plans now need to take responsibility for STD prevention because an effective system for such prevention cannot occur without MCOs.[114] In addition, MCOs have a social and normative responsibility to improve the health of the public.[115]

Population-based behavioral interventions can be brought to bear on exposure, transmission, and duration factors. Further attention must be given to helping parents become better at providing STD information. Currently, a small percentage of adolescents receive STD prevention information from parents.[116] Schools are the main source of STD information for most teenagers,[117] indicating that school-based interventions can play a significant role in informing young people about STD exposure and transmission issues and in motivating them to modify their behaviors.[118] (See Educational and Community-Based Programs focus area.) Both school-based health information and school-based health service programs are potentially beneficial to young persons; however, all programs need to be linguistically accessible and culturally competent, including those for LGBT populations.[119]

Mass media campaigns have been effective in bringing about significant changes in awareness, attitudes, knowledge, and behaviors concerning other health problems, such as smoking.[120] When asked to name specific STDs, very few people can name the most common STD—HPV.[121] A third of people (36 percent) are not aware that having an STD increases a person's risk of becoming infected with HIV.[122] National communication efforts, inclusive of messages for LGBT audiences, are needed to help overcome widespread misinformation and lack of awareness about STDs.

Summary of LGBT Research

STDs among men who have sex with men. HIV continues to be the most serious of all STDs, and a disproportionate number of cases are still borne by men who have sex with men (MSM), including bisexual men.[123] In addition, other STDs may increase the efficiency of HIV transmission. However, insufficient data exist regarding the prevalence of HIV infection among lesbians, bisexual women, and transgender persons.

In comparison to heterosexual men, MSM are at increased risk not only for HIV, but also certain STDs.[124, 125, 126] Getting accurate estimates of the prevalence rates of STDs among MSM is virtually impossible because of the dual stigma associated with STDs and homosexuality. MSM are generally believed to be at increased risk for a range of STDs, including urethritis, proctitis, pharyngitis, prostatitis (due to gonorrhea or chlamydia), hepatitis A virus (HAV), hepatitis B virus (HBV), syphilis, herpes, genital warts caused by HPV, molluscum contagiosum, and HIV. However, additional data on infection patterns and prevalence are needed.[127]

STDs can hold dire consequences for MSM living with HIV, including chronic or life-threatening complications such as cytomegalovirus, herpes, and anal cancer associated with certain strains of HPV.[128] In recent years, HIV prevention programs have played an important role in the steady decline of STD transmission among gay and bisexual men.[129] However, recent U.S. and international studies provide evidence that rates of unprotected anal intercourse and STDs may be on the rise.[130, 131] Increases in rectal gonorrhea were reported among MSM in San Francisco,[132] whereas increases in syphilis have been reported among MSM in Seattle. In 1998 and 1999, community-based clinics in New York, Boston, and Atlanta, and public health departments in Los Angeles, Chicago, Miami, Washington, D.C., and other U.S. cities, as well as several cities abroad, reported epidemic rates of HAV.[133] These increases in STDs among MSM coincide with a decrease in the number of MSM who reported that they "always used condoms" [134] and an increase in the proportion of MSM reporting that they have unprotected anal sex.[135, 136] These trends underscore a clear need for "renewed efforts to reduce the rates of STD and HIV transmission among MSM, and for the development of new surveillance techniques to assess the efficacy of these efforts."[137] Additionally, MSM who are engaging in sex with men outside of a primary relationship with a woman put their female sex partners at increased risk.

HAV and HBV infection and immunization among MSM. HAV and HBV are vaccine-preventable diseases that are highly prevalent among MSM. Even though vaccines to

prevent HAV and HBV are available, and even though CDC recommends vaccination for sexually active MSM, vaccination rates among MSM are low.[138] (See Immunization and Infectious Diseases focus area.)

Healthy People 2010 underscores the importance of the hepatitis B vaccine and reports that HBV coverage is minimal, especially among high-risk groups. Healthy People 2010 points to a lack of awareness among providers, difficulty in reaching high-risk youth via traditional service delivery settings, and limited financial support for wide-scale implementation as barriers to vaccination. (See Immunization and Infectious Diseases focus area.) Increasing the rates of HBV vaccination among MSM is vitally important. HAV is an STD among MSM that can be prevented by vaccination.

STDs among women who have sex with women. The prevalence of STDs among women who have sex with women (WSW) and the risk of STD transmission between WSW have received little study. Furthermore, because the majority of WSW have had sex with men at some point during their lives, they may be at risk for a range of STDs, including herpes, HPV, HIV, and HBV as a result of these exposures. Data strongly support that HPV and trichomonas are transmitted between female sex partners,[139, 140] and cases of HIV, HBV, and HAV transmission have been reported.[141, 142]

Bacterial vaginosis (BV) is a condition in which overgrowth of commensal anaerobic flora dominates the hydrogen peroxide-producing lactobacilli that predominate in the healthy vagina.[143] BV confers an increased risk of preterm delivery, low birthweight, and postpartum/postabortal endometritis. For reasons that are not yet understood, BV may be markedly more prevalent among WSW than among women who have sex with men.

Despite clear evidence of HPV and cervical neoplasia among WSW, including those who have never had sex with men, WSW may not seek or receive Pap tests as frequently as standard guidelines recommend. Untreated STDs in women can cause infertility, which could cause problems for increasing numbers of lesbians who wish to have families through pregnancy. Several large studies have shown that WSW attending STD clinics who report also having sex with men have substantially higher risk profiles for acquiring HIV than do women who do not have sex with women.[144]

STDs among LGBT adolescents. STDs are among the most commonly diagnosed infectious diseases in adolescents; nearly two-thirds of cases occur in young people under age 25.[145] Younger adolescents, especially females, are least likely to be considered at risk or to be screened if they are asymptomatic.[146] LGBT youth who are sexually active are at risk for STDs, and young MSM are particularly vulnerable. Lesbian and bisexual female youth who have sex with gay male peers are at increased risk. Risk is heightened by a lack of accurate health promotion and prevention information as well as by the lack of supportive environments for socialization that promotes anonymous sexual encounters and other high-risk behaviors.[147]

STDs among transgender persons. No prospective studies have been done on the risk of STDs for transgender persons. Given the fact that MSM are at increased risk for specific

STDs, additional research is needed to ascertain the degree to which transgender persons who have sex with MSM or WSW are at risk. Moreover, many transgender individuals take hormones via injection, and needle-sharing is a practice that may increase the risk for HIV and other STD transmission.

Cultural concerns for LGBT populations. Some subpopulations of MSM have been shown to have more sexual partners than heterosexual men, thereby increasing their risk for STDs.[148] For a certain segment of the MSM population, sex partners may be anonymous, with little or no chance to discuss a partner's sexual history. In addition, young MSM, especially racial/ethnic youth, remain difficult to reach, in part because they typically do not have a regular source of care[149] and have not yet benefited from increased access to education and information that often comes with being actively involved in the gay community. In addition, MSM may not be reached effectively by health promotion campaigns unless they are specifically targeted with culturally sensitive messages.[150, 151]

Because drug use is associated with an increased risk for STDs, gay men and other LGBT people who use drugs and alcohol are also at increased risk for STDs. People who exchange sex for money to buy drugs further enhance their risk.[152] This public health issue can be further complicated by increases in the number of anonymous sex partners. This is an issue of particular importance to those gay men who use stimulants and libido-enhancing recreational drugs.[153] The extent to which these drugs are used in conjunction with unsafe sex among lesbians, bisexuals, and transgender people is unclear, but some cross-sectional data suggests that use may be widespread in some LGBT communities.[154]

The social stigma associated with STDs continues to present a serious challenge for STD prevention, education, screening, detection, and treatment. As noted in Healthy People 2010, STD-related stigma may be the most important social factor contributing to the transmission of STDs in the United States. Most Americans are not comfortable discussing such intimate aspects of personal life, especially as they relate to sexual activity. This stigma may be compounded for the LGBT community as studies indicate that only between 18 and 49 percent of LGBT patients disclose their sexual orientation to their physician.[155, 156, 157] Furthermore, given the increases in data showing suboptimal Pap testing among WSW, and the well-documented occurrence of HPV-associated cervical neoplasia in these women, WSW may not be aware of their screening needs or of the risk of HPV-associated cervical neoplasia in WSW who have not had sex with men.[158]

Discussion of Healthy People 2010 Objectives

25-5. (Developmental) Reduce the proportion of persons with human papillomavirus (HPV) infection.

Rates of rectal precancer and cancer among MSM appear to be on the rise.[159] The etiology of precancers and cancers of the anus, penis, cervix, vagina, and vulva is oncogenic HPV (specific subtypes are associated with this risk). Host factors can contribute to its acquisition and include the presence of chronic illness, immune deficiency (especially HIV disease),

cigarette smoking, and frequency of exposure. Recent research shows a strong correlation between cervical and anal neoplasia,[160] thus permitting parallels in our understanding of the natural history of both diseases. HPV is also transmitted between female sex partners, and associated cervical neoplasm in WSW who report no prior sex with men has been well documented.[161, 162, 163, 164]

The anatomical, virological, and pathological analogies between cervical and anal neoplasia suggest that interventions to enhance screening, diagnosis, and treatment in the precancerous phase would avert and possibly arrest the otherwise expected progression to anal cancer, especially in HIV-infected persons. The use of anal Pap tests has been demonstrated to be a cost-effective approach.[165] High-resolution anoscopy is used to evaluate abnormal Pap tests and permit directed histologic sampling of the anus.[166] Because WSW, especially those who are no longer sexually active with men, have been documented to have less frequent Pap tests and fewer visits for gynecologic care, they may be more at risk for cervical dysplasia and progression to invasive carcinoma.[167, 168, 169, 170, 171]

The incidence of anal intraepithelial neoplasia and invasive anal cancer is higher in HIV-infected persons than noninfected individuals.[172, 173] It is estimated that there are 70 cases per 100,000 persons with HIV infection,[174] which is twice the rate of cervical cancer prior to routine cervical sampling with the Pap test.[175] The life expectancy of HIV-infected people enhanced by highly active antiretroviral therapy has resulted in prolonged immunosuppression, which increases the risk for the development of malignancies, including anal cancer. Homosexual men have a high rate of progression from low- to high-grade squamous intraepithelial lesions (correlating with anal neoplasia 3, or carcinoma in situ) when followed by anal cytology and histology.[176]

25-11. Increase the proportion of adolescents who abstain from sexual intercourse or use condoms if currently sexually active.

A majority (86 percent) of U.S. individuals favor sexuality education in the public schools, and 86 percent also believe that birth control information should be available to adolescents.[177] School-based sexuality education programs are generally of two types: (1) abstinence-only programs that emphasize sexual abstinence as the most appropriate choice for young people, and (2) sexuality and STD/HIV education programs that cover abstinence as well as condoms and other methods of contraception to provide protection against STDs or pregnancy.

To date, the few published evaluations of abstinence-only programs have found little or no effect on initiation of sexual activity.[178, 179, 180] However, due to this limited number of studies, definitive conclusions cannot be drawn about this approach.

Programs that typically emphasize abstinence, but also cover condoms and other methods of contraception, have a larger body of evaluation evidence that indicates either no effect on initiation of sexual activity or, in some cases, a delay in the initiation of sexual activity.[181] This evidence gives strong support to the conclusion that providing information about contraception does not increase adolescent sexual activity by hastening the onset of sexual

intercourse, increasing the frequency of sexual intercourse, or increasing the number of sexual partners. In addition, some of these evaluated programs increased condom use or contraceptive use among adolescents who were sexually active.[182, 183, 184, 185, 186, 187, 188, 189]

Abstinence promotion and STD prevention messages typically assume heterosexual orientation, thereby negating the thoughts or experiences of LGBT adolescents or adolescents questioning their sexual orientation or gender identity. Studies of adolescent sexual orientation show that the age of "coming out" or self-identification as lesbian or gay has been dropping steadily.[190]

Average Age (Years) Event Occurs

	Adults* (Retrospective Studies)		Adolescents** (Prospective Studies)	
Behavior/Identity	Males	Females	Males	Females
First awareness of homosexual attraction	13	14-16	9	10
First homosexual experience	15	20	13	15
Self-identification as lesbian or gay	19-21	21-23	16	16

* Troiden, R.R. Homosexual identity development. 9:105, 1988.
** Herdt, G., and Boxer, A. , 2nd ed. Boston, MA: Beacon Press, 1996.

LGBT and questioning youth need targeted, culturally competent messages with which they can identify. Obviously, female adolescents, whether heterosexual, bisexual or lesbian, can become pregnant for a variety of reasons (e.g., choosing to have children, hiding sexual orientation, failure to use contraceptives).[191]

A 1999 study by Saewyc and associates examined the prevalence of heterosexual behavior and related risk factors and pregnancy histories among lesbian and bisexual teenagers. Overall, bisexual or lesbian respondents were about as likely as heterosexual women ever to have had intercourse (33 and 29 percent, respectively). However, the bisexual or lesbian respondents had a significantly higher prevalence of pregnancy (12 percent) and physical or sexual abuse (19 to 22 percent) than heterosexual adolescents.[192] These same researchers also found that American Indian adolescents reported higher prevalence of gay, lesbian, and bisexual orientations than Euro-Americans. Gay and bisexual males were more likely than other males to report early heterosexual intercourse, more consistent contraception, and a higher prevalence of abuse and running away. Likewise, lesbian and bisexual females were more likely to report early onset of heterosexual intercourse, more frequent intercourse, and running away, but not sexual or physical abuse.[193] Culturally competent messages should be sensitive and appropriate to LGBT adolescents and should include instructions on condom usage in all relevant contexts and information on hepatitis vaccination.

Estimates of lesbian and gay homeless youth vary, but youth service providers agree that rates are very high, ranging from 20 to 40 percent in various studies.[194, 195, 196] This population may be at extremely high risk for STDs due to multiple behavioral and social factors, including

limited access to services, stigma and discrimination, having sex for money, having multiple and anonymous partners, and using drugs and alcohol. Brief risk-reduction messages have been shown, in some studies, to lead to substantial increases in condom use.[197, 198, 199] Other studies have shown little effect.[200, 201] More extensive counseling, either individual or small group, can produce additional increases in consistent condom use.[202]

25-13: Increase the proportion of tribal, State, and local sexually transmitted disease programs that routinely offer hepatitis B vaccines to all STD clients.

Among MSM, Hepatitus B virus is spread through sexual contact. The Centers for Disease Control and Prevention recommends routine vaccination against Hepatitis B for sexually active MSM. Hepatitus A virus is spread through oral-fecal routes of transmission, which includes oral-anal contact, or other sexual contact that can spread infected feces. The CDC has also recommended rountine vaccination against Hepatitus A for sexually active MSM[203]

In spite of nearly 5 years of promotion, the vaccination rate among MSM seems to be below 20 percent.[204, 205, 206] In addition, only 5 percent of State and local STD programs offered hepatitis B vaccines in accordance with CDC's 1998 guidelines. These data highlight missed opportunities for vaccinating MSM for both hepatitis A and B. Providers need to be educated to ask appropriate and sensitive sexual history questions and to vaccinate all sexually active LGBT people against HAV and HBV. Providers also should be aware that other modes for hepatitis B transmission include parental exposure by needles used for recreational drugs or hormonal injections.[207] Another mode of HAV and HBV transmission may be through the sharing of sexual paraphernalia.

CDC Hotlines for STDs

CDC National STD Hotline:	1-800-227-8922
	1-800-342-2437
En español:	1-800-344-7432

American Social Health Association Hotlines

National Herpes Hotline:	1-919-361-8488
National HPV and Cervical Cancer:	1-919-361-4848

25-14: (Developmental) Increase the proportion of youth detention facilities and adult city or county jails that screen for common bacterial sexually transmitted diseases within 24 hours of admission and treat STDs (when necessary) before persons are released.

Public health and corrections officials should be aware that many youth in juvenile detention facilities and adults in jails and prisons engage in same-sex behavior, even though they may be, or may identify themselves as, heterosexual. Incarcerated individuals may be more likely to exchange sex for money or drugs or have acquired STDs prior to their entering custodial facilities.

25-15. (Developmental) Increase the proportion of all local health departments that have contracts with managed care providers for the treatment of nonplan partners of patients with bacterial sexually transmitted diseases (gonorrhea, syphilis, and chlamydia).

Goals of the National STD Action Plan:

- Educate the public about STDs through National STD Awareness Month and Web sites (www.ashastd.org and www.iwannaknow.org for teens).
- Educate consumers and health care providers about state-of-the-art diagnostics, treatments, and emerging vaccines.
- Help consumers and health care providers communicate more effectively about STDs.
- Promote positive health behaviors among individuals who are infected with STDs.
- Educate policymakers about STD prevalence, the costs and benefits of prevention, and early diagnosis and treatment.
- Improve communication on issues of race and ethnicity and STDs.

As this is a developmental objective, there were no national baseline data at the time the document went to print. The proposed national data source is the Survey of STD Programs, National Coalition of STD Directors (NCSD).[208] Syphilis, gonorrhea, and AIDS are reportable diseases in every State, and chlamydia is reportable in most States.[209] However, NCSD is a national partnership of State, county, city, and territorial STD prevention and control directors whose mission is to promote policies, programs, and strategies that reduce the prevalence of STDs.[210] Perhaps a nongovernment data organization might be better positioned to survey the organizations required to track progress on the objective. For example, the Center for Health Services Research and Policy (CHSRP), formerly the Center for Health Policy Research, is the major health services research center for the George Washington University Medical Center and has already conducted research in this area.[211] CHSRP often works in concert with various entities and could form an alliance with, for example, the Gay and Lesbian Medical Association or the National Coalition for LGBT Health.

Unfortunately, STDs have tended to be low priorities, not only for most managed care organizations but also for some health agencies.[212] Within these organizations, persons with responsibility for STDs typically have not been involved in the strategic decisionmaking process and therefore not represented in contract negotiations among managed care organizations, States, or counties. Given the "partnership" structure of NCSD, as explained by Charles Rabins at a meeting of Healthy People 2010, the likelihood is low that many members of NCSD were involved in establishing State Medicaid managed care contracts or the State Children's Health Insurance Program.[213]

Stereotypes and misperceptions are pervasive among staff of MCOs, health agencies, and LGBT health centers. Traditionally, public health agencies and community-based organizations serving populations such as LGBT individuals provided clinical services for diseases that potentially endanger the public health (e.g., STDs) that private-sector

physicians were unwilling or reluctant to treat.[214] Because of the stigma surrounding STDs, many people value confidential services and do not access STD-related services from their health plan for fear that their employer, family, or insurer will find out.[215]

California prepared a model document for use by local public health agencies with MCOs.[216] The San Francisco Department of Health and contracting Medicaid MCOs agreed to use identification numbers that do not reveal the nature of the service when billing the health plan for services provided to plan enrollees. The health department also requires that contractors inform members of the right to access out-of-plan services for STDs without prior authorization.[217]

With the exception of New York and California, the memoranda of understanding between public health agencies and MCOs did not obligate the MCOs to provide public health agencies the necessary information either to carry out their epidemiological surveillance activities or to conduct other activities essential to the control of STDs.[218] The most notable activity potentially affected by the absence of such data is partner notification, and testing and treatment for possibly infected partners. Because many partners may not be members of the MCO to which the infected partner belongs, the ability to follow up with notification and support for the cost of treatment is pivotal. Interestingly, the laboratories, not physicians, are the prime source of information about notifiable diseases, including STDs.[219] New York is the only State that classifies any laboratory that tests specimens drawn in the State as doing business in-State and requires a laboratory to report test results, regardless of location.[220] Because many MCOs use centralized laboratory services that are furnished by out-of-State suppliers, State public health laws in fact may not reach this critical source of data.[221]

No MOUs in the Rosenbaum et al., study conducted in 2000 required adherence to public health standards with respect to STDs, and none addressed the issue of payment for treatment of potentially infected partners. Interviews with public health officials suggested that alternative sources of funding (e.g., Federal grants from CDC and other Federal agencies) may have diminished their interest in addressing in contractual language the treatment of nonplan partners.[222] However, these alternative sources of funding, although important, are not necessarily needed if managed care contracts are written to be inclusive of all medical services necessary to prevent and treat STDs. The current absence of this specific language is an opportunity for all groups interested in prevention of STDs, especially LGBT health care organizations, to craft model language that can modernize public health policy and alter current managed care policy by establishing reimbursement relationships with out-of-plan individuals or providers.

25-16. (Developmental) Increase the proportion of sexually active females aged 25 years and under who are screened annually for genital chlamydia infections.

The proposed national data sources are the Office on Population Affairs data reported in Family Planning Annual Report and the STD Surveillance System (STDSS), CDC, National

Center for HIV, STD, and TB Prevention. Response rates to STDSS vary by disease and patient population. Estimates of completeness for case reporting of chlamydia are only 20 percent in contrast to syphilis at 65 percent and gonorrhea at 50 percent. Data on sexual orientation or gender identity are not collected. The STD Surveillance Report is published annually and is supplemented by the Chlamydia Prevalence Monitoring Annual Report. More information can be found on the Internet at www.cdc.gov/wonders/STD/contents.html.[223]

The National Guideline Clearinghouse (NGC) is a public resource for evidence-based clinical practice guidelines. NGC is sponsored by the Agency for Healthcare Research and Quality (formerly the Agency for Health Care Policy and Research) in partnership with the American Medical Association and the American Association of Health Plans.

The magnitude of the risk of sexually transmitting infections between WSW and how this compares to that of heterosexual women is unknown.[224] Attempts to use national or local surveillance to estimate the risk of STD transmission between women are limited by the fact that many risk classification schemes have either excluded same-gender sex among women or subsumed it under a hierarchy of other behaviors viewed as higher risk.[225] Classical STDs, including chlamydia, are rare in women who have sex with women only, in part because of sexual behavior and in part because of issues related to transmission efficiency.[226] However, many, if not most, lesbians and bisexual women have had sex with men, and an estimated 21 to 30 percent of lesbians report continued sex with men.[227, 228, 229]

25-18. Increase the proportion of primary care providers who treat patients with sexually transmitted diseases and who manage cases according to recognized standards.

Many health care providers are not adequately trained to provide culturally competent STD prevention and treatment services in a way that is appropriate and relevant to LGBT populations.[230] Furthermore, many providers are not comfortable with talking about the intimate aspects of sexual behavior, and other providers lack education on the relationship between STDs and increased risk for HIV infection. These factors may be operative in providers' decisions to provide elemental STD-related counseling, screening and management, and to perform routine Pap testing among WSW.

At the same time, LGBT individuals who are not "out" to their health care providers may not receive appropriate STD prevention counseling, accurate diagnoses, or culturally appropriate treatment.[231, 232, 233] Given that many LGBT individuals may be reluctant to seek care from mainstream providers because of previous negative experiences with the health care system, health care providers need to make a concerted effort to create a health care delivery environment that is not only open to serving LGBT populations but also conducts active outreach to engage LGBT clients. At the same time, LGBT people do not understand that they have specific health needs and, therefore, see no reason to inform their health care providers about their sexual orientation or gender identity.[234] (See Health Communication focus area.)

Services—RECOMMENDATIONS

"Sexual history" risk assessment tools that are culturally and linguistically appropriate need to be developed and widely disseminated.

Additional efforts are needed to increase, at all potential sites for screening, the proportion of LGBT people screened for STDs and, if found positive, provided treatment services.

There is a need for culturally appropriate STD prevention outreach for LGBT youth and youth questioning their sexual orientation.

All STD media campaigns should be inclusive of all population sectors including LGBT youth and adults.

Education and Training—RECOMMENDATIONS

Professional organizations of health care providers should address sexual orientation and gender identity concerns in continuing medical education courses, clinical guidelines, risk assessment, and screening policies.

Health professions schools, including schools of medicine, nursing, physician assistants, public health, health educators, and others, should partner with all existing LGBT health centers for purposes of STD clinic staffing as well as management and professional training.

All health care professionals should counsel their LGBT patients (or refer them to community-based organizations) regarding the risk of STDs and methods for reducing or preventing high-risk behaviors. Counseling for STDs should be reimbursed without copayments or other financial disincentives by Medicaid programs, managed care organizations, or other health plans.

Education is needed for LGBT individuals—especially youth—that condom usage provides no protection against hepatitis A and STDs transmitted by genital-oral contact.

Health care providers and consumers must be made aware of the risks of HPV and how it is transmitted and prevented, including the need for routine Pap testing for WSW.

Beth Israel Deaconess Medical Center in Boston has an Intraepithelial Neoplasia Clinic that implements a multidisciplinary approach to STD treatment and prevention. The team includes an HIV oncologist, an infectious disease specialist, a colorectal surgeon, a gynecologist, and a virologist. Together, the team contributes to clinical care and plans research activities related to anal neoplasia.

Policy—RECOMMENDATIONS

STD-related performance measures specific to LGBT populations should be included in the Health Plan Employer Data Information Set (HEDIS) developed by the National Committee for Quality Assurance as well as in other health

services performance measures of public and private health plans.

Local health departments, with the assistance of the State health department, should consult with the LGBT community in determining how to provide high-quality, comprehensive STD-related clinical services.

Health plans should provide for and cover comprehensive STD-related services, including screening, diagnosis, treatment, and counseling for plan members and their sex partners, regardless of the partners' insurance status.

LGBT organizations should work with an independent group to serve as a catalyst for social change toward a new norm of healthy sexual behavior in the United States that would include a long-term national initiative to increase knowledge and awareness of preventing and treating STDs.

The homeless may be at greater risk for STDs as a result of abusing substances and engaging in high-risk sexual behaviors (e.g., exchanging sex for drugs or money). CDC is funding a special STD screening program for the homeless in three sites in Chicago. The target population is primarily homeless youth and screening for gonorrhea and chlamydia. In partnership with The Night Ministry, an organization providing health care services to the homeless and sex workers, the Chicago Department of Health is using a mobile health unit staffed by a nurse to access three high prevalence sites per night. This program is scheduled to be completed in December 2001.

Research—RECOMMENDATIONS

Research is needed to identify the incidence and prevalence of STDs within LGBT populations and to identify which sexual practices increase the risk of specific STDs.

Sexual orientation and gender identity measures should be included within the CDC STD Surveillance System, the National Health and Nutrition Examination Survey, and CDC's National Center for HIV, STD, and TB Prevention.

Specific data on the prevalence of anal neoplasia in men with a history of receptive anal sex should be collected, with special emphasis on individuals with anogenital HPV and HIV infection.

Terminology

STD complications: Serious health problems that occur following an acute bacterial or viral STD. Among the most serious of these complications:

Cancer: Includes cervical cancer and its precursors (due to some strains of human papillomavirus) and liver cancer that can result from chronic infection with hepatitis B virus.

Infection of a fetus or newborn: Includes conditions such as congenital syphilis, neonatal herpes, HIV infection, eye infections, and pneumonia.

Pelvic inflammatory disease (PID): Can cause permanent damage to the female reproductive tract and lead to ectopic pregnancy, infertility, or chronic pelvic pain.

Preterm birth: Can result from maternal infection.

Sexually transmitted HIV infection: Can be facilitated by the presence of an inflammatory or ulcerative STD in one or both sex partners.

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Substance Abuse

Healthy People 2010 Goal

Reduce substance abuse to protect the health, safety, and quality of life for all, especially children.

Overview

Substance abuse is pervasive and affects all populations, youth to elderly, in the United States. It takes an enormous toll on the Nation—in both human and economic terms—and remains a significant concern to the lesbian, gay, bisexual, and transgender (LGBT) community. Although no national data are available, a recent review of the literature based on smaller population studies suggests that lesbians and gay men may still be at heightened risk for substance abuse.[1] Much less is known about bisexual or transgender women and men, but these groups also may be at increased risk for substance abuse. In addition to being discriminated against by many heterosexuals, they are frequently further marginalized by the gay and lesbian community.[2, 3] Like the general population in the United States, substance abuse in the LGBT community is associated with a myriad of public health challenges, including human immunodeficiency virus (HIV) and acquired immonudeficiency syndrome (AIDS), sexually transmitted diseases (STDs), violence (of particular concern, acts committed by and against the LGBT community), and chronic disease conditions such as cirrhosis of the liver. This chapter addresses substance abuse as it affects all populations, but particularly the disparities and issues affecting LGBT populations.

LGBT youth use alcohol and other drugs for many of the same reasons as their heterosexual peers: to experiment and assert independence, to relieve tension, to increase feelings of self-esteem and adequacy, and to self-medicate for underlying depression or other mental health problems.[4] Adolescents grow up in an environment that assumes heterosexuality of everyone*. There is scant acceptance available to LGBT youth within most sectors of their world (e.g., families, peers, schools, churches). Youth of color face additional stresses and challenges in integrating their sexual, gender, racial, and ethnic identities.[5]*

To become visible as LGBT, youth risk painful repercussions with few or no avenues of support. Subsequently, homelessness is a serious consequence for gay youth for a variety of reasons. For many, simply being LGBT is the reason why they may be banished from their

families of origin. Homeless youth are at high risk for exploitation. Without an education or job skills, they may engage in illicit behaviors, such as exchanging sex for food, drugs, or shelter.[6]

Abusing substances can occur at any age although the focus of most substance abuse prevention programs is on the adolescent. Ironically, substance abuse often is undetected or neglected among older adults, particularly older LGBT people. LGBT elders may feel vulnerable and under pressure to appear heterosexual. Efforts to self-medicate simply increase the invisibility of this segment of the senior community and their particular health needs—including treatment of their substance abuse.

Issues and Trends

Epidemiological data and information related to substance abuse among the LGBT population are, for the most part, limited to regional or local studies of specific populations (e.g., lesbians, men living with or at risk for HIV). The two most commonly cited substance abuse data sets—the National Household Survey on Drug Abuse and the Monitoring the Future Study—at present do not include sexual orientation or gender identity as demographic variables in their data sets, nor do they ask questions that would yield data for the different populations within the LGBT community. Moreover, the same challenges that confront substance abuse research in general also pertain to studies designed to result in a reliable, accurate picture of the incidence and prevalence of substance abuse among LGBT populations. These include:

- Clear and consensus-based terms and definitions for "lesbian," "gay," "bisexual," and "transgender." Although widely recognized and accepted, these terms are often clouded by ambiguity when used for research purposes. Similarly, in most existing studies, definitions of sexual orientation are based on self-report, or no mention is made of how this variable was assessed[7]
- The impact of stigma and, in some jurisdictions, the fear of legal impact on those individuals participating in and accurately reporting for studies of substance abuse
- Ethical issues, particularly related to assurances of confidentiality for those participating in prevention and treatment programs, which are important sources of information on use patterns and factors that influence recovery
- A lack of standard diagnostic criteria to assess substance abuse or substance dependence

Studies of alcohol and other drug use in the LGBT community have focused primarily on lesbians and gay men. Few have been designed specifically to include bisexual or transgender persons. The relative lack of national data—and of data for the bisexual and transgender population in particular—is due largely to the cost of oversampling smaller populations in general and concerns regarding the statistical significance of the data obtained. This renders comparison of substance abuse indicators and risk factors among these populations difficult. However, a synthesis of available research indicates that

substance abuse is at least as serious a public health problem for the LGBT community as it is for the general population in the United States.[8] Data on substance use, together with information regarding barriers to care and factors that contribute to recovery, inform culturally relevant and effective prevention and treatment strategies.

Early research on substance abuse among lesbians and gay men reported alarmingly high rates of drinking and other drug use.[9, 10] These qualitative research studies were carried out in the absence of disaggregated data for this population from national data sets. However, because of the nature of the research (relatively small, nonrepresentative samples and lack of comparison groups), the results could not—nor were they intended to —be generalized to the LGBT population. Studies conducted in the 1980s reported lower rates of heavy drinking among lesbians than earlier studies. However, these studies suggested that, compared with heterosexual women, lesbians were more likely to drink and more likely to experience alcohol-related problems.[11, 12, 13] Overall, recent data suggest that substance use among lesbians and gay men—particularly alcohol use—has declined over the past two decades. However, both heavy drinking and use of drugs other than alcohol appear to be prevalent among young lesbians and gay males, and among some older groups of lesbians and gay men.[14, 15] Reasons for this may include greater awareness and concern about health and more moderate drinking among women and men in the general population, some lessening of the social stigma and oppression of lesbians and gay men, and changing norms associated with drinking in some lesbian and gay communities.

"Club" drugs such as amyl nitrite, ketamine, and ecstasy, or 3,4-methylenedioxymethamphetamine (MDMA), are receiving national attention. Many of these drugs have been in use for several decades, but the prevalence seems to have increased sharply, especially at late-night dance clubs and at dance parties known as "raves."[16] Although no national studies can verify the prevalence of ecstasy, among LGBT people, Cohen, who has written one of the most definitive books on ecstasy, alluded to its popularity among gay and lesbian populations.[17] Klitzman and colleagues explored the association between abuse of ecstasy and high-risk sexual behaviors among gay men. Although the study had many methodological limitations, the results suggested there was a strong association with high-risk sexual behaviors and MDMA.[18] The National Institute on Drug Abuse is funding a study to investigate methamphetamine and other drug abuse patterns of men who have sex with men in relation to HIV risk behaviors.[19]

Few substance abuse studies have included sufficient numbers of bisexual persons to permit separate analyses, and no studies to date have focused exclusively on this subset of the population. Data from bisexual men and bisexual women are usually combined with that of gay men and lesbians, respectively. This most likely reflects an unexplored assumption that bisexual men and bisexual women share more in common with gay men and lesbians, respectively, than with heterosexual men or women. Therefore, many of the studies of presumed gay men or lesbians are likely to include some proportions of bisexual men or bisexual women. Notably, bisexual men are included in studies of gay men in much greater numbers than bisexual women in studies of lesbians. One reason for this is the

disproportionately high number of studies that have as a major aim greater understanding of risk factors associated with STDs, including HIV/AIDS, among men who have sex with men. Thus, it is *behavior*, rather than *identity*, that is of primary concern in most of the research on substance use among gay and bisexual men.

Scant research has been carried out concerning substance abuse among transgender persons,[20] and the few studies that do exist have been conducted as part of HIV-related research. These studies have typically employed convenience samples from large urban areas, and their conclusions cannot be generalized to transgender persons as a whole. Nevertheless, they do provide evidence of the extent of substance abuse problems in some urban transgender groups. One 1999 study done in San Francisco by the Department of Public Health found that, in the preceding 6 months, the drugs most commonly used by male-to-female (MTF) transgender persons were: marijuana (64 percent), speed (30 percent), and crack cocaine (21 percent); female-to-male (FTM) transgender persons reported using only marijuana frequently (43 percent).[21] Another study, the results of which were publicized in 1999, reported that alcohol, cocaine/crack, and methamphetamines were the drugs most commonly used by MTF transgender persons in Los Angeles.[22] Another study, published in 1997 by the San Francisco Department of Public Health, of transgender individuals participating in focus group discussions in San Francisco found that lack of educational and job opportunities and low self-esteem were important factors contributing to drug and alcohol abuse.[23]

Disparities

There is evidence to suggest that gay men and lesbians perceive themselves to be at increased risk for alcoholism and substance abuse, that they have an increased need for treatment, and that they face barriers to treatment. Gay men and lesbians report alcohol problems nearly twice as often as heterosexuals, even though heavy drinking patterns do not seem to differ significantly by sexual orientation.[24] Alcohol consumption rates among gay men and lesbians do not seem to decrease with age as quickly as they do among heterosexuals.[25, 26, 27, 28]

Too few studies of substance use or abuse in LGBT populations have included sufficient numbers of racial/ethnic minority persons to permit separate analyses. However, the interaction of gender and race/ethnicity also is apparent in LGBT populations, though not always in the same form as in the general population. There is some evidence to suggest that African American men are more likely than White men to trade sex for drugs.[29] Because heavy drinking is prevalent in the Latino heterosexual culture and gay male culture, Latino gay men may have higher rates of drinking than either group alone.[30]

Some studies done in the early 1990s indicated that treatment facility staff members often are not trained in providing gay- and lesbian-specific treatment and that facilities often have few or no gay staff members.[31] Meanwhile, other studies done during the same period and in 1997 suggest that gay, lesbian, and bisexual clients are more willing to participate in treatment programs that address gay issues and are less likely to adhere to treatment

recommended by homophobic mental health care providers.[32, 33] Additional research is needed to better understand the unique treatment needs of LGBT populations and the role of cultural factors in shaping and influencing patterns of substance use and sexual behavior. Such factors—such as reliance solely on bars and clubs as a means of socialization, stress caused by discrimination and prejudice, and advertising by liquor companies in magazines and publications that target gay men and lesbians—have been documented but continue to be insufficiently understood.[34, 35]

Notwithstanding the urgent need to address substance abuse among the LGBT adolescent population, there continues to be a serious lack of alcohol-free and drug-free alternative activities for both coming-out or questioning youth and the LGBT adult population. In part because of this lack of opportunities, coming-out youth may have few other options than to enter LGBT society via clubs and bars, where they are susceptible to exposure to the use of tobacco, alcohol, and illicit drugs. Without question, LGBT communities share the responsibility for establishing safer and healthier opportunities for LGBT individuals to gather and socialize. At the same time, there are indications that LGBT communities are to be among those populations apparently targeted by the alcohol industry.[36]

Environmental as well as individually oriented prevention is useful for reducing consumption among youth and reducing alcohol-related problems among adults. Many environmental prevention strategies that have demonstrated effectiveness in the general population may also be appropriate for LGBT communities. These strategies might include responsible beverage services, promotion of alcohol-safe community events, and development of policies related to alcohol and other drugs in LGBT service and social organizations.[37] LGBT communities may also consider developing guidelines for organizations and community events on limiting alcohol and tobacco sponsorship and promotions.[38]

Accessible substance abuse treatment may be most problematic for transgender individuals. Many substance use programs are not sensitive to the needs of transgender individuals, and few have the capacity to address the realities faced by the transgender population.[39, 40] For example, the Transgender Substance Abuse Treatment Policy Group of the San Francisco Lesbian, Gay, Bisexual, Transgender Substance Abuse Task Force reported that transgender clients in substance abuse treatment programs experienced verbal and physical abuse by other clients and staff; requirements that they wear only clothes judged to be appropriate for their biological gender; and requirements that they shower and sleep in areas judged to be appropriate for their biological gender.[41] The reality is that transgender individuals tend to be "invisible" in program evaluation, intake, assessment, and other points in substance abuse prevention and treatment. Culturally sensitive instruments need to be designed and tested to evaluate the effectiveness of substance use programs at all levels (e.g., prevention, treatment, outpatient, inpatient, detoxification). This is especially important for programs serving youth.

Opportunities

Healthy People 2010 states that the direct application of prevention and treatment research knowledge is particularly important in solving substance abuse problems. Developing adaptations of research-proven programs for diverse racial and ethnic populations, field-testing them with high-quality process and outcome evaluations, and providing them where they are most needed are critical. Interventions appropriate to the population to be served, including interventions to address gaps in substance abuse treatment capacity, must be identified and implemented by Federal, tribal, regional, State, and community-based providers in a variety of settings.

For LGBT populations, however, it is unclear if prevention and treatment strategies that have demonstrated success in heterosexual populations will yield the same benefits for LGBT individuals. For example, studies indicate that school-based programs focused on altering perceived peer-group norms about alcohol use[42, 43] and developing skills in resisting peer pressures to drink[44, 45, 46] do reduce alcohol use among participating students. Communitywide programs involving school curricula, peer leadership, parental involvement and education, and community task forces also have reduced alcohol use among adolescents.[47] It is not known, however, if these strategies are equally successful in preventing alcohol and other drug use among LGBT students.

Many opportunities to prevent drug-related problems have been identified. Core strategies for preventing drug abuse among youth include raising awareness, educating and training parents and others, strengthening families, providing alternative activities, building skills and confidence, mobilizing and empowering communities, and employing environmental approaches. All of these strategies hold promise for preventing alcohol and other drug use among LGBT and questioning youth. In particular, creating and sustaining safer, alternative venues for LGBT and questioning youth to "come out" would represent a major step forward.

For substance abuse prevention to be effective, people need access to culturally, linguistically, and age-appropriate services; job training and employment; parenting training; general education; more behavioral research; and programs for women, dually diagnosed patients, and persons with learning disabilities. Particular attention must be given to young persons under age 18 who have an addicted parent because these youth are at increased risk for substance abuse. Because alcoholism and drug abuse continue to affect lesbians, gay men, and transgender persons at two to three times the rate of the general population,[48] culturally competent programs that address the special risks and requirements of LGBT individuals are needed.

Discussion of Healthy People 2010 Objectives

26-9: Increase the age and proportion of adolescents who remain alcohol- and drug-free.

Available data related to youth who identify as lesbian, gay, or bisexual; who have had same-sex experiences; or who are perceived by their peers as being lesbian, gay, or bisexual and are subsequently harassed show a significantly higher prevalence use of alcohol and other drugs than their peers who identify as heterosexual or who have had no sexual experience. In a 1997 Massachusetts Youth Risk Behavior Survey of lesbian and gay youth and those who reported having same-gender sex, 46 percent reported ever having used hallucinogens, 77 percent reported ever having used marijuana, and 33 percent reported having ever used cocaine.[49]

Illicit drug use among LGBT youth. One school-based study, which used CDC's Youth Risk Behavior Survey and was the first to examine the association between sexual orientation and health-risk behaviors, found that self-identified lesbian, gay, and bisexual youth, who made up 2.5 percent of the cohort, were more likely than heterosexual youth in the sample to have used multiple substances. The study also found that lesbian, gay, and bisexual youth were more likely to have been victimized, threatened, and engaged in a variety of risk behaviors, including suicidal ideation and attempts as well as high-risk sexual behavior.[50] A longitudinal study of African American and Hispanic gay and bisexual adolescent males found that protective factors and reduced sexual risk-taking were associated with reduced substance use, anxiety, and depression as well as increased self-esteem.[51]

The 1997 Vermont Youth Risk Behavior Survey found that youth with same-gender sexual experience used drugs and alcohol significantly more than other youth. Some 64 percent smoked cigarettes in the past 30 days; 16 percent drank alcohol daily for the past 30 days; 22 percent reported smoking marijuana 10 or more times in the past 30 days; 29 percent reported using cocaine in the past 30 days; and 19 percent injected illegal drugs two or more times in their life.[52]

The 1997 Wisconsin Youth Risk Behavior Study compared 9th through 12th graders who reported having been threatened or hurt because someone thought they were lesbian, bisexual, or gay with those who reported no such harassment. Of those who reported harassment based on the perception of being lesbian, bisexual, or gay, 53.3 percent had smoked cigarettes in the last 30 days; 51.7 percent had used marijuana in the past 30 days; 38.3 percent had sniffed inhalants (glue, aerosol cans, paints) ever; 25.0 percent had used LSD ("acid") ever; and, 23.3 percent had used cocaine (powder, freebase, or crack) ever.[53]

CDC's Youth Risk Behavioral Survey and its Behavioral Risk Factor Surveillance System questionnaire would serve as an ideal future data collection survey for past-month use among LGBT individuals. The Center for Substance Abuse Treatment (CSAT) has invited the National Association of Alcoholism and Drug Abuse Counselors and five other professional associations (the American Association of Marriage and Family Therapists, the American Counseling Association, the American Psychological Association, the American

Psychiatric Association, and the National Association of Social Workers) to gather the information needed to develop a national plan on addictions. Each association will collect information specific to CSAT's needs through a practitioner research network—a group of professionals from a variety of settings/services who provide information on clinical and service delivery issues. The questionnaire asked gender identity and sexual orientation questions of both providers and the clients they treat. (More information is available online at www.lewin.com/naadac.)

26-10: Reduce past-month use of illicit substances.

Past-month use of illicit substances is a measure used in nearly all standardized national, State, and local surveys. However, these surveys do not measure past-month use using sexual orientation or gender identity as demographic variables.

In 1996, the National Household Survey on Drug Abuse (NHSDA), administered by the Substance Abuse and Mental Health Services Administration (SAMHSA), asked one question that focused on sexual behavior and the relationship between substance use and the risk of HIV transmission. Because the question was asked during only one survey year, longitudinal analyses are not available. Even if NHSDA had continued to ask the question, only longitudinal analyses regarding sexual behavior—not sexual orientation—would have been possible.

CDC, which administers the Youth Risk Behavior Survey and the Behavioral Risk Factor Surveillance System survey, permits States to add additional questions, including questions related to sexual orientation or gender identity. Several States, such as Massachusetts and Vermont, have subsequently revised their surveys to include questions specific to sexual orientation. To date, no States measure gender identity as a demographic variable in data collection.

There is a need to develop a simple, standardized way to obtain valid, LGBT-specific data from a variety of venues across the United States, including the use of quantitative and qualitative research methods to elicit information on use patterns, effective prevention programs, and treatment-seeking and recovery behaviors.

Qualitative research can yield critical information for prevention and treatment programs targeting the LGBT community. For example, such research can be used to gather information regarding the role of alcohol and other drugs in the LGBT socialization process, including bars and "circuit parties"—large, international dance events organized and attended by gay and bisexual men. Held at primarily urban venues across the United States, circuit parties have become an increasingly popular alternative to the more traditional local club and bar scene, with participants often flying thousands of miles to attend any one of a number of weekend-long annual events held across the country.

Illicit substance use among gay and bisexual men. An analysis of NHSDA data found that people with same-sex partners were more likely to use illicit substances than people with opposite-sex partners.[54] About one-third of nearly 170 gay and bisexual men who

participated in a survey on MDMA (ecstasy) reported using the drug at least once a month.[55] A survey conducted at the April 2000 Millennium March in Washington, D.C., asked 730 men who self-identified as gay males, "How often are party drugs used in your close circle of friends?" Some 26.3 percent reported that party drugs are used once a month, 13.4 percent reported party drugs are used one or more times a week, 21.9 percent reported one or two times a year, and 38.4 percent reported that party drugs are never used in their circle of friends.[56]

There is also evidence that, even though drug use and heavy alcohol use may decline as gay and bisexual men get older, levels of substance use still remain high and may continue to jeopardize the health of gay and bisexual men.[58]

The 1992 Research Symposium on Alcohol and Other Drug Problem Prevention Among Lesbians and Gay Men Proceedings (California Department of Alcohol and Drug Programs) included consensus among participating researchers that there was more heavy drinking among lesbians and gay men than in the general population and that it persisted later into life than is typical in general population samples. In fact, lesbians were shown to drink more heavily than either nonlesbian women or straight men and more like gay men.[57]

Most gay and bisexual men living with HIV infection and substance use disorders either discontinue or reduce substance use before or subsequent to finding out they are HIV-positive, most likely in an attempt to adopt a healthier lifestyle; however, persistent substance abuse or dependence among some HIV-positive men is accompanied by higher levels of distress and diminished quality of life, which underscores their need for treatment.[59] Meanwhile, of 3,220 HIV-negative men who have sex with men who participated in an HIV vaccine preparedness study, 49 percent reported using marijuana, 29 percent reported using nitrate inhalants, 21 percent reported using amphetamines or similar stimulants, 14 percent reported using cocaine, and 14 percent reported using hallucinogens. Nearly 90 percent of all participants reported alcohol use.[60]

Illicit drug use among lesbians and women who have sex with women. Comparisons of data on lesbians and women from the general population show that lesbians tend to drink more than other women. It is important to note that lesbians and gay men are less likely to abstain from alcohol use. Lower rates of abstention show up more consistently in studies than higher rates of "heavy" drinking and may contribute to higher rates of reported problems.[61] Lesbians also report greater difficulties related to alcohol consumption.[62] The 1988 National Household Survey on Drug Abuse data on the prevalence of 12 illicit and licit drugs by sex and age group and the demographic predictors of past-year frequency of marijuana, alcohol, and cigarette use in a southern State found differences between gay men and lesbians in the use of specific substances and the demographic predictors of drug use.[63]

A Seattle-based study comparing risk factors for HIV and other STDs in women who reported having had sex with both men and women to women who reported having had sex with men found only that women with a history of bisexual behavior were more likely to

report past-month drug use than exclusively heterosexual women.[64] Meanwhile, a self-report survey of 263 lesbians found that levels of stress, social support, and coping styles were not predictive of problematic substance use.[65] The K-Y Community Health Survey asked 307 self-identified lesbians, "How often are party drugs used in your close circle of friends?" Although 61.9 percent reported that party drugs are never used in their group of friends, 11.4 percent reported once a month, 5.9 percent reported one or more times a week, and 20.8 percent reported one or two times a year.[66] These findings add to the growing, yet preliminary, body of knowledge that party drug use among lesbians is on the rise.

Illicit substance use among transgender people. Except for studies that specifically examined transgender people, there is little information about illicit substance use among transgender individuals. One study examining the past month substance use of 209 transgender women found that 37 percent used alcohol, 13 percent used marijuana, 11 percent used methamphetamine, 11 percent used crack, 7 percent used powdered cocaine, and 2 percent used heroin.[67] Generally, other studies of substance use are not designed to identify transgender persons within the study sample. It should be noted that asking about sexual orientation or the number of lesbian and gay clients served does not identify transgender men and women.

26-12: Reduce average annual alcohol consumption.

Long-range trends on apparent per capita ethanol consumption by beverage type provide a historical perspective on national patterns of alcoholic beverage consumption. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) uses a drinking population aged 14 and older to calculate per capita consumption rates. NIAAA, with the National Institute of Child Health and Human Development, announced in May 2000 the results of their first study to determine whether future drinking may be predicted by response to stress during infancy. According to NIAAA Director Enoch Gordis, M.D., "If borne out in humans, these findings elucidate the alcohol-stress relationship in two ways: They confirm that early life stress can influence later alcohol consumption, and they offer a promising biological marker of risk for excessive drinking."[68]

The K-Y Community Health Survey conducted in the year 2000 asked more than 1,030 respondents about their weekly alcohol use. Among 730 self-identified gay male respondents, 45.1 percent reported that they consume alcohol once a week or less, 28.4 percent reported using alcohol two or three times a week, and 14.6 percent reported using alcohol four times a week. Among 307 self-identified lesbian respondents, 57.4 percent reported using alcohol once a week or less, 20.5 percent reported consuming alcohol two or three times a week, and 14.6 percent reported using alcohol four times a week. Nearly 12 percent of gay males and nearly 6 percent of lesbians who participated in the survey reported that they never use alcohol. Lesbians ranked alcohol abuse as the second highest health concern for the community, and more than 30 percent of gay men reported the same concern.[69]

26-13: Reduce the proportion of adults who exceed guidelines for low-risk drinking.

Most States in the United States and the District of Columbia collect data on alcoholic beverage sales data. For States with no such data, shipment data are obtained from the Beer Institute (which also includes data from the Distilled Spirits Council of the United States). State population estimates for persons aged 14 and older were obtained from the U.S. census. (To calculate State-level estimates of per drinker ethanol consumption, estimates of abstainers are taken from CDC's Behavioral Risk Factor Surveillance System.)

Future potential data sources for collecting LGBT-specific data relevant to this objective include the following:

- Alcohol Epidemiologic Data System, from NIAAA. Specific instruments include the National Alcohol Survey, a multistage-area probability sample of adult respondents, aged 18 and older whose ninth issuance was in 1995-96. (One variable was quantity/frequency measures of total alcohol consumption.)
- NIAAA and CDC's National Center for Health Statistics, National Health Interview Survey, Alcohol Sections, 1983 and 1988. Variables included detailed information on quantity and frequency of alcohol consumption.
- SAMHSA's National Household Survey on Drug Abuse. Variables include detailed information on consumption.
- National Institute of Child Health and Human Development and 17 other Federal agencies' National Longitudinal Study on Adolescent Health, Wave I (1994) and Wave II (1995), which includes a variable on alcohol consumption.
- U.S. Department of Labor, National Opinion Research Center and Center for Human Resource Research's National Longitudinal Survey of Youth (1979-97), a multistage, stratified area probability sample of youth aged 14 to 21. Variables include consumption of various alcoholic beverages.
- CDC's Youth Risk Behavior Survey.

Many of these surveys will be repeated in the future depending upon funding and interest. The dates given should be used only as reference points for previous iterations of the surveys.

26-17: Increase the proportion of adolescents who perceive great risk associated with substance abuse.

The perception of risk in using illegal drugs is an important factor in decreasing drug use. As perception of harm decreases, use tends to increase.[70] Therefore, youth, including LGBT and questioning youth, need to be informed of the many risks, such as HIV infection, associated with substance use. People who use or abuse drugs or alcohol sometimes reported being so high or intoxicated that they forgot to use a condom.[71] Therefore,

informing youth about the connection between substance use and other problem behaviors, such as unsafe sex, dating violence, and suicide, is critically important.

The 1998 National Household Survey on Drug Abuse found the percentage of adolescents aged 12 to 17 who perceive great risk associated with substance abuse is on the decline.[72] The percentage perceiving great risk in using marijuana once a month decreased from 40 percent in 1990 to 30.8 percent in 1998. The percentage of youth perceiving great risk in using cocaine once a month decreased from 63 percent in 1994 to 54.3 percent in 1998. Perception of risk in having five or more drinks once or twice a week decreased from 58 percent in 1992 to 47 percent in 1998.[73] Because NHSDA does not include sexual orientation or gender identity as a demographic variable in its data set, data on LGBT and questioning youth are not available. The attitude of influential adults about alcohol and other drugs is another critical predictor of attitudes in youth. It is important that surveys measure both identity and behaviors because questions about identity, behavior, and attraction often yield different response rates. Identity questions generally have the lowest response rate because many people involved in same-sex relationships do not identify with terms commonly used in surveys. Questions about behavior and attraction may be less intimidating or invasive for the respondent, and as a result, may produce more accurate information.[74]

Many adults who have regular contact with youth communicate ambivalent messages about alcohol and drug use.[75] This may be particularly true for LGBT and questioning youth whose primary venues for "coming out" are bars and clubs. LGBT adults who consume alcohol, drugs, and tobacco products may have a powerful role in influencing young LGBT people's perception of risk. As a result, the messages about harm and risk that they receive are sometimes impacted by LGBT community dynamics and denial. Risk and harm messages targeted to youth, including LGBT youth, therefore, must take this into account.

26-18: (Developmental) Reduce the treatment gap for illicit drugs in the general population.

Healthy People 2010 defines treatment gap as "the difference between the number of persons who need treatment for the use of illicit drugs and the number of persons who are receiving treatment in a given year." The document estimates that, given this definition—which includes illicit drugs only—5.3 million Americans are in need of treatment services that are not available.

Healthy People 2010 also addresses the critical gap in treatment services for alcohol problems, but does not estimate the number of individuals for whom services are not available, suggesting only that ". . . availability of resources and access to clinically appropriate and effective treatment for alcohol problems are limited." However, an estimated 5.6 million individuals meet the diagnostic criteria for alcohol abuse, and it can be assumed that a significant proportion of them do not have access to treatment. There have been no specific studies of treatment gaps for the LGBT population; there are therefore no precise numerical estimates of treatment gaps. Although there have been rough estimates of needs for treatment for specific populations based on proportions in the general population, these are not considered to be of adequate validity.

There is evidence that "gay men and lesbians . . . have increased need for drug and alcohol treatment, and that they face particular barriers in accessing it."[76] The barriers to treatment for both illicit drugs and alcohol, several of which are cited in Healthy People 2010 for the general U.S. population, are essentially the same for the LGBT communities:

- Financial barriers that result from public funding mechanisms (e.g., Substance Abuse Prevention and Treatment Block Grant Program, Medicaid, Medicare, demonstration programs) and from private-sector funding sources (which may allocate only a limited number of treatment slots)
- Financial barriers related to inadequate health and disability insurance coverage
- Lack of culturally appropriate treatment methods
- Lack of trained personnel
- Lack of knowledge and information regarding treatment effectiveness

26-21: (Developmental) Reduce the treatment gap for alcohol problems.

Little attention has been paid to the lack of treatment programs designed to reach LGBT populations. There are presently no requirements that block grant programs, or other Federal grant programs, include LGBT populations in the classification of "vulnerable" populations that could be targeted through these funding mechanisms. Through demonstration research programs (e.g., CSAT-sponsored targeted capacity grants), several treatment programs that target LGBT populations have been funded and are participating in cross-site studies of treatment effectiveness. Some treatment programs funded through other federally funded initiatives (e.g., Residential Programs for Women and Their Children) and other State-funded programs have services that meet the specific needs of LGBT populations. However, most of these are outpatient programs.

Self-help groups are another source of treatment. According to Beatty and colleagues, as of 1999, the Fellowship of Alcoholics Anonymous (AA) reported that, in addition to the more than 500 AA gay groups in the United States, many AA groups are "gay-friendly," and Women for Sobriety, although not as widespread as AA, is increasingly used by lesbians, who find the support more culturally appropriate. However, the authors note, "gay-specific inpatient treatment centers are scarce, considering the number of gay individuals with alcohol and drug abuse problems."[77]

Education and training of treatment program staff in cultural issues related to and appropriate services for the LGBT population are critical if the availability of effective services is to be enhanced. Whether or not the number of treatment slots is increased, treatment staff must be adequately prepared to provide culturally appropriate and LGBT-competent treatment services for alcohol and other drug use as well as for the physical, mental health, and other service needs associated with substance abuse. Citing a 1991 report, Dean suggests that "Assessments of alcohol and drug treatment facilities have

documented lack of staff training in treatment issues for gay and lesbian alcoholics, and few or no gay staff."[78]

There also is a need for LGBT-specific standards of care and protocols that are generally acceptable or sanctioned by national accreditation bodies (e.g., American Society of Addiction Medicine, Health Care Quality Assurance). Such standards could be used as the basis for certification of clinical staff or licensing of treatment programs as well as the basis for staff training programs.

Adequate data are needed to estimate the need for, demand for, access to, and availability of treatment facilities for LGBT populations. As with Healthy People 2010, this Companion Document recommends that the National Household Survey on Drug Abuse be reviewed as a potential data source. In order to use this periodic survey to obtain useful data on various aspects of treating LGBT populations for substance abuse, specific questions regarding gender identity, gender presentation, sexual orientation, and sexual practices would have to be added to the current survey instrument. In addition to this survey, three additional federally supported surveys are potential sources of data: (1) Treatment Episodes Data System (SAMHSA), (2) National Hospital Ambulatory Medical Care Survey (CDC), and (3) National Health Interview Survey (CDC). As with NHSDA, questions regarding gender identity/presentation and sexual orientation/practices would have to be added to these surveys. For the latter two, specific questions regarding access to and use of alcohol and other drug treatment would be added.

In addition to these national data sets, both public (Federal and State) and private (foundation, corporation, and third-party payer) funding should be significantly expanded to support research related to treatment-seeking behavior by the LGBT population. Additional research is also needed on the availability of culturally appropriate alcohol and other drug treatment services and effectiveness of treatment in the LGBT population. These studies could be supported through existing Federal initiatives (e.g., CSAT Expanding Capacity program) or through new initiatives directed toward the LGBT population. The studies could include both quantitative and qualitative research methods.

There are no available research studies that have identified best practices among alcohol and other drug treatment programs. LGBT-specific standards for existing treatment services are severely lacking, and LGBT-identified and LGBT-appropriate programs for those who need and could benefit from them are not widely available. Anecdotal evidence suggests that alcohol and other drug treatment programs frequently fail to consider the identities and needs of transgender persons, thereby compromising effectiveness. Treatment personnel may inappropriately require transgender persons to conform to the gender of their birth sex. In the case of inpatient treatment programs, this may result in persons who live full-time as women being housed with men or being required to use male rest rooms. Such policies predictably interfere with the treatment relationship and are not conducive to recovery. Programs may also inappropriately require transgender persons to stop using cross-gender hormones as part of a treatment or detoxification protocol. This can cause significant mental distress and can reduce treatment adherence and effectiveness.

26-23: (Developmental) Increase the number of communities using partnerships or coalition models to conduct comprehensive substance abuse prevention efforts.

According to Healthy People 2010, "a comprehensive program of interventions at the community level is crucial to effective substance abuse prevention." Citing a study of 48-community partnerships funded by SAMHSA's Center for Substance Abuse Prevention (CSAP), Healthy People 2010 describes seven characteristics that are shared among partnerships in communities showing statistically significant reductions in substance abuse. These characteristics have been adapted to include treatment and prevention foci as well as findings of other studies of integrated (comprehensive) health and social service delivery programs and systems. Therefore, apparently successful partnerships or coalitions in communities showing statistically significant reductions in substance abuse treatment have:

- A communitywide vision that reflects the consensus of diverse groups and citizens throughout the community
- A strong core of community partners
- An inclusive, broad membership of organizations from all parts of the community
- Specific mechanisms for avoidance or resolution of conflict
- Decentralized groups that implement a large number of locally tailored prevention and treatment programs that effectively target local causes of drug use and empower residents to take action and made decisions
- Services that are culturally appropriate for the population(s) served
- Low staff turnover
- Clearly defined and implemented agreements among programs for referrals and shared resources
- Extensive prevention and treatment activities and support for improvements in local prevention and treatment policies

Neither this CSAP-funded research nor any readily available studies regarding community partnerships and coalitions related to substance abuse disaggregate information to indicate the level of involvement of LGBT organizations and individuals in such community partnerships and coalitions. There are examples of involving LGBT organizations (primarily gay organizations) in community coalitions formed to address HIV/AIDS. However, there is no evidence that LGBT representatives or organizations have been involved on a routine basis in the planning and implementation of programs funded by federally supported initiatives related to integrated services (e.g., Starting Early Starting Smart, HIV Outreach).

Research on the impact of partnerships and coalitions on the incidence and prevalence of alcohol and other drug use and on treatment effectiveness is minimal. The only available

study of impact of prevention-focused programs is the CSAP-funded study cited above. That study, however, does not provide data regarding the involvement of LGBT organizations or individuals in the partnerships. Because of the increasing attention to community-based partnerships and integrated services, it is important that research related to the impact of these efforts on substance abuse treatment outcomes among the LGBT population be supported.

Services—RECOMMENDATIONS

- Health education and prevention-oriented materials on health risks related to substance abuse should be developed for and directed to LGBT youth.
- On college campuses, where binge drinking often occurs, LGBT students or local LGBT-friendly health clinics need to be included in health education and prevention programs aimed at reducing binge drinking.
- Providers should review how consumer data are collected for statistical purposes, program reporting requirements, and funding or reimbursement sources and should discuss with the data collection entities how best to collect baseline data on health needs and services usage by LGBT consumers.

Education and Training—RECOMMENDATIONS

- Mental health and substance abuse counselors should receive cultural competency training that includes addressing the health and other needs of LGBT youth and adults.
- Substance abuse and mental health providers, as well as LGBT persons, need to be made aware that people who meet the "disability" eligibility criteria in Medicare may be eligible for Medicare-covered alcohol and other drug treatment services.
- Culturally competent health education materials on low-risk drinking, or responsible alcohol use, and high-risk drinking need to be developed for and directed to the LGBT community.

Policy—RECOMMENDATIONS

- Federal and State funding for health services programs need to be linked to community-based prevention and treatment efforts; LGBT persons need to be included in the community-based planning process along with representatives from other underserved or unserved populations; and cultural competency guidelines need to be established so that individuals are not denied access to care based on their sexual orientation or gender identity.
- Community partnerships and coalitions should seek cultural competency training and technical assistance from LGBT organizations and service agencies so community planners may better understand and incorporate the health care needs of LGBT populations into planning efforts.

- Federal and State governments should develop demonstration projects that support community partnerships and coalitions that are convened to address the substance abuse prevention and treatment needs of LGBT communities.

Research—RECOMMENDATIONS

- Sexual orientation and gender identity should be included as demographic variables in national substance abuse surveys, such as NHSDA and the Monitoring the Future Study.
- Model programs for school youth education programs that address homophobia and drug abuse should be developed.
- Additional studies are needed to assess the drinking habits of midlife and older LGBT individuals.

Terminology

Alcohol abuse: A maladaptive pattern of alcohol use that leads to clinically significant impairment or distress, as manifested by one or more of the following occurring within a 12-month period: recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home; recurrent alcohol use in physically hazardous situations; recurrent alcohol-related legal problems; or continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol. In the literature on economic costs, alcohol abuse means any cost-generating aspect of alcohol consumption; this definition differs from the clinical use of the term, which involves specific diagnostic outcomes.

Alcohol dependence: A maladaptive pattern of alcohol use that leads to clinically significant impairment or distress, as manifested by three or more of the following occurring at any time in the same 12-month period: tolerance; withdrawal; often taking alcohol in larger amounts or over a longer period than was intended; persistent desire or unsuccessful efforts to cut down or control alcohol use; spending a great deal of time in activities necessary to obtain alcohol or recover from its effects; giving up or reducing important social, occupational, or recreational activities because of alcohol use; or continued alcohol use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol.

Binge drinking: Defined by the National Household Survey on Drug Abuse as drinking five or more drinks on the same occasion on at least 1 day in the past 30 days; defined by the Monitoring the Future Study as drinking five or more drinks on the same occasion during the past 2 weeks.

Co-occurring disorders: The simultaneous presence of two or more disorders, such as the coexistence of a mental health disorder and substance abuse problem.

Drug dependence: A pattern of drug use leading to clinically significant impairment or distress, as manifested by three or more of the following occurring at any time in the same 12-month period: tolerance; withdrawal; use in larger amounts or over a longer period of

time than intended; persistent desire or unsuccessful efforts to cut down; spending a great deal of time in activities necessary to obtain drug(s); giving up or reducing important social, occupational, or recreational activities; or continued use despite knowledge of having a persistent or recurrent physical or psychological problem.

Inhalants: Fumes or gases from common household substances, such as glues, aerosols, butane, and solvents, that are inhaled to produce a high.

Injection drug use: The use of a needle and syringe to inject illicit drugs (e.g., heroin, cocaine, steroids) into the vein, muscle, skin, or below the skin. Injection drug use places the user at great risk for transmitting or contracting a number of blood-borne infectious diseases, including HIV, hepatitis B, and hepatitis C.

Substance abuse: The problematic consumption or illicit use of alcoholic beverages, tobacco products, and drugs, including misuse of prescription drugs.

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Tobacco Use

Healthy People 2010 Goal

Reduce illness, disability, and death related to tobacco use and exposure to secondhand smoke.

Overview

This chapter on tobacco use among lesbian, gay, bisexual, and transgender (LGBT) populations provides a literature review of tobacco use and its health implications for the LGBT community. It details tobacco initiation and use trends, and the potential health issues affecting LGBT populations because of smoking and exposure to secondhand smoke. Health disparities by age, race, ethnicity, socioeconomic status, education, biological sex, gender expression, and sexual orientation are summarized. The needs and opportunities to expand research and data collection on LGBT populations and their use of tobacco products are explored. Included in this review are strategies to incorporate LGBT populations in the population data to track the health promotion objectives of Healthy People 2010 concerning tobacco control and smoking cessation; recommendations for the inclusion of LGBT populations, particularly LGBT youth, in tobacco control efforts; and information on ways cultural competency measures may be effectively employed to better reach and serve LGBT populations. This chapter can be used as an educational tool for people interested in promoting healthy behaviors and preventing tobacco-related diseases among LGBT communities.

Issues and Trends

Tobacco use is one of today's most challenging health and social problems. Early use of tobacco as well as alcohol has been linked clearly to later substance abuse and behavioral problems.[1, 2] Scientific knowledge about the health effects of tobacco use has increased greatly since the first Surgeon General's report on smoking was released in 1964.[3, 4] The current Surgeon General's Report acknowledges that smoking rates among teens and adults could be cut in half within the next 10 years if the United States would fully implement antismoking programs using effective approaches that are already available.[5]

Rigorous surveillance, prevention, and treatment research are needed to change the cultural, psychosocial, and environmental factors that influence tobacco use, and to improve our understanding of smoking patterns and identify strategic tobacco control opportunities. Community-based programs can address risk factors that are identified for specific population groups. However, little is known about tobacco use among lesbian, gay, bisexual, and transgender populations and the effectiveness of prevention and treatment strategies within LGBT populations.

The single most important high-risk behavior associated with the leading chronic diseases is cigarette smoking.[6] Although cigarettes have multiple components, most attention is accorded to nicotine. This drug—nicotine—is not only highly addictive but also has been proven to contribute to cardiovascular disease.[7] The "safe cigarette," long sought after, has not been found.[8, 9]

Other popular forms of tobacco, such as cigars and bidis (small, imported, brown cigarettes that are hand-rolled in Tendu or Tamburni) are not safe alternatives to smoking commercial cigarettes. Cigar use causes cancer of the larynx, mouth, esophagus, and lung.[10] Research shows that bidis are a significant health hazard to users, increasing the risk of coronary heart disease and cancer.[11] Reports have shown an increase in the popularity of bidis, particularly among youth, despite their potential negative health implications.[12]

The rate of smoking among adults in 1997 was 25 percent.[13] Studies have found higher levels of cigarette use among gay men and lesbians than among heterosexuals.[14,15,16,17] Recent representative studies of tobacco use seem to confirm that the prevalence rate of tobacco use among gay men is dramatically higher than among men in the general population. For

The American Legacy Foundation (ALF) is a philanthropic organization formed as a result of the historic 1999 tobacco settlement agreement. Its purpose is to promote national, State, and local smoking cessation and tobacco control programs. In November 2000, ALF convened more than 50 health researchers and professionals serving the LGBT population for a national health forum focused on tobacco use in the LGBT community. Forum participants discussed the various ways tobacco use impacts the LGBT community and made recommendations to ALF for the promotion of LGBT-specific tobacco control and smoking cessation programs. Forum participants reported a high prevalence of smoking in the LGBT community—particularly among youth, LGBT persons with low socioeconomic status, and LGBT people with mental illness. In addition, forum participants identified secondhand smoke as a potential health risk for LGBT people, since LGBT people are disproportionately represented as employees and consumers in venues (i.e., bars, clubs, and restaurants) with a more tolerant attitude toward smoking. Furthermore, participants reported an increase in smoking as a cultural norm among LGBT youth, particularly rural youth, runaway/homeless youth, and youth who accessed LGBT youth centers. Given the clear health needs of this community, ALF has prioritized LGBT populations for targeted interventions, research, and a range of health promotion activities designed to reduce smoking and other tobacco use. (More information can be found online at www.americanlegacy.org.)

example, a study reporting in 1999 found that 41.5 percent of gay adults in a household-based sample identified as smokers[18]—a rate that far exceeds the rate reported in other studies of men in the general population.[19, 20]

Tobacco initiation and addiction usually begin in adolescence. Among adults in the United States who have ever smoked daily, 82 percent tried their first cigarette before age 18, and 53 percent became daily smokers before age 18.[21]

Specific risk factors affecting youth initiating tobacco use include personal/individual, family, school, peer group, community, and society.[22] Many of the most important risk factors affecting tobacco use can be categorized as uncontrollable variables, such as genetic predisposition, age, and gender. More amenable to change are personal risk factors, including a lower self-image and lower self-esteem than peers, the belief that tobacco use provides a benefit, and the lack of ability to refuse offers to use tobacco.[23] From the prenatal stage through adolescence, the family—parents, caregivers, or parent surrogates—is the main influence in the development of youth and children, and the crucible in which problem behaviors and their antecedents are shaped.[24] For youth, failure in school is one of the strongest predictors of tobacco use.[25] The negative influence of peers is well established as one of the most important factors for youth, and the influence of peers continues to be important through adulthood.[26] There are many community risk factors that have been culled from the research.[27] One community risk factor that is relevant for LGBT youth is cultural disenfranchisement—i.e., a perception among youth that the dominant/mainstream culture is not relevant to them. Societal-level risk factors relate to national economic and employment conditions, discrimination, and marginalization of groups.[28] The relevance of these societal factors to LGBT people, especially youth, cannot be overstated.

The combination of influencing factors increases the risk of LGBT youth initiating tobacco use. In spite of the potential for increased risk, the short- and long-term effects of known risk factors, especially internalized and externalized homophobia, on smoking behaviors among LGBT youth is unstudied. And although youth have emerged as a major focus for tobacco use control efforts, LGBT youth with their specific risk circumstances have not been identified for preventive interventions.

Tobacco use among adolescents increased in the 1990s. Data from the 1999 Monitoring the Future Study indicated that past-month smoking among 8th-, 10th-, and 12th-graders was 18, 26, and 35 percent, respectively. These rates represented increases of 20 to 33 percent since 1991.[29] Data from the Youth Risk Behavior Survey revealed that past-month smoking among 9th- to 12th-graders rose from 28 percent in 1991 to 36 percent in 1997.[30] In 1997, past-month cigar use among 9th- to 12th-graders was 22 percent (11 percent of females and 31 percent of males).[31] The data necessary to determine tobacco use among LGBT youth were not collected in these studies as respondents were not questioned regarding sexual orientation or gender identity.

Tobacco use is responsible for more than 430,000 deaths per year among adults in the United States, representing more than 5 million years of potential life lost.[32] If current

tobacco use patterns in this Nation persist, an estimated 5 million persons under aged 18 will die prematurely from a smoking-related disease.[33]

In addition to smoking tobacco, exposure to secondhand smoke has serious health effects.[34, 35,36] Researchers have identified more than 4,000 chemicals in tobacco smoke. Of these, at least 43 cause cancer in humans and animals.[37] Each year, because of exposure to secondhand smoke, an estimated 3,000 nonsmokers die of lung cancer.[38, 39] Studies also have found that secondhand smoke exposure causes heart disease among adults.[40,41] Data reported from a study of the U.S. population aged 4 and older indicated that, among non-tobacco users, 88 percent had detectable blood levels of serum cotinine, a biological marker for exposure to secondhand smoke.[42] Asthma and other respiratory conditions often are triggered or made more severe by tobacco smoke. Smoking seems to be the cultural norm for many social settings frequented by LGBT people (e.g., bars, circuit parties, dance clubs, youth centers), thereby giving weight to the notion that LGBT persons may be at disproportionately high risk for exposure to secondhand smoke and its associated negative health effects. However, additional research is needed to support or invalidate this thinking.

Disparities

Disparities in tobacco use exist among certain racial and ethnic populations. The 1998 Report of the Surgeon General[43] responded to the need to analyze thoroughly the smoking-related health status of racial and ethnic groups and to determine if there was a differential risk for tobacco addiction.[44] High risk might derive not only from personal characteristics, but also from social factors, such as changes in location, acculturation, and targeted advertising. Tobacco use varies within and among racial and ethnic groups. In general, the data suggest that "acculturation influences smoking patterns in that individuals tend to adopt the smoking behavior of the current broader community. . . ."[45]

American Indians and Alaska Natives (34 percent) are more likely to smoke than other racial and ethnic groups, with considerable variations in percentages by tribe.[46] Hispanics (20 percent) and Asians and Pacific Islanders (17 percent) are less likely to smoke than other groups. Regional and local data, however, reveal much higher smoking levels among specific subpopulation groups of Hispanics and Asians and Pacific Islanders.[47] Smoking levels among Vietnamese and Korean Asian Americans are higher than previously reported, according to a 1997 multilingual survey.[48] Additional research is needed to determine if sexual orientation or gender identity among people of color increases their risk for tobacco use.

Among adolescents, smoking rates differ between Whites and African Americans.[49, 50] By the late 1980s, smoking rates among White teens were more than triple those of African American teens. In recent years, smoking has started to increase among African American male teens, but African American female teens continue to have lower smoking rates.

Education and socioeconomic status are significant factors in determining the likelihood of tobacco use, including that among gay men and lesbians. Gay men and lesbians with higher

education levels are less likely to use cigarettes as frequently as those with lower levels of education.[51] Persons with 9 to 11 years of education (35 percent) have significantly higher levels of smoking than individuals with 8 years or less of education or 12 years or more. Individuals with 16 or more years of education have the lowest smoking rates (12 percent). Individuals below the poverty level are significantly more likely to smoke than individuals at or above the poverty level (33 percent compared to 25 percent)[52]—a fact that has important implications for the prevalence of smoking among LGBT individuals and families living in poverty.

Opportunities

Efforts to reduce tobacco use in the United States range from individually based interventions, primarily smoking cessation strategies, to more population-based interventions. Population-based interventions emphasize prevention of initiation, reduction of exposure to environmental tobacco smoke, and systems changes to promote smoking cessation.[53,54,55,56,57,58,59] Federal, State, and local government agencies and numerous health organizations have joined together to develop and implement these population-based approaches.

Smoking cessation research has generated the most advanced and effective brief and intensive behavioral intervention protocols.[60] Generally, these programs help patients to:

- Set a target date and specific plan for quitting
- Identify and cope with temptations likely to provoke relapse
- Effectively utilize nicotine replacement or other medications
- Solicit support from family or friends
- Secure continued followup and support services
- Prevent relapse

The U.S. Department of Health and Human Services' Agency for Healthcare Research and Quality, in partnership with the American Association of Health Plans and the American Medical Association, has developed a comprehensive Internet-based source for clinical practice guidelines. The National Guidelines Clearinghouse™ makes available a full range of current guidance on treatments for specific medical conditions or behaviors such as tobacco. (More information can be obtained online at www.guideline.gov.) More than 50 guidelines are relevant to tobacco, cigarette smoking, cessation programs, physician counseling, and nicotine replacement therapy.

Population-based community research studies and evidence from California, Florida, Massachusetts, and Oregon have shown that comprehensive programs can be effective in reducing average cigarette consumption per person. Both California and Massachusetts increased cigarette excise taxes and designated a portion of the revenues for comprehensive

tobacco control programs. Data from these States indicate that (1) increasing excise taxes on cigarettes is one of the most cost-effective short-term strategies to reduce tobacco consumption among adults and to prevent initiation among youth, and (2) the ability to sustain lower consumption increases when the tax increase is combined with an antismoking campaign.[61] In addition, recent data from Florida indicate that past-month smoking decreased significantly among public middle school students (from 19 to 15 percent) and high school students (from 27 to 25 percent) from 1998 to 1999 following implementation of a comprehensive program to prevent and reduce tobacco use among youth in the State.[62] Unfortunately, because sexual orientation and gender identity were not variables within these studies, it cannot be determined whether these strategies will yield similar success in LGBT communities.

The goals of comprehensive tobacco prevention and reduction efforts include preventing people from starting to use tobacco, helping people quit using tobacco, reducing exposure to secondhand smoke, and identifying and eliminating disparities in tobacco use among population groups. These principles hold true for LGBT populations as well. To address these goals, several approaches are being implemented: community programs, media interventions, policy and regulation, and surveillance and evaluation. Specifically, the following elements are used to build capacity to implement and support tobacco use prevention and control interventions: a focus on change in social norms and environments that support tobacco use, policy and regulatory strategies, community participation, establishment of public and private partnerships, strategic use of media, development of local programs, coordination of statewide and local activities, linkage of school-based activities to community activities, and use of data collection and evaluation techniques to monitor program impact.

The importance of these various strategic elements has been demonstrated in a number of States, such as Arizona, California, Florida, Massachusetts, and Oregon.[63] In these and other States, tobacco control programs are supported through funding from the Federal Government, private foundations, State tobacco taxes, State lawsuit settlements, and other sources. These programs address issues such as reducing exposure to secondhand smoke, restricting minors' access to tobacco, treating nicotine addiction, limiting the impact of tobacco advertising, increasing the price of tobacco products, and directly regulating the product (e.g., requiring product ingredient reporting).

Tobacco control programs and materials should be culturally and linguistically appropriate. Given the racial, ethnic, age, and gender diversity within the LGBT community, this concept is especially applicable to LGBT populations. It is essential that tobacco control programs, the agencies and organizations that sponsor these programs, and the staff and personnel who administer such initiatives are LGBT-competent, sensitive to the needs of LGBT persons, and respectful of the rights of LGBT individuals to confidentiality and privacy.

Summary of LGBT Research

Smoking among lesbians and gay men. Studies of tobacco use in gay and lesbian populations, like surveys of alcohol use, tend to use nonrandom samples. In most cases, subjects typically include bar patrons who report tobacco use rates that are substantially higher than their heterosexual counterparts.[64] However, unlike studies of alcohol use, more recent representative studies of tobacco use seem to confirm the earlier suspicion that the prevalence rate of tobacco use among gay men is dramatically higher than among men in the general population. For example, 41.5 percent of gay men in a household-based sample identified as smokers[65]—a rate that far exceeds the 28.6 percent rate reported among men in the general population.[66]

Lesbian adults have been found to smoke more than heterosexual women. Data reported by the Institute of Medicine (IOM) point to significant differences in cigarette smoking status by sexual orientation. Two times as many lesbians reported heavy smoking than heterosexual women. The IOM report also suggests that, even though this issue is understudied, lesbians may experience high levels of psychosocial stress, which may be complicated by low socioeconomic status.[67] Smoking has also been found to be more prevalent among poor women than women of higher socioeconomic status,[68, 69] and among women who experience high levels of stress.[70, 71] Smoking rates may be especially high among lesbians of low socioeconomic status who also experience stress.

Some studies have found no indication that cessation interventions differ by gender. However, they acknowledge that the issue is understudied. Women may face different stressors and barriers to quitting, such as greater likelihood of depression, weight-control concerns, and issues surrounding childcare. Thus, cessation programs should be studied for differences by gender as well as sexual orientation to ensure that these suggested differences are identified and addressed.[72]

Representative studies of tobacco use among lesbians have not been completed. Nonrandom studies suggest that lesbians may smoke more and have a higher body mass index than heterosexual women, and that they may be at increased risk for cardiovascular disease and cancer.[73, 74, 75] Comparisons between young gay men and lesbians found that lesbians may actually smoke more than young gay men, which raises serious concerns about their risk of tobacco-related morbidity and mortality and underscores the need for additional research.[76] Lesbians and gay men have consistently reported higher levels of cigarette smoking (current, in the past year, and lifetime use) across all age levels than their heterosexual counterparts.[77, 78] More than 37 percent of LGBT respondents in one survey were current smokers,[79] whereas 36 percent of gay male and lesbian respondents (versus 30 percent of heterosexuals) in another national marketing survey identified as current smokers.[80] In an Australian study, more than half (54 percent) of the gay men in the Brisbane sample currently smoked,[81] compared to nearly 40 percent in the Melbourne sample.[82]

The most scientifically rigorous study to date on tobacco use among gay and bisexual men revealed that they were more likely to smoke cigarettes than men in the general population. Some 47.8 percent of the sample reported current cigarette smoking—significantly higher

than rates found in a general sample of adult men (28.6 percent). Smoking rates for gay men were also significantly higher than for men in general using both national prevalence estimates and State prevalence estimates for Arizona and Oregon separately. This held true even when prevalence estimates were stratified by age and education. Half of the youngest cohort of gay men aged 18 to 24 were current smokers, suggesting that smoking among gay men will continue to represent an enormous public health challenge in the years to come.[83]

Smoking among transgender persons. To date, no empirical data on tobacco use among transgender populations exist. However, smoking may be highly prevalent among transgender persons given identified risk factors: poverty, low educational attainment, a high prevalence of injection and noninjection substance use and abuse, stressful living and work environments (e.g., unstable housing, violence), incarceration, human immunodeficiency virus (HIV) seropositivity, and sexual risk patterns.[84] These risk factors suggest that tobacco use may be high among transgender populations. Additional research is needed to shed new light on the prevalence of tobacco use in this population and to design culturally competent interventions.

Smoking among HIV-positive persons. The medical literature contains conflicting reports on the effect of cigarette smoking on medical conditions related to the course of HIV infection.[85, 86, 87, 88, 89] Researchers have consistently found, however, an association between cigarette smoking and bacterial pneumonia, hairy leukoplakia, oral candidiasis, and dementia related to acquired immunodeficiency syndrome (AIDS) among people with HIV.[90, 91, 92, 93, 94, 95, 96, 97] The effect of cigarette smoking on the development of Pneumocystis carinii pneumonia (PCP) and Karposi's sarcoma (KS) is unclear. However, some research has indicated that cigarette smoking is related to the development of PCP, that smoking predicts a shorter time of progression to a diagnosis of AIDS, and that smoking is associated with a higher risk of death.[98, 99, 100] Other researchers have found no relationship between smoking and incidence of PCP or KS, progression to AIDS diagnosis, or death.[101, 102, 103, 104] One study found that 57 percent of HIV-positive men and women were current smokers.[105] In comparison to HIV-negative individuals, HIV-positive persons were significantly more likely to smoke.[106, 107]

Smoking and tobacco use among LGBT youth. Another study revealed that adolescent males who engage in same-sex sexual behavior also reported increased rates of tobacco use in comparison to their heterosexual peers, and that a higher number of male sexual partners was associated with higher rates of tobacco use, substance use, victimization, and use of violence.[108] However, there is no way to know where gay adolescents fit into initiation of smoking trends, to what degree LGBT youth are initiating smoking, or if LGBT youth are more likely than their heterosexual peers to start smoking or quit at an earlier age.

Tobacco-related illness in LGBT populations. As a result of high smoking rates, the burden of tobacco-related health problems is great among LGBT populations, including an increased risk of lung cancer and chronic obstructive pulmonary disease, and an increased risk for such cancers as esophageal cancer due to the co-occurrence of cigarette smoking and heavy alcohol use among LGBT individuals.[109, 110] Several investigators have

hypothesized that lesbians are at higher risk for breast cancer than heterosexual women due to higher rates of risk factors (e.g., obesity, alcohol consumption, nulliparity) and lower rates of breast cancer screening.[111, 112] Given the high prevalence of smoking among lesbians, tobacco-related health problems—such as lung, breast, and cervical cancer—may be elevated compared to women in general.

Tobacco marketing in LGBT communities. There is evidence that the tobacco industry aggressively targets the LGBT community.[113] A survey of more than 300 gay men and lesbians in Los Angeles revealed that 59 percent of respondents either "disagree" that tobacco companies target the LGBT community or were "not aware" that they were being targeted. Some 44 percent of those same respondents, however, reported that they recalled seeing tobacco companies sponsor bar and night club events to promote their products, and 50 percent reported using cigarettes during the 7 days prior to completing the survey. Some 53 percent also "agreed" that tobacco use is an "acceptable" norm among their peers.[114]

Tobacco companies have been enormously successful in adopting the strategies of alcohol businesses—positioning the tobacco industry as a valuable "friend" to LGBT communities. This is particularly true for community LGBT youth organizations that are dependent on the tobacco industry and funding for prevention of HIV and sexually transmitted diseases (STDs) to provide services to their underserved populations. A spokesperson for Philip Morris Companies, Inc., noted that in 1990 the company contributed more than $800,000 to AIDS-related charities and the following year donated $10,000 to the Gay and Lesbian Alliance.[115] At the same time, LGBT community leaders, organizers, health professionals, advocates, and HIV/AIDS service organizations seem to remain oblivious to the impact of tobacco money on their own work and are often resistant to discussions of these issues. In some instances, this resistance may stem from their own use of tobacco.

Developing partnerships with key individuals within large advertising and marketing firms could help facilitate the development of appropriate media messages that both serve the advertisers' function (e.g., selling a product) and the LGBT community (e.g., increasing positive LGBT images, reducing health-negative behaviors, reducing homophobia, and addressing other issues of concern to the LGBT community). Assisting LGBT youth and adult service organizations dependent on tobacco industry funding to identify and cultivate alternative funding to meet their financial needs would loosen the tobacco industry's grip on the LGBT community.

The need for new, LGBT-specific knowledge. There is a lack of concrete data on tobacco use among LGBT persons. In addition, there is a lack of formative or market research on youth who are either coming out or questioning their sexuality and for whom preventive strategies could be effective in stopping the onset of tobacco use. Within the LGBT network of health and social services, attempts to address tobacco use have been few and far between—and easily overshadowed or abandoned in the face of other more immediate crises, such as HIV/AIDS or breast cancer. Finally, there are no evaluated model programs for preventing tobacco use in LGBT populations, no rigorous evaluations of the very few LGBT-specific smoking cessation programs offered in a handful of localities, and no tracking treatment programs for LGBT people enrolled in managed care organizations.

Discussion of Healthy People 2010 Objectives

27-1: Reduce tobacco use by adults.

Existing research indicates that a broad range of health care providers can effectively deliver cessation interventions, yet only a minority of smokers reports being advised to quit.[116] There are well-documented problems with access to appropriate and culturally competent health care and health insurance for LGBT individuals.[117, 118, 119, 120, 121, 122, 123, 124] If those who want to quit smoking do not have access to a culturally competent health care provider who is educated and prepared to screen for tobacco use and able to administer the appropriate intervention, they may miss out on important counseling and nicotine replacement therapies that also might be covered by insurance. Commonly, over-the-counter nicotine replacement therapies are not covered by health insurance plans and may be cost-prohibitive for individuals to purchase out-of-pocket.

The Urban Men's Health Study is a household-based instrument with a probability sample of men who have sex with men (MSM) in San Francisco, Los Angeles, New York, and Chicago. A followup tobacco study conducted by Dr. Ron Stall and Dr. Greg Greenwood is expected to yield new data on smoking among MSM, including current and lifetime tobacco use, attempts to quit smoking, and attitudes about smoking. The study is funded by the California Tobacco-Related Disease Research Program, Urban Men's Health Study, and National Institute of Mental Health.

Whenever possible, smoking cessation programs should be tailored to the different needs of the diverse populations being served. The Agency for Healthcare Research and Quality guidelines recommend that, when there is a lack of studies on smoking treatment in minority communities, more research should be conducted to better understand the treatment needs of the population and to develop culturally appropriate interventions.[125] This recommendation is directly applicable to LGBT communities and should be considered a top public health priority.

To track the success of targeted interventions for LGBT populations and to document improved outcomes, researchers, policymakers, program planners, and others concerned with reducing LGBT tobacco use must work to obtain a more accurate measurement of how many LGBT persons use tobacco products. Better surveillance data on LGBT tobacco use are urgently needed. Existing research seems to indicate that LGBT populations smoke at significantly higher rates than the general population. However, obtaining accurate estimates of smoking prevalence in the LGBT community is difficult because:

- Large-scale household-based surveys do not ask the sexual orientation or gender identity of respondents.
- Large-scale household-based health studies that have samples of LGBT people do not ask about tobacco use.
- Most studies to date have relied on convenience samples (e.g., people in bars or clinics), where smokers were more likely to be present.

- Due to small sample sizes, studies have been unable to examine effectively whether groups of LGBT populations are disproportionately affected by tobacco use. It is crucial that ethnicity/race, age, gender, education, geography, and socioeconomic status be included as demographic variables in studies of LGBT tobacco use as well as the effectiveness of tobacco use interventions.

27-2: Reduce tobacco use by adolescents.

Little is known about tobacco use among LGBT youth, in part because many young people do not self-identify as LGBT until early adulthood, and because of the distrust LGBT youth frequently have of adults, institutions, authority figures, and the health system. However, Stall and colleagues found that smoking rates were highest among younger gay and bisexual men,[126] theorizing that smoking initiation among this group occurred during adolescence. LGBT youth may be at particularly high risk to initiate tobacco use given risk factors: lack of support from family and peers, depression, low self-esteem, and stressful life events related to "coming out."[127]

27-3: (Developmental) Reduce initiation of tobacco use among children and adolescents.

Psychological and behavioral factors significantly influence the onset of smoking behavior in youth. These include poor self-esteem, peer pressure, misperceptions about the number of youth who actually smoke, and exposure to opinion leaders who influence behavior.[128, 129]

The younger the person is when he or she begins to smoke, the more likely the person is to be a smoker as an adult. Nearly all smoking begins in adolescence. However, if initiation is delayed until adulthood, rates of new smoking decline significantly.[130] Adolescents with fewer coping skills to resist peer influences are more likely to smoke.[131, 132] Youth who smoke are also more likely to attempt suicide and engage in high-risk activities. Although the act of smoking is not causal in nature, these behaviors are found in greater numbers of LGBT youth when compared with the general population and should be considered as a constellation of related behaviors. The exact nature of this relationship or interrelationship is unknown but should be considered an opportunity for a targeted, comprehensive health promotion program.

LGBT youth are more likely to have lower self-esteem because of external and internalized homophobia.[133] LGBT youth often experience low perceived levels of adaptive social support due to internalized or externalized homophobia. Because lower self-esteem is associated with smoking, this places LGBT youth at greater risk for smoking. Smoking behavior is usually the first substance used prior to the initiation of alcohol and other drug use.[134] There is a high rate of substance abuse among LGBT teens, generally associated with difficulty in adaptive coping.[135] If smoking behaviors among LGBT teens can be prevented or delayed, other substance use may be prevented or delayed as well.

27-5: Increase smoking cessation attempts by adult smokers.

Culturally competent smoking intervention services for the LGBT community have not been developed, and research on the topic is lacking. The absence of research on tobacco use cessation treatment or interventions that are specific to the LGBT community pales in comparison to treatment development and research of LGBT-specific interventions for other health risks (e.g., alcohol and drug use, STD/HIV treatment and prevention) as well as ethnic-specific tobacco treatment research and intervention. Existing research indicates that although a broad range of health care providers can effectively deliver cessation interventions, only a small number of smokers report being advised to quit.[136]

The Last Drag Program in San Francisco, an LGBT-affirming, community-based smoking cessation group, serves as a promising smoking cessation model for LGBT populations. Created in the early 1990s, the intervention is based upon the volunteer models of smoking cessation supported by the American Cancer Society and the American Lung Association. Outcome data are minimal, and the model has not been empirically tested. However, 42 to 47 percent of participants reported successfully becoming nonsmokers by the end of an 8-week class. Two-thirds of the clients are men, one-third are people of color, and one-tenth do not identify as gay.

Additional future data may become available through the Queer Tobacco Intervention Project (QueerTIP), which is a 1-year (2000-2001), State-funded Pilot Community-Academic Research Award to build partnerships to reduce smoking in the LGBT community. The program is conducting a community-based pilot research project to design and evaluate tobacco cessation services specifically designed for LGBT populations. Although the long-term goal is to reach every segment of the LGBT community, the current scope of the pilot project is limited due to funding constraints. Over the course of the next year, the project will establish and evaluate a comprehensive tobacco intervention program designed specifically to reach young lesbians, bisexual women, transgender persons, and all LGBT persons. The project is built on four primary goals:

Another potential model is the King County (Seattle, Washington) Sexual Minorities Tobacco Coalition. Launched in 1995, the coalition joined forces with Emily Brucker to develop Out and Free, a smoking cessation guide that applies the skills learned during coming out to quitting smoking. The goal of the coalition is to increase awareness of the risks of smoking, conducting advocacy, encouraging appropriate public policy, and promoting cessation.

- To strengthen collaborations among researchers, health advocates, and community providers and organizations serving the LGBT community in San Francisco
- To review tobacco services and research to date with the LGBT community to identify best treatment and intervention approaches

- To develop comprehensive tobacco intervention services specifically designed for the LGBT community, including a CORE [Commitment, Opportunity, Responsibility, and Education] smoking cessation model and a multicomponent network system for referrals to LGBT-positive treatment providers
- To submit a proposal for a 3-year, community-based, randomized clinical trial of LGBT-positive tobacco intervention services

27-6: Increase smoking cessation during pregnancy.

No data are available on smoking rates during pregnancy among lesbians and bisexual women. Although a significant degree of planning may occur prior to pregnancy among lesbians, a number of issues still merit attention. For lesbians who smoke and are pregnant, many health care providers may be unable to provide culturally competent care and counseling. Some lesbian mothers-to-be may not reveal their sexual orientation to their health care provider and remain closeted throughout the prenatal care process. Specific issues facing adolescent girls and young adult women who are questioning their sexuality and are pregnant need to be addressed. In addition, as in all households, male partners and other individuals living in the household must stop smoking so that the mother and fetus are not exposed to secondhand smoke.

Many individuals in the LGBT community are parents or planning to be parents. As a result, the same tobacco prevention and smoking cessation principles recommended to heterosexual individuals who are parents or planning to be parents should be used in counseling LGBT individuals who are parents or contemplating parenthood. However, such strategies need to be accessible to LGBT individuals and delivered in an LGBT-competent way. In addition, some LGBT youth who live with their families of origin have the same opportunity as their non-LGBT counterparts to assist their mothers in trying to stop smoking if the mothers are pregnant. This educational opportunity is mutually beneficial to all parties.

27-7: Increase tobacco use cessation attempts by adolescent smokers.

Several challenges are associated with introducing tobacco cessation attempts among LGBT youth. Access to adequate health insurance that covers the cost of smoking cessation products presents the most formidable challenge. Some youth who live in metropolitan areas can participate in smoking cessation courses that may be offered by LGBT community centers. QuitNet is an Internet Web site that brings proven scientific methods online to deliver support to smokers whenever they need it. (More information is available online at www.quitnet.org.)

In addition, youth smoking cessation is complicated by the fact that developmental and psychosocial issues can influence the effectiveness of smoking cessation efforts and that few youth report the onset of smoking. In many cases, smoking serves a social function for youth attempting to improve self-image and exhibit what they believe to be normative behavior. LGBT youth often experience a greater sense of being different (cognitive

dissonance) that they may try to decrease though using behaviors that allow them to feel part of the mainstream group of youth. Given the complexity of these factors, smoking cessation efforts aimed at LGBT youth must address the psychological function that smoking serves, or cessation efforts are unlikely to be effective.

27-8: Increase insurance coverage of evidence-based treatment for nicotine dependency.

The American Association of Health Plans (AAHP) was awarded a 4-year, $1.4 million grant from the Robert Wood Johnson Foundation to assist AAHP in developing and managing a broad technical assistance program to support the foundation's recently announced Addressing Tobacco in Managed Care Program. Specific activities of AAHP's National Technical Assistance Office (NTAO) are cofunded by the Centers for Disease Control and Prevention and the Agency for Healthcare Research and Quality.

AAHP is coordinating the NTAO efforts with its member plan, the Health Alliance Plan in Detroit, Michigan, to develop a multifaceted tobacco resource center. Information will be available to health plans, the medical and academic communities, public health, and health care consumers through numerous ongoing programs and activities. During the 4-year project, NTAO will direct an ongoing process to:

- Develop a comprehensive network of key contacts in health plans responsible for smoking cessation and health promotion
- Establish a clearinghouse of tobacco prevention information gathered from academic and professional journals, conferences, newsletters, and white papers

The goal of NTAO is to provide health plans with all the resources necessary to implement and support comprehensive tobacco prevention and cessation programs within the health plan's membership or the larger community, using proven and available methods as a tool to design interventions most appropriate to the plan's target populations. NTAO expects to compile diverse examples of best practices that will be easily adaptable in a variety of managed care settings. (More information can be obtained online at www.aahp.org.)

Although there appear to be no data on insurance coverage for evidence-based treatment of nicotine dependence for LGBT populations, some LGBT persons lack insurance coverage for nicotine dependency treatment. In addition, treatment interventions were not designed with the needs of LGBT smokers in mind, and providers may not have the skills or knowledge to deliver those interventions in a culturally competent manner.

Diseases related to tobacco use exact an enormous financial toll on the public-sector health care system. Private-sector health care organizations should assume at least partial responsibility for reducing future tobacco-related morbidity and mortality by increasing LGBT access to nicotine treatments and ensuring that LGBT individuals have equal access to early diagnosis and treatment services for tobacco-related illnesses.

27-9: Reduce the proportion of children who are regularly exposed to tobacco smoke at home.

Many children and adolescents living in LGBT families are exposed to secondhand (or environmental) tobacco smoke. LGBT parents who smoke may be reluctant to disclose their smoking habit to health care providers. This presents a barrier to parents receiving smoking cessation counseling and continues to expose their children to risk. LGBT parents and other LGBT adults who smoke tobacco at home need to be educated about the risks to others living in the home and encouraged to seek treatment. In addition, the treatments available to LGBT individuals who want to quit should be LGBT-competent and delivered in a nonstigmatizing, nonjudgmental way.

27-10: Reduce the proportion of nonsmokers exposed to environmental tobacco smoke.

Bars and clubs serve as an important gathering place for many LGBT individuals. However, exposure to secondhand smoke has presented a serious concern for nonsmokers seeking a physically safe, LGBT-affirming place to socialize and congregate.

Several LGBT advocacy groups—such as Community Focus, the Coalition of Lavender Americans on Smoking and Health, and the California Lavender Smoke-Free Network—played a role when California bars and restaurants were required to become smoke-free. One group used the anticipated implementation of smoke-free bar rules to conduct intercept surveys at LGBT pride events in Los Angeles, in part designed to begin preparing the LGBT community for the prospect of nonsmoking gay bar life. The Los Angeles planning group also did some outreach to gay bar and tavern owners in advance of the new regulation's taking effect. A very popular bar in West Hollywood, California, hosted a smoke-free night once a week. The increased patronage on the smoke-free nights was significant in encouraging other such businesses to plan to comply with the new laws rather than ignore or actively resist.

27-12: Establish laws on smoke-free indoor air that prohibit smoking or limit it to separately ventilated areas in public places and worksites.

Healthy People 2010 recognizes that legislative change is required to ensure that all workers in the United States, including LGBT people, should be protected from secondhand smoke. Such policies not only safeguard the health of nonsmokers but can also provide the impetus for a smoker to quit.

In the LGBT community, gay businesses are often the most common places where LGBT persons gather to socialize. The store or business owners and staff have the right to perform their jobs in a safe environment, and the patrons and customers have the right to shop or safely congregate, without being exposed to secondhand tobacco smoke. Federal, State, and

local governments should work in partnership with LGBT business owners and managers to implement and enforce smoke-free environments that safeguard the health of employees and customers.

27-16: (Developmental) Eliminate tobacco advertising and promotions that influence adolescents and young adults.

Media portrayals directly and indirectly influence how youth and young adults, including LGBT young people, perceive smoking. Advertising affects how youth perceive smoking by influencing their perception of smokers. If the media or advertising is used to promote the onset of smoking, then media can be effective in discouraging smoking or preventing tobacco use. Media messages that overtly include LGBT youth in general are rare, yet media messages represent an untapped resource in conveying positive messages about self-esteem and in discouraging smoking. Federal, State, and local agencies should join forces with LGBT national and community organizations to sponsor counteradvertising that promotes health-positive messages and discourages tobacco use.

27-17: Increase adolescents' disapproval of smoking.

Attitudes and beliefs are an important part of influencing behavior. LGBT youth are likely to differ in key ways from heterosexual youth on general attitudes and beliefs about the desirability of smoking. Exactly how they differ is unknown. However, effective programs need to be specifically tailored to the targeted group. Hence, smoking cessation programs should take into account how attitudes that support smoking may function as barriers to tobacco cessation and prevention strategies and should include modification of these attitudes as part of the program activities directed to LGBT youth or the community.

27-18: (Developmental) Increase the number of tribes, Territories, and States and the District of Columbia with comprehensive, evidence-based tobacco control programs.

Although the LGBT community may not be directly connected to the tobacco control programs in States, Territories, and tribal jurisdictions, LGBT populations should be reflected in local strategies as they are among the general population. It is crucial that LGBT individuals be actively involved in the planning, implementation, and evaluation of tobacco control programs to ensure that they are LGBT-competent, nondiscriminatory, and reflective of the LGBT community's needs.

Services—RECOMMENDATIONS

- Smoking prevention and cessation programs must be LGBT-competent, affordable, and accessible to LGBT individuals.
- LGBT-oriented community centers and other LGBT-affirming community-based organizations should be recognized as resources and included in developing, implementing, and evaluating culturally competent smoking cessation and prevention programs.

Education and Training—RECOMMENDATIONS

- Because clinical cessation guidelines may be used as a training tool for educating health care providers, LGBT-specific concerns regarding tobacco use and LGBT-competent prevention and treatment services should be reflected and addressed in such guidelines.
- Health care providers need training on how to provide culturally competent care to LGBT smokers and to adhere to guidelines on tobacco screening and treatment.
- Counter-advertising campaigns that promote health-positive messages should be conducted and targeted to LGBT populations. Such campaigns could be modeled after the "Truth" campaign and California Department of Health Services antismoking campaigns.

Policy and Advocacy—RECOMMENDATIONS

- LGBT individuals must have access to comprehensive, nondiscriminatory health insurance that covers smoking cessation products and services.
- LGBT communities must be educated about tobacco advertising and its role in promoting tobacco use.
- Health-positive environments for LGBT and questioning youth must be funded, supported, and sustained so that LGBT youth have healthier venues in which to socialize and "come out."

Research—RECOMMENDATIONS

- Sexual orientation and gender identity must be included in national and local data sets to study differences in smoking rates and treatment success.
- Data are needed on a variety of LGBT-specific tobacco-related issues so that culturally competent social marketing and public education campaigns, prevention activities, and cessation programs can be established and implemented.

Terminology

Consumption: The amount of tobacco products consumed or used by the population. Consumption usually is measured in units, such as the number of cigarettes smoked or pounds of spit tobacco used over a given period of time.

Counteradvertising: The placement of pro-health advertisements on TV, on radio, in print, on billboards, on movie trailers, on the Internet, and in other media.

Nicotine dependency: Highly controlled or compulsive use, use despite harmful effects, withdrawal upon cessation of use, and recurrent drug craving.

Secondhand smoke: A mixture of the smoke exhaled by smokers and the smoke that comes from the burning end of the tobacco product.

Serum cotinine: A biological marker for tobacco use and exposure to environmental tobacco smoke measured in the blood. Cotinine is a breakdown product of nicotine.

Spit tobacco: Chewing tobacco, snuff, or smokeless tobacco.

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Violence Prevention

Healthy People 2010 Goal

Reduce injuries, disabilities, and deaths due to violence.*

Overview

Violence is one of the Nation's most preventable public health problems. It contributes significantly to mortality and physical health morbidity, and it has serious mental health and social consequences—not only for the survivor but also for the victim's family, the lesbian, gay, bisexual and transgender (LGBT) community, and society at large. Violence resulting from hate crimes, domestic violence, suicide, and other forms of physical, sexual, emotional, and environmental violence takes a heavy toll on the LGBT population. Between one-quarter and one-third of all LGBT individuals experience domestic violence. LGBT individuals are more than four times as likely as the general population to have attempted suicide. Despite the prevalence of violent acts against the LGBT population and other populations suffering from high rates of violence, as well as the far-reaching individual and societal consequences, the public health, educational, social service, and criminal justice systems generally do not have adequate policies, procedures, and programs in place to address this significant and costly public health challenge.

Issues and Trends

Violence in the United States is pervasive and changes not only quantity of life but also quality of life. On an average day in the United States, 53 persons die from homicide, and a minimum of 18,000 persons survive interpersonal assaults; 84 persons complete suicide; and as many as 3,000 persons attempt suicide.[1, 2, 3, 4, 5, 6, 7] (See Mental Health and Mental Disorders focus area.) Domestic violence alone affects a significant proportion of the U.S. population either as direct victims or as witnesses of abuse directed toward spouses or intimate partners, children, and elders.[8] The past two decades have seen dramatic changes

* In Healthy People 2010, this focus area or chapter is entitled *Injury and Violence Prevention.* However, only the first two objectives that are discussed in the Companion Document correspond to "injury" prevention in Healthy People 2010. As the discussion focuses mainly on Violence, the Chapter title is appropriately *Violence Prevention.*

in the response to domestic violence in States and communities throughout the country. To date, a great deal of the change has occurred within the criminal and civil justice systems.[9] There is an awareness that the problem of violence, especially violence against women, is complex and requires coordinated service responses involving health care and social services agencies as well as justice systems.

Identifying violence as a public health issue is a concept that has emerged in the past decade. In 1991, former U.S. Surgeon General C. Everett Koop wrote that:

> "Traditionally, when confronted by the circumstances of violence, [we] . . . have deferred to the criminal justice system. Over the years we have tacitly and, I believe, mistakenly agreed that violence was the exclusive province of the police, the courts, and the penal system. To be sure, those agents of public safety and justice have served us well. But when we ask them to concentrate more on the prevention of violence and to provide additional services for victims, we may begin to burden the criminal justice system beyond reason. At that point, the professions of medicine, nursing and the health-related social services must come forward and recognize violence as their issue and one that profoundly affects the public health."[10]

Violence is a learned behavior and, therefore, preventable.[11] In addition to immediate physical, emotional, or psychological injury, the sequelae of violence is often serious and lifelong. Long-term effects may include permanent mental and physical disabilities resulting from physical damage; sexually transmitted diseases, including HIV; pregnancy and its complications; depression, anxiety, post traumatic and stress disorders; substance abuse; and other conditions that might be prevented if the violence had not occurred.

General issues that impede the public health response to progress in this area include the lack of comparable data sources, lack of standardized definitions and definitional issues, lack of resources to establish adequately consistent tracking systems, and lack of resources to fund promising prevention programs. In addition, violence prevention is not a priority for most policymakers.[12] As it is with most other public health problems, cultural competence is needed in dealing with violence as a health care problem.[13]

Standardized terminology pertaining to violence and abuse is still evolving and changing. Not only are various definitions being developed for standardization for health and social service delivery and research, but also within the legal system, especially as established by court decisions. The lack of standardized terminology stems largely from the fact that the American system is a federal system of 50 semi-sovereign states.[14] In addition, experts in the area of violence and abuse prevention employ different definitions and a variety of terminology. The following are some key terms and/or constructs.

- *Violence* is the intentional use of physical force or power, threatened or actual, against another person or against oneself or against a group of people, that results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation.[15]

- *Maltreatment* is a generic term for many types of abuse and neglect of people of all ages. There are for major types of maltreatment: physical abuse, neglect, sexual abuse, and psychological or emotional abuse.[16, 17, 18]
- *Assault* is the unlawful attack or attempt to attack through force or violence to do physical injury to another; may involve the use of firearms, knives, or other weapons, or aggravated use of hands, fist, or feet.[19]
- *Neglect* is the refusal or failure to fulfill any part of a person's obligations or duties by a person who has fiduciary responsibilities. Neglect can be physical or emotional, or educational when applied to children, such as allowance of chronic truancy.[20, 21]
- *Physical violence and/or abuse* is the intentional use of physical force with the potential for causing death, injury, or harm. Physical violence or abuse includes, but is not limited to scratching, pushing, shoving, throwing, grabbing, biting, choking, shaking, poking, hair pulling, slapping, punching, hitting, burning, and use of restraints or one's body, size, or strength against another person. The unwarranted administration of drugs and physical restraints, force-feeding, and physical punishment of any kind are additional examples of physical abuse. Physical violence includes use of a weapon (gun, knife, or other object) against a person.[22, 23]
- *Sexual violence and/or abuse* is divided into three categories: (a) the use of physical force to compel a person to engage in a sexual act against his or her will, whether or not the act is completed; (b) an attempted or completed sex act involving a person who is unable to understand the nature or condition of the act, to decline participation, or to communicate unwillingness to engage in the sexual act due to age, illness, disability, influence of alcohol or other drugs, intimidation or pressure; and/or (c) abusive sexual contact. Sexual contact includes, but is not limited to, unwanted touching, and sexually explicit photographing.[24, 25, 26]
- *Psychological/emotional abuse* is trauma to the victim caused by acts, or threats of acts, such as verbal assaults, insults, intimidation, humiliation, and harassment, controlling what the victim can and cannot do, withholding information from the victim, becoming annoyed if the victim disagrees, isolating the victim from others.[27, 28, 29, 30]
- *Psychological/emotional abuse as a type of violence* acknowledges the aforementioned definition; yet, to be considered a type of violence, there must also have been prior physical or sexual violence (or the threat of such violence).[31]
- *Victim* is the person who is the target of violence or abuse.[32]
- *Perpetrator* is the person who inflicts violence or abuse, or causes these to be inflicted, on the victim.[33]
- *Violent intimate partner* includes current and former spouses (legal and common law) and non-marital partners (boyfriend, girlfriend, same-sex partner, dating partner) who has perpetrated violence on his/her partner. Partners may or may not be cohabitating.[34]

- *Violence against women (VAW)* is composed of three components: physical violence; sexual violence; and threats of physical and/or sexual violence.[35]
- *Violence and abuse against women (VAAW)* is composed of five components: the three aforementioned (physical violence; sexual violence; and threats of physical and/or sexual violence), as well as stalking and psychological/emotional abuse.[36]

These definitions, intended for the general population, also apply to the LGBT community. In addition to these categories, this chapter addresses suicide, a public health concern recognized in Healthy People 2010, and hate crimes. Hate crime, as defined in Section 280003(a) of the Violent Crime Control and Law Enforcement act of 1994 (28 U.S.C. 984 note) is a term used to describe crimes against individuals where the victim was selected because of race, skin color, ethnicity/national origin, sexual orientation, gender, religion or disability. A hate crime under this provision is not, in fact, a specific crime.[37] The provision refers to penalty enhancements for crimes motivated by biases against a victim. As of July 2000, only seven States (Arkansas, Hawaii, Indiana, Kansas, New Mexico, South Carolina, and Wyoming) do not have any hate crimes laws.

As a result of mounting national concern over crimes motivated by bias, Congress enacted the Hate Crime Statistics Act of 1990. In 1999, there were 7,876 hate crime incidents reported to the Federal Bureau of Investigation (FBI). The incidents involved 9,301 separate offenses, 9,802 victims, and 7,271 known offenders. Of the total reported incidents, 4,295 were motivated by racial bias, 1,411 by religious bias, 1,317 by sexual orientation bias, 829 by ethnicity/national origin bias, 19 by disability bias, and 3 by multiple biases. Intimidation was the single most frequently reported offense, accounting for 35 percent of the total. Following intimidation were damage, destruction, or vandalism of property, 29 percent; simple assault, 19 percent; and aggravated assault, 12 percent.[38] Among students nationwide, 13 percent reported that they had been called a hate-related word or name. Overall, 36 percent of students reported seeing hate-related graffiti at school.[39]

The likelihood that today's children are exposed to some form of violence—in the streets, at school, at home, or in the media—is enormous. Despite the tragedy at Columbine High School in Littleton, Colorado on April 20, 1999, far more children are victims of serious physical violence within their homes than are severely injured in acts of violence on school grounds or elsewhere.[40] Addressing the needs of children who have been abused or neglected is one of the most important goals of the Administration on Children, Youth and Families (ACYF). To achieve this goal, ACYF collects data on child maltreatment through the National Child Abuse and Neglect Data System (NCANDS) and provides a summary of these data to policymakers, child welfare practitioners, researchers, and concerned citizens. The following statistics are from the latest ACYF Report on Child Maltreatment:[41]

- Approximately 903,000 children were victims of maltreatment nationwide.
- More than half (53.5 percent) of victims suffered neglect, while almost a quarter (22.7 percent) suffered physical abuse, and 11.5 percent were sexually abused.

- Three-fifths (60.4 percent) of perpetrators were female. Female perpetrators' median age was 31 and male perpetrators' median age was 34.
- In cases of sexual abuse, more than half (55.9 percent) of victims were abused by male parents, male relatives, or other males.
- An estimated 1,100 children died as a result of child abuse or neglect .
- Children not yet a year old accounted for 37.9 percent of the fatalities, and 77.5 percent were not yet aged 5 years.
- Perpetrators of fatalities were considerably younger than perpetrators in general. Nearly two-thirds (62.3 percent) were younger than 30 years of age, compared to the percentage of all perpetrators who were younger than 30 (38.7 percent).

Child abuse and neglect are defined in both Federal and State legislation. Each State is responsible for providing its own definitions within the civil and criminal context.

Children are also exposed to violence through the media. Children and adolescents in the United States spend an average of 3-5 hours per day with a variety of media, including television, radio, videos, videogames, and the Internet.[42] A content analysis of music videos revealed that rap videos and rock videos had the highest portrayal of violence and weapon carrying.[43] Considerable research exists to document concerns about the relationship between children who are abused and/or exposed to violence and the increased risk of them becoming offenders.[44, 45, 46]

The maltreatment of children and violence against women often go hand-in-hand.[47] In 1998, there was an estimated 876,340 violent victimizations against women by intimate partners and an estimated 160,000 violent victimizations against men by intimate partners.[48] Although most women in the U.S. fear attack by strangers, 1996 FBI data indicate that 51 percent of all murdered women were killed by someone they knew and that 30 percent were killed by their husbands, ex-husbands, or boyfriends.[49] Approximately 34 percent of rapes are estimated to occur in the victim's home, where children may be present to see or hear the sexual assault of their mothers or caregivers.[50]

The needs of battered women, possibly their children, and their batterers span several social service systems, and may require interventions by one or more of the criminal and civil justice systems, social services, health care or mental health care agencies, and support systems for battered women and their families. Research indicates that more than one-fifth, and perhaps as many as one-third, of women receiving care in hospital emergency rooms have symptoms related to domestic violence.[51] Most commonly, women seeking such health services do not identify themselves as battered women and health care providers do not identify them as such. Some jurisdictions require health care providers to report domestic violence to law enforcement agencies.[52] While this requirement was undoubtedly appropriately constructed, the unintended impact may result in having fewer battered women seek care. The avoidance of services may occur most frequently when the batterer is an intimate partner.

Over the past 25 years, States have become increasingly concerned with the problem of elder abuse, both domestic and institutional, and have enacted legislation in an attempt to prevent and treat the problem. The National Center on Elder Abuse documented 71 laws in the 50 States, the District of Columbia, Puerto Rico, Guam, and the Virgin Islands that address neglect and violence toward the elderly.[53] Congress, under the Family Violence Prevention and Services Act of 1992 (P.L. 102-295), required that a study of the national incidence of abuse, neglect, and exploitation of elderly persons be conducted. The Administration of Children and Families (ACF) was responsible for administering those provisions of the legislation. In concert with resources and experts from the Administration on Aging (AoA), ACF conducted the study between October 1994 and December 1997.[54] (Given the parameters of the legislation, the target population was non-institutionalized elderly, thereby excluding elders living in hospitals, nursing homes, assisted living facilities, or other institutional or group facilities.) The best national estimate is that a total of 449,924 elderly persons, aged 60 and over, experienced abuse and/or neglect in non-institutionalized settings. Approximately 90 percent of the perpetrators were related to the victims. Only 16 percent of these cases of abuse and/or neglect were reported to State Adult Protective Services agencies.[55]

Abuse of the elderly in institutional care first came to public awareness in the late 1970s and early 1980s through research findings and Congressional hearings.[56, 57, 58] While there exists the national incidence study for domestic elder abuse, statistics concerning elder abuse in the institutional setting remain relatively unknown.[59] Therefore, no national statistics are available. In 1995, more than 300 confirmed cases of abuse or neglect were reported by Virginia, Maryland, and the District of Columbia nursing homes.[60]

Disparities

The decade between 1983 and 1993 was marked by an unprecedented surge of lethal and nonlethal violence among young people in the United States.[61] For millions of youth and their families, a period of life that should have been distinguished by good health and great promise was instead marred by injuries, disability, and death.[62]

The highest victimization rates for child maltreatment victims were for the 0-3 age group (14.8 victims per 1,000 children of this age in the population), and rates declined as age increased. Victimization rates by race and ethnicity ranged from a low of 3.8 among Asian/Pacific Islander victims per 1,000 children of the same race to 20.7 among African Americans. The victimization rate for American Indians/Alaska Natives was 19.8, for Hispanics 10.6, and for Whites 8.5.[63]

Although overall school crime has decreased since 1992, the rate of serious violent crime—including rape, sexual assault, robbery, and aggravated assault—against students at school stayed fairly consistent from 1992 to 1998.[64] Students of all ethnic groups reported fearing attack or harm at school less often in 1999 than they did in 1995. However, in both years, larger percentages of Black and Hispanic students than White students feared such attacks.[65] Younger students, ages 12 through 14, were more likely than older students, ages 15

through 18, to be victims of crime at school.[66] School-associated violent deaths remain rare events.[67] For the complete school year, July 1, 1998 through June 30, 1999, 34 incidents resulted in 50 school-associated violent deaths (students and non-students). Thirty-eight of these deaths were homicides, nine were suicides, two adults were killed by a law enforcement officer in the course of duty, and one death was an unintentional shooting.[68]

Certain racial and ethnic groups experience more deaths than Whites. Rates for the Black population compared with the White population were at least 1.5 times greater for seven of the leading causes of death, with the largest ratio being for homicide.[69] Problems of race and Hispanic-origin classification affect the level of Hispanic death rates and the relative levels compared with the non-Hispanic population. Hispanic origin on the death certificate may be underreported by an estimated 7 percent.[70]

Age-adjusted rates were higher for the White population than the Black and Hispanic population for suicide.[71] (Note: The age-adjusted death rate, which eliminates the distorting effects of the aging of the population, was at a record low of 471.7 per 100,000 U.S. standard population.) For White males between the ages of 15-24, the three leading causes of death with rates are accidents (54.1), suicide (39.4), and homicide (14.7). For Black males between the same ages, the three leading causes of death with rates are homicide (96.5), accidents (30.3), and suicide (15.0). For Hispanic males at comparable ages, the three leading causes of death and rates are accidents (52.3), homicide (41.1), and suicide (13.4).

The mortality figures for females aged 15 to 24 years, according to race, are slightly different than for males. For White females, the three leading causes of death with rates are accidents (20.4), malignant neoplasms (growths or tumors) (3.7), and suicide (3.5). For Black females of comparable age, the causes of deaths with rates are accidents (13.0), homicide (12.6), and malignant neoplasms (4.0). And for Hispanic females aged 15 to 24 years, the three leading causes of death with rates are accidents (13.7), homicides (4.2), and malignant neoplasms (3.4).[72] Research has not demonstrated any higher risk of completed suicide associated with same-gender sexual orientation for either adults or adolescents.[73, 74] Given the aforementioned suicide statistics, especially for males, post-mortem classifications of same-gender sexual orientation probably are underestimated.

Kipke and colleagues (1997) explored 432 homeless youths' histories of exposure to violence, perpetration of violence, and fear of violent victimization.[75] The youths, between the ages of 13 and 23, reported a high rate of violence with no difference between females and males. However, females were more likely to report having been sexually assaulted and fearing victimization, and less likely to report perpetrating violence. With a few exceptions, ethnic identity was not a significant predictor of exposure to violence.

As to elder maltreatment, women are disproportionately represented as victims.[76] The oldest elders (age 80 and over, also known as "the frail elderly") are abused and neglected at two to three times their proportion of the elderly population.[77] Racial/ethnic statistics depended upon the methodology of data collection. From data submitted by the 1,100 trained "sentinels" from public and private agencies that had frequent contact with elderly

community residents, fewer than 10 percent of abused or neglected elderly were minorities. On the other hand, higher proportions of victims of most forms of abuse and neglect reported to Adult Protective Service (APS) were Black.[78] Other racial/ethnic categories, especially Hispanic elderly, were low to both APS and to sentinels. Further research is needed to ascertain whether low rates for Hispanics, in particular, are due to lower rates of reporting and detection of abuse and neglect, perhaps because of language barriers, or due to lower rates of actual abuse.

A National Coalition of Anti-Violence Programs (NCAVP) report on domestic violence in the LGBT population indicates that the age and race/ethnicity disaggregations are generally comparable to reports of domestic violence in the general population. For example, under 1 percent of reported domestic violence incidents is among the population under 18 years of age, while more than half (52 percent) is among those aged 30 to 44. This likely reflects the fact that the younger LGBT population is much less likely to feel safe in reporting their sexual orientation and to be aware of LGBT centers to which they can report such incidences. In terms of race and ethnicity, as with the general population, people of color are over-represented in reported incidents, in part because, as the NCAVP report indicates, the three largest reporting sites are in cities with significant proportions of populations of color.[79]

Hate crimes are message crimes, according to Dr. Jack McDevitt, a criminologist at Northeastern University in Boston.[80] They are different from other crimes in that the offender is sending a message to members of a certain group that they are unwelcome in a particular place, whether a neighborhood, street, school, workplace, church, restaurant, park, or any other place. By far the largest determinant of hate crimes is racial bias, with African Americans at greatest risk.[81] Ethnic minorities in the United States often become targets of hate crimes because they are perceived to be new to the country even if their families have been here for generations, or simply because they are seen as different from the mainstream population. Most religiously motivated hate crimes are acts of vandalism with the overwhelming majority directed against Jewish people.[82] Gender-based violence is a significant social and historical problem, with women the predominant victims. Hate crimes against people with disabilities are motivated by the perception that such people are not equal, deserving, contributing members of society, and therefore, attacking them is an acceptable moré .[83]

The most socially acceptable, and probably the most widespread, form of hate crime, especially among adolescents and young adults, is targeting LGBT people.[84, 85, 86, 87] Franklin (1997) has identified the following group of perpetrators involved in hate crimes against LGBT people:[88]

- Ideology perpetrators who report that their crimes stem from the negative beliefs and attitudes that people in the community have about LGBT people. Thus, these people are enforcing social morals.
- Thrill seekers, typically adolescents, who commit assaults to alleviate boredom, to have fun and excitement, and to feel strong.

- Peer-dynamics perpetrators who also tend to be adolescents who commit hate crimes to prove their toughness and heterosexuality to friends.
- Self-defense perpetrators who believe that LGBT people are sexual predators and the assaults are responses to aggressive sexual propositions.

Transgender people may experience greater disparities than any other group in being the victims of violence. Although this statement may be debatable, transgender people have been excluded from almost every hate crime bill, whether at theFederal, State or local level.[89] Four States have included transgender people in their hate crimes laws—Minnesota (1993), California (1998), Vermont (2000), and Missouri (2000).[90] The first major study on violence and discrimination against transgender people in the United States[91] found that 60 percent experienced some form of harassment and/or violence sometime during their lives, and 37 percent experienced some form of economic discrimination.

While more documented research is needed, almost all transgender people, whether female-to-male (FTM) or male-to-female (MTF), admit that preventing the experience of violence within their lives is a ubiquitous aspiration.[92]

Opportunities

There is a growing awareness of the need to enact appropriate laws and more vigorous enforcement with education and training initiatives designed to reduce different types of violence. The Federal Government has a central role to play in the legislative arena as well as in funding program development and promoting awareness of initiatives that work. Poverty, discrimination, lack of education, and lack of employment opportunities are important risk factors for violence and must be addressed as part of any comprehensive solution to the epidemic of violence. Strategies for reducing violence should begin early in life, before violent beliefs and behavioral patterns can be adopted.

In 1992, Congress approved several new hate crime and prejudice reduction initiatives as part of the 4-year Juvenile Justice and Delinquency Prevention Act reauthorization.[93] The Act included a requirement that each State's juvenile delinquency prevention program include a component designed to combat hate crimes and a requirement that the Justice Department's Office of Juvenile Justice and Delinquency Prevention (OJJDP) conduct a national assessment of youths who commit hate crimes, their motives, their victims, and the penalties received for the crimes. OJJDP provided funds for the development of a wide-ranging curriculum, "Healing the Hate"—appropriate for educational, institutional, and other settings—to address prevention and treatment of hate crimes committed by juveniles.[94]

In 1992, Congress also acted to incorporate antiprejudice initiatives into The Elementary and Secondary Education Act (ESEA), the principal Federal funding mechanism for the public schools.[95] Title IV of the Act, Safe and Drug-Free Schools and Communities, also included a specific hate crimes prevention initiative—promoting curriculum development and "professional training and development for teachers and administrators on the cause,

effects, and resolutions of hate crimes or hate-based conflicts."[96] In July 1996, the Department of Education provided almost $2 million in new grants to fund the development and implementation of "innovative, effective strategies for preventing and reducing the incidence of crimes and conflicts motivated by hate in localities directly affected by hate crimes." [97]

Over the past year, the Bureau of Justice Assistance (BJA) has provided essential funding for the development of a four-part law enforcement training curriculum, piloted in three train-the-trainer conferences in the fall of 1998.[98] BJA also provided funding for the International Association of Chiefs of Police (IACP) for its national Hate Crime Summit held in June 1998. In addition, BJA is funding an important new initiative to develop and provide training for prosecutors in responding to hate crimes. The National District Attorneys Association, through its research arm, the American Prosecutors Research Institute, is developing these training materials, best practices, and model protocols for effective response to hate crimes. Hate violence can be addressed effectively through a combination of presence, prevention, and outreach to the community that is the hallmark of community policing. During 1999, the Community Oriented Policing Services (COPS) provided essential funding for the IACP Hate Crime Summit and for the production and distribution of the Justice Department's law enforcement hate crime training initiative. In addition, the COPS Office funded several bias crime-related initiatives under the $40 million Problem-Solving Partnership grant program.

Determining the prevalence of hate crimes is difficult for many reasons. Federal law enforcement officials have only been compiling nationwide hate crime statistics since 1991, the year after the Hate Crime Statistics Act (HCSA) (28 U.S.C. 534) was enacted. The HCSA requires the Justice Department to acquire data on crimes which "manifest prejudice based on race, religion, sexual orientation, or ethnicity" from law enforcement agencies across the country and to publish an annual summary. In 1992, at the direction of Congress, the Department of Justice's Office for Victims of Crime (OVC) provided funds to improve the response of law enforcement and victim assistance professionals to victims of hate crimes.[99]

In the Violent Crime and Law Enforcement Act of 1994 (Public L. No. 103-322, 108 Stat. 1796), Congress expanded coverage of the HCSA to require FBI reporting on crimes based on "disability." In September of 1994, the Violence Against Women Act (VAWA) of 1994 (42 U.S.C. 13981), which is comprehensive legislation dealing with the increasing problem of violent crime against women, was passed by Congress. One provision of VAWA is a new Federal civil remedy for victims of gender-based violent crimes which provides them with the right to compensatory and punitive damage awards as well as injunctive relief. Under a grant funded by the Bureau of Justice Statistics (BJS), scholars and researchers from the Center for Criminal Justice Policy Research at Northeastern University in Boston are studying differences in reporting rates among law enforcement agencies—and identifying strategies for increasing and sustaining reporting participation by these State and local officials. In addition, BJS is currently integrating questions about hate crime into its National Crime Victimization Survey (NCVS).[100]

As with most other offenses, reporting hate crimes is voluntary on the part of local jurisdictions. Some States started submitting data only recently, and not all jurisdictions within States are represented in their reports.[101] Another obstacle to obtaining an accurate count of hate crimes is the reluctance of many victims to report such attacks. In a study of gay men and lesbians by Herek and associates (1997), about one-third of the hate crime victims reported the incident to law enforcement authorities, compared with two-thirds of gay and lesbian victims of nonhate crimes.[102] Dunbar (1997), who studies hate crime in Los Angeles County, has found that victims of severe hate acts are the least likely of all hate crime victims to notify law enforcement agencies, often out of fear of future contact with the perpetrators.[103] It also appears that some people do not report hate crimes because of fear that the criminal justice system is biased against the group to which the victim belongs and, consequently, law enforcement authorities will not be responsive. The National Council of La Raza holds that Hispanics often do not report hate crimes because of mistrust of the police.[104]

Many potentially effective culturally and linguistically competent intervention strategies for violence prevention exist, such as parent training, mentoring of youth, and home visitation.[105] The Center for Mental Health Services (CMHS), a component of the Federal government's Substance Abuse and Mental Health Services Administration (SAMHSA), is developing a matrix of evidence-based prevention interventions from the CMHS School Violence Prevention Initiative. (More information is available online at www.samhsa.gov/cmhs.) Other integrated, multidisciplinary public health and social services approaches—including cross-training of service delivery staff, coordination of referral mechanisms, and counseling of both survivors and perpetrators—are seen as effective.

In addition to strategies and approaches, many resources exist devoted to preventing different types of violence and making society safer for all of us throughout the lifespan. In response to an alarming increase in hate crime among youth, the Southern Poverty Law Center (SPLC) founded the Teaching Tolerance Organization in 1991. This organization is a national education project dedicated to helping teachers foster equity, respect, and understanding in the classroom and beyond (www.splcenter.org). The Teaching Tolerance handbook, Responding to Hate at School, is a step-by-step, easy-to-use guide designed to help administrators, counselors, and teachers react promptly and effectively whenever hate, bias, and prejudice occur.[106]

Massachusetts is a model State for the ongoing efforts to address antigay bigotry in public schools The report, "Making Schools Safe for Gay and Lesbian Youth," is available from the Governor's Commission on Gay and Lesbian Youth, State House, Room 111, Boston, MA, 02133, 617-828-3039.

Legal measures are also a possible remedy against violence. A number of Federal and State laws prohibit acts or threats of violence, as well as harassment and discrimination, based on race, color, religion, national origin, sexual orientation, gender and/or disability. Section 245, 18 U.S.C., is the principal Federal hate crime statute, although neither sexual orientation nor gender identity is included. In the first Federal appellate case on antigay

violence in schools, Lambda, the nation's oldest and largest lesbian and gay legal organization founded in 1973, successfully represented Jamie Nabozny, who suffered severe antigay abuse for 4 years in his Wisconsin middle and high schools.[107] In its landmark ruling, the court said, "…The Equal Protection clause does, however, require the State to treat each person with equal regard, as having equal worth, regardless of his or her status…We are unable to garner any rational basis for permitting one student to assault another based on the victim's sexual orientation." The court remanded the case for trial, and in November 1996, a jury found three school administrators liable for discriminating against Jamie Nabozny. The school settled the case for just under $1 million.[108] The Human Rights Campaign (HRC) has established FamilyNet (www.hrc.org/familynet) for all LGBT people as a place where practical information, community support and expert advice on a menagerie of topics, including violence, can be obtained.

Finally, sources of funding violence prevention exist in the public and private sector. For example, the Violence Against Women Office, of the Office of Justice Programs, United States Department of Justice was created in 1995 to implement the 1994 Violence Against Women Act (VAWA) and to lead the national effort to stop domestic violence, sexual assault, and stalking of women. The Violence Against Women Office works with U.S. Attorneys to ensure enforcement of the Federal criminal statutes contained in the 1994 Act, assists the Attorney General in formulating policy related to civil and criminal justice for women, and administers more than $270 million a year in grants to help States, tribes, and local communities transform the way in which criminal justice systems respond to violent crimes against women. The National Funding Initiative on Violence Prevention (NFCVP) is a partnership among public and private funders, experts in violence prevention, and other disciplines and community collaborations. Since its establishment in 1994, the NFCVP has raised over $10.4 million from both Federal and philanthropic sources to support strategies that emphasize citizen engagement, promote community empowerment, and comprehensively address the range of factors undermining community safety. Additional information is available online at www.peacebeyondviolence.org.

Summary of LGBT Research

This section focuses on a range of issues associated with violence prevention related to LGBT populations. Specifically, this chapter addresses reported hate-motivated crimes, domestic violence, other physical and sexual violence, and suicide. These categories generally follow those reported by the Department of Health and Human Services (DHHS) and the Department of Justice (DOJ). However, it should be noted that the categories are not necessarily mutually exclusive. For example, "other physical violence" may include hate-motivated violence or domestic violence that has not been reported or documented as such.

Hate-motivated violence: Most hate crime perpetrators are not crazed, hate-filled neo-Nazis or "skinheads."[109] Dunbar's research (1997) reveals that fewer than 5 percent of the perpetrators of the 1,500 hate crimes committed in the Los Angeles area between 1994 and 1995 were members of organized hate groups.[110] Most hate crimes are carried out by otherwise law-abiding people who see little wrong in their actions. However, extreme hate

crimes tend to be committed by people with a history of antisocial behavior.[111] Examples of horrific crimes include the dragging death of James Byrd on June 7, 1998 in Jasper, Texas,[112] the torturous death of Matthew Shephard on October 12, 1998 in Laramie, Wyoming (www.mattshepard.org), and the mass shooting with one fatality (Danny Overstreet) on September 22, 2000 in a gay bar in Roanoke, Virginia.[113] Although alcohol and drugs sometimes help fuel the commission of both hate crimes and extreme hate crimes, the main determinant appears to be personal prejudice, a situation that impairs people's judgment, blinding the perpetrators to the immorality of their behaviors.[114]

Aggressive behavior, denigration, and other forms of violence against LGBT people have been documented in a myriad of settings, including schools and colleges, the armed services, jails and prisons, homes, workplaces, and other public places.[115, 116, 117, 118, 119, 120, 121 122, 123] It is widely hypothesized that hate crimes or hate-motivated violence can inflict psychological damage far greater than other types of violence as a result of assaulting the victim's identity as well as his or her person or property.[124, 125] Twenty-two (22) gay- or lesbian-related homicides were reported by national tracking programs in 1995. Including States without tracking programs, 70 is the statistical estimate of nationwide gay- or lesbian-related homicides occurring in 1995. Of those 70 homicides, only two victims were women, and both were killed by family members.[126] A 1999 report by the NCAVP points to a 12 percent rise in homicides resulting from hate-motivated violence against LGBT individuals over the previous year (26 murders in 1998; 29 in 1999).[127] These numbers underrepresent a national total of anti-LGBT murders because they include only those murders reported to a mere 13 reporting sites across the country. Furthermore, this 12 percent rise is in stark contrast to the nation's murder rate generally, which has declined to its lowest level in decades.[128]

Antihomosexual violence may be different from more usual forms of violence in several ways. Homicides committed against LGBT persons often are more violent than homicides committed in the general population.[129, 130] Similarly, it is more likely that the assailant and victim are strangers and that there will be a higher ratio of assailants to victims.[131, 132] While hate-based violence occurs against LGBT persons of all ages, younger LGBT persons appear to be particularly vulnerable.[133] In those circumstances, family members and community authorities are often the perpetrators of homophobic hate crimes,[134] and many gay and lesbian adolescents have been forced out of their homes or schools because of abuse related to their sexual orientation.[135, 136, 137] Violence is most often learned at home,[138] a fact that has powerful implications on how LGBT persons who experience violence in the home perceive violence and how perpetrators of violence perceive their own behavior.

Many surveys of hate crime, specifically, or of personal violence, in general, are unable to estimate on a State, regional, or national level, the incidence and prevalence of hate crimes against the LGBT population[139, 140] Only one published study focuses exclusively on antilesbian hate crimes.[141] However, a larger lesbian health survey that included questions on violence and hate crimes revealed that more than half of respondents had experienced a verbal hate crime, and about 1 in 20 had been physically assaulted due to her sexual orientation.[142] Other research has found that about 75 percent of lesbians have experienced

at least one verbal hate crime, and 1 in 10 reported experiencing a hate-motivated physical assault in the past.[143, 144, 145]

The California Penal Code Section 13023 (1989) requires the State Attorney General to submit an annual report to the Legislature regarding crimes motivated by the victim's race, ethnicity, religion, gender, sexual orientation or physical or mental disability as reported by law enforcement agencies. In 1999, of 1,962 reported hate crime events 59.8 percent were motivated by the race/ethnicity of the victim; 22.2 percent were motivated by the sexual orientation of the victim; 17.2 percent were motivated by the religion of the victim; 0.1 percent were motivated by the physical/mental disability of the victim; and 0.7 percent were motivated by the gender of the victim. Of the sexual orientation hate crimes, 77.8 percent were antimale homosexual; 15.4 percent were antifemale homosexual; and the remaining 7.8 percent were antihomosexual. There were 13 gender hate crimes. All 13 were antitransgender.[146]

The Safe Schools Coalition of Washington publishes the results of its documentation of antigay abuse of youth in Safe Schools Anti-Violence Document Project Third Annual Report (1997). To order copies of the report, call or write the Northwest Coalition Against Malicious Harassment, P.O. Box 16776, Seattle, WA, 98116, 206-233-9136, or download at www.safeschools-wa.org.

An estimated 20 to 26 percent of 746 gay and bisexual men in New York City who participated in a longitudinal study reported being the victims of antigay violence or discrimination at least once a year from 1985 to 1991. Half of the participants experienced at least one such event in one of the years, while 26 percent of the sample reported experiencing violence in two or more years of the study.[147] The study by Herek and associates (1997) revealed that antigay victimization is a common experience for gay men, lesbians, and bisexuals in the Sacramento area.[148] In this study, roughly one fifth of the respondents had experienced an antigay property crime. Verbal harassment and threats were even more prevalent, with approximately one-half of the respondents experiencing at least one incident in the previous year, and most of the sample reporting at least one incident since age 16. Further, individuals who experienced physical assault because of their sexual orientation appeared to have higher levels of psychological distress. Bias crime assault survivors were more anxious and angry than others and experienced more symptoms of depression and Post Traumatic Stress Disorder (PTSD). They also displayed less willingness to believe in the general benevolence of people and rated their own risk for future victimization somewhat higher than did others.[149]

A Youth Risk Behavior Survey (YRBS) conducted in Seattle in 1995 showed that, when compared with heterosexual youth, LGBT youth were almost six times more likely to be targets of offensive comments or attacks, three times more likely to be injured in a fight to the point of requiring medical attention, and more than twice as likely to have missed at least one day of school in the last month because of fearing for their safety. A Massachusetts YRBS conducted in 1997 showed that, compared to their heterosexual classmates, LGBT youth were more than 4 times as likely to have been threatened with or

injured by a weapon at school in the past 12 months, twice as likely to have been in a physical fight, and 4.5 times as likely to have missed at least one day of school in the last month because of fearing for their safety.[150] One study showed that up to half of LGBT students had experienced physical harassment,[151] while another study revealed that more than 90 percent of LGBT youth had been verbally abused at school.[152]

LGBT youth are not the only victims of antigay violence. In fact, four out of five victims of antigay violence are actually heterosexual. When compared with the general heterosexual student population, straight victims of antigay violence exhibit lower academic performance, were 1.5 times as likely to use drugs, more than twice as likely to consider or plan suicide, more than 3 times as likely to have attempted suicide, and 5 times as likely to have attempted suicide to a degree of requiring medical treatment. Straight victims of antigay violence report levels of risk behavior similar to LGBT victims of violence.[153] A Wisconsin YRBS reported that, regardless of sexual orientation, youth who experienced antigay harassment were more likely to have used cigarettes (1.5 times), inhalants (2.5 times), LSD (2.6 times), and cocaine (3.3 times); considered suicide (2.2 times), attempted suicide (4 times), been pregnant or gotten someone pregnant (3 times), and vomited or taken laxatives to lose weight in the past 30 days (4.7 times).[154] Victims and observers of antigay harassment are often hesitant to report such incidents because they fear further or increased violence from offenders.[155]

The psychological toll of violence based on sexual orientation is significant. In fact, recovery from bias-based violence takes much longer than recovery from random violence.[156] Trauma associated with hate crime victimization probably lasts longer than one year, perhaps as long as five years.[157, 158] Environments that deny youth the opportunity to learn and participate, or subject youth to ongoing humiliation, lead to diminished self-esteem, undermine self-confidence, and create a "pervasive sense of insecurity and self-doubt."[159] Environments where violence is tolerated, combined with lowered self-esteem, exacerbate psychological distress.[160] LGBT students who are victims of antigay violence have higher risk-taking and self-endangerment behaviors compared with LGBT or heterosexual students who have not been victimized. In addition, studies show that "youth who feel vulnerable to physical attack are more likely to commit acts of violence."[161] Other behaviors include increased drug use, lower academic performance, and considering, planning, and attempting suicide.[162] Perhaps the most frightening consequence of victimization is its relationship with suicidality, which becomes more and more direct as the severity of the violence increases.[163]

Hate Crimes Reporting. The summary of data regarding LGBT-related hate crimes must be considered in light of existing reporting systems. The FBI definition of hate crimes, described earlier in this chapter, acknowledges a specific motivation for a criminal event. The Hate Crimes Statistics Act of 1990 (P.L.101-275) was developed to shed new light on the scope of the problem in the United States. However, in 1999, 85 percent of the 12,122 participating agencies (representing two-thirds of all local departments that could participate) reported zero hate crimes in their jurisdictions during the year.[164] Such underreporting is likely related to two factors. First, many States do not currently recognize

crimes committed with a bias against sexual orientation as hate crimes. And second, sexual orientation is not included in the 30-year-old Federal hate crime statute. If crimes are not recognized accurately as bias crimes, they cannot be reported. Thus, LGBT statistics are considered vastly underestimated in national statistics. Also, similar to previous years, the number of antigay hate crimes recorded for the FBI report is significantly lower than the number of crimes logged for the same year by the National Coalition of Anti-Violence Programs, a gay organization which monitors antigay violence.[165]

Underreporting of hate-motivated violence against the LGBT population has been documented in a number of studies. For example, one longitudinal study found that only 13 to 14 percent of violent incidents against gay men each year were reported to the police.[166] Victims are often reluctant to disclose their sexuality to authorities for fear that such disclosure may subject them to additional punishment. According to a summary of antigay violence and victimization surveys conducted between 1988 and 1991, this fear may be well founded since 16 to 30 percent of LGBT victims had reported being victimized by police.[167]

Other physical violence. Studies of child sexual abuse and adult sexual assault among the LGBT population reveal divergent results, as might be expected given generic reporting problems related to sexual abuse and assault, and given the stigma experienced by LGBT populations. For example, some studies report that lesbians aged 25 and younger[168] experience rates of abuse and assault that are similar to the general female population.[169] Another study of male-male rape of adolescent and adult gay males in New York found that gay males are more likely to have been sexually assaulted than heterosexual men.[170] Tjaden and associates (1999) used data from a nationally representative telephone survey conducted from November 1995 to May 1996 to compare lifetime experiences with violent victimization among men and women with a history of same-sex cohabitation and their counterparts with a history of marriage and/or opposite-sex cohabitation only.[171] The study found that respondents who had lived with same-sex intimate partners where significantly more likely than respondents who had married or lived only with an opposite-sex partner to have been: (1) raped as minors and adults; (2) physically assaulted as children by adult caregivers; and (3) physically assaulted as adults by all types of perpetrators, including intimate partners. The study also confirms previous reports that intimate partner violence is more prevalent among gay male couples than heterosexual couples. On the other hand, intimate partner violence is not more prevalent among lesbians than heterosexual couples, thereby suggesting that intimate partner violence is perpetrated primarily by men, whether against same-sex or opposite-sex partners.[172]

The long-term consequences of sexual abuse are severe and well documented. Among the general population, such crime has been associated with substance abuse, depression, suicidal ideation, and a need for mental health services.[173] There may be particular consequences for the LGBT population. For example, one study that compared sexually abused gay men to gay men who reported no such abuse found that those who had been sexually abused demonstrated higher levels of internalized homophobia and an earlier onset of sexual activity than nonabused gay males.[174] Another study found that gay and bisexual men who reported a history of childhood sexual abuse demonstrated higher HIV risk-taking

behaviors,[175] a finding that has also been documented in studies of Latino and African American men.[176, 177] In a study of 228 gay male perpetrators, Farley (1996) found the following contributing to gay interpersonal violence—40 percent abused drugs, 87 percent had previous mental health problems, 93 percent reported physical abuse as a child, 67 percent reported sexual abuse as a child, 40 percent reported alcohol abuse in their family of origin, and 80 percent had a previous history of being an abuser in an adult relationship.[178]

Finally, male-male adult and adolescent sexual assaults almost always involve unprotected anal intercourse, which magnifies the trauma of sexual assault and potential consequences because of risk of HIV infection.[179] Notwithstanding the prevalence of all types of physical assaults against the LGBT population, health personnel (in particular, emergency medical personnel), staff at rape crisis centers, social service providers, and criminal justice personnel are generally unfamiliar with the psychological or physical examination needs of LGBT survivors.[180, 181]

Domestic violence. A myth only recently being identified and addressed is that women do not batter other women in their relationships.[182] This myth has been one of the biggest obstacles to dealing with the problem of lesbian and bisexual women battering in this country.[183] Kerry Lobel and the National Coalition Against Domestic Violence Lesbian Task Force's publication, Naming the Violence: Speaking Out Against Lesbian Domestic Violence (1986), was a milestone for the battered women's movement as it first acknowledged the problem.[184] A positive correlation between substance abuse and domestic violence is generally accepted, and high rates of substance abuse in the lesbian and gay community may exacerbate the level of domestic violence.[185]

The NCAVP collects data from 14 LGBT antiviolence programs and nine "mainstream" domestic violence programs in 13 cities. According to their report on 1998 data, the NCAVP found that "attempts to gauge the actual prevalence of violence in LGBT relationships have generally found rates roughly equal to rates estimated in heterosexual couples (i.e., between 25 and 33 percent of LGBT couples experience battering behavior)." [186] In cases in which the gender identity of the survivor was known, 49 percent were male, 48 percent were female, 3 percent were MTF transgender, and less than 1 percent were FTM transgender. With regard to sexual orientation, the majority of reporting survivors was either gay (47 percent) or lesbian (36 percent). Nine percent were bisexual. [187, 188]

A few studies of intimate partner violence or sexual assault in lesbian relationships, though limited by small samples,[189, 190, 191] revealed intimate partner violence rates slightly lower (11.4 percent)[192] than rates reported by heterosexual women.[193] Bisexual women may have these problems as well; however, the data is almost nonexistent. Bisexual women have felt that they exist between two worlds, unaccepted in either.[194] Intimate partner violence among gay men also is documented,[195] [196] [197] with prevalence rates comparable to or somewhat higher than those observed among heterosexual couples.[198]

Lesbians and gay males who are the victims of domestic violence often find that police, health practitioners, and social service providers lack training and resources on the nature

and dynamics of homosexual intimate partner violence. For example, the laws of a number of States exclude battered lesbians and gay men by defining domestic violence only as violence between members of the opposite sex or as violence occurring between spouses, former spouses, or family members who are related by blood or consanguinity.[199] Thus, many law enforcement officials have no legal basis on which to intervene. Shelters for battered persons are rarely equipped to accommodate men, and groups for batterers, which are themselves uncommon, are generally not open to women. However, Johnson (1999) discusses his experience with groups at Fenway Community Health Center in Boston, MA as well as with groups in San Francisco, New York City, and Los Angeles.[200] Also, in Massachusetts, there is a battering group for lesbians and bisexual women.[201]

Receiving support for domestic violence is critical for lesbians as many of them may lose their entire support system.[202] Another issue faced by service providers which distinguishes the lesbian domestic violence issue from others is the inability to determine which of a lesbian or bisexual client is the actual batterer. Women are more likely to fight back against a lesbian batterer and could move from being the victim to being the perpetrator.[203] [204]

Not only have all the domestic services (and the movement itself) been developed assuming a female survivor of battering, but society has deeply ingrained biases against men who fit into society's picture of the victim.[205] Men who have been battered are often so reluctant to admit they have been abused that they have to experience extreme violence before they will seek assistance. Many men find it difficult to leave a battering relationship since they feel they must stay and "stand their ground" or "take it like a man."[206]

Suicide and Suicidal Ideation in LGBT Populations. (See Mental Health focus area.) An association between same-gender sexual orientation and elevated lifetime prevalence of suicide ideation and attempts has been reported in several studies of general population probability samples of adolescents and adults.[207, 208, 209, 210, 211, 212, 213] In addition, research studies on convenience samples of LGBT people have commonly found higher rates of reported suicide attempts and ideation than general population research would lead one to expect.[214, 215, 216, 217, 218, 219, 220, 221] As one example, the results of the National Lesbian Health Care Survey (NLHCS) found that more than half of the sample had experienced thoughts of suicide at some time, and 18 percent had attempted suicide.[222] This compares to 33 percent and 4 percent, respectively, for women in the United States as reported in the Epidemiologic Catchment Area studies.[223]

Van Kesteren and colleagues reported a disproportionately high number of suicide deaths in MTF transsexuals compared to the general population.[224] However, after reviewing more than 2,000 cases, Pfafflin and Junge found reports of only 16 possible suicide deaths following surgical sex reassignment.[225] Dixen and colleagues found that, among 479 MTF and 285 FTM transsexuals seen in the Palo Alto program, about 25 percent and 19 percent respectively had attempted suicide prior to transition.[226] Most other studies report a pre-transition suicide attempt rate of 20 percent or more, with MTFs relatively more suicide-prone than FTMs.[227] In the Washington Transgender Needs Assessment Survey, the suicidal ideation rate was 35 percent, and the attempt rate was 16 percent.[228] Another form of self-

harm in transgender persons is attempted or completed autocastration or genital mutilation. A study of a cohort of transgender individuals who applied for services at gender identity clinics reported that genital mutilation was attempted by 9 percent of the males, while breast mutilation was attempted by 2 percent of the females.[229]

Several recent population studies have reported alarmingly high rates of suicide ideation and attempts among young people who identify themselves as homosexual or report same-sex sexual partners. For example, six studies found that rates of various measures of suicide ideation and attempts were three to seven times higher among gay and lesbian youth than heterosexual youth.[230, 231, 232, 233, 234, 235] Mediating factors for suicidal ideation among LGBT youth include depression, substance abuse, and victimization.[236, 237, 238, 239, 240] The suicidal ideation rate in one needs assessment of young transgender people was 28 percent, with 17 percent reporting actual suicide attempts.[241]

Discussion of Healthy People 2010 Objectives

15-10: Increase the number of States and the District of Columbia with statewide emergency department surveillance systems that collect data on external causes of injury.

Statewide emergency surveillance systems could provide an urgently needed mechanism for collecting data on external injuries caused by domestic violence, bias crimes, and other sources of injury to LGBT individuals. Data instruments for the collection of such data should be developed and implemented to generate new knowledge on causes of injury against LGBT individuals that may be bias-based in nature.

The current data source for this objective is the External Cause of Injury Survey, American Public Health Association (APHA). Twelve States had statewide emergency department surveillance systems that collected data on external causes of injury in 1998. The following is how the current question appears on the survey:

- Are International Classification of Disease, 10th Revision, Clinical Modification (ICD-10-CM) data routinely collected in the statewide emergency date system?

APHA could be approached to determine the feasibility of collecting LGBT data on this survey. However, the likelihood of adding LGBT data to the database is low because most emergency departments do not collect such data and LGBT people might be uncomfortable with supplying such information, given the possible ramifications. A more likely scenario would be for a researcher to do a probability study of LGBT people and external causes of injury.

15-11: Increase the number of States and the District of Columbia that collect data on external causes of injury through hospital discharge data systems.

As with the previous objective, the current data source is the External Cause of Injury Survey, APHA. Twenty-three States collected data on external causes of injury through

hospital discharge data systems in 1998. The following is how the current question appears in the survey:

- Is the collection of ICD-10-CM data in the statewide hospital discharge data system mandated by State law or a ruling by another body?

The term "mandate" refers to a State law or a ruling by another body (e.g., the State Hospital Association) that requires hospitals to collect ICD-10-CM data. Currently, there are no established procedures for collecting data on external causes of injury that may be bias-related upon discharged from a hospital. Data systems for collecting such information should be developed and implemented upon discharge from a hospital; however, issues of confidentiality need to be carefully considered in establishing such a system.

15-32: Reduce homicides.

This objective is one of the measures of Leading Health Indicators. (See Introduction for description of Leading Health Indicators.)

Homicide was the 13th leading cause of death for 18,272 persons in the United States (6.8 per 100,000 population) in 1998.[242] The homicide rate among males aged 15 to 24 years in the United States is 10 times higher than in Canada, 15 times higher than in Australia, and 28 times higher than in France or Germany.[243]

The data source for this objective is the National Vital Statistics System (NVSS), the Center for Disease Control and Prevention (CDC), the National Center for Health Statistics (NCHS); FBI Uniform Crime Reports, U.S. Department of Justice.[244] The NVSS for mortality began in 1900 but not all States participated before 1933. Geographic estimates are available on a national, regional, State, and county basis. Beginning with 1989 data, some changes were initiated to increase confidentiality protection. Identifying information, including date of death and geographic indicators for counties of less than 100,000 persons, are not available for public use.[245]

The mode of administration of the NVSS is as follows: Administrative records (death certificates) completed by physicians, coroners, medical examiners, and funeral directors are filed with State vital statistics offices; selected statistical information is forwarded to NCHS to be merged into a national statistical file. Beginning with 1989, revised standard certificates replaced the 1978 versions; the next scheduled revision is 2003. Demographic information on the death certificate is provided by the funeral director and is based on information supplied by an informant. Medical certification of cause of death is provided by the physician, medical examiner, or coroner.

The primary survey content includes: year of death, place of decedent's residence, place death occurred, age at death, day of week and month of death, Hispanic origin, race, marital status (beginning in 1979), place of birth, gender, underlying and multiple causes of death for all States, injury at work (beginning in 1993), hospital and patient status, educational attainment (beginning in 1989) for selected States, and occupation and industry (beginning in 1984) for selected States.

Demographic data include: gender, race, Hispanic origin (beginning in 1984), age at death, place of decedent's residence, educational attainment (beginning in 1989) for selected States, marital status, and industry and occupation for selected States. Race and ethnic origin are separate items on the death certificate. Beginning with 1992 data, California, Hawaii, Illinois, New Jersey, New York, Texas, and Washington reported expanded Asian and Pacific Islander categories of Asian Indian, Korean, Vietnamese, Samoan, and Guamanian. The rest of the States reported a combined Other Asian and Pacific Islander category in addition to the categories of White, Black, American Indian, Chinese, Hawaiian, Japanese, and Filipino that all States report. As of 1997, all States began reporting Hispanic origin. The categories reported include Mexican, Puerto Rican, Cuban, Central and South American, and Other Hispanic.

A 1999 report by the NCAVP points to a 12 percent rise in homicides resulting from hate-motivated violence against LGBT individuals over the previous year (26 murders in 1998; 29 in 1999).[246] These numbers underrepresent a national total of anti-LGBT murders because they include only those murders reported to a mere 13 reporting sites across the country.

15-33: Reduce maltreatment and maltreatment fatalities of children.

The 1997 Child Maltreatment Report from the States to the National Child Abuse and Neglect Data System found there were approximately 984,000 victims of maltreatment, a decrease from more than 1 million victims in 1996 in the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, and Guam. The rate of child victims was 13.9 per 1,000 children in the general population in 1997, which is slightly higher than the rate of 13.4 victims per 1,000 children in 1990. There were an estimated 1,196 fatalities due to child maltreatment in the 50 States and the District of Columbia. The findings regarding the types of maltreatment were as follows: 55.9 percent neglect, 24.6 percent physical abuse, 12.5 percent sexual abuse, and 6.1 percent emotional abuse. It is also important to note that 58.8 percent of the substantiated or indicated reports of maltreatment were from professional sources: legal, medical, social service, or education professionals. Based on data from 39 States, 75.4 percent of the perpetrators were the victims' parents, 10.2 percent were relatives, and 1.9 percent were individuals in other caretaking relationships.[247]

Information needs to be collected about new cases and causes of maltreatment. National surveys of new cases are needed to describe the magnitude of the problem. In addition, existing interventions and their impact need to be evaluated. Some long-term studies on home-visitation programs for young mothers have shown potential for preventing child abuse and neglect.

There are two subobjectives: reduce maltreatment of children and reduce child maltreatment fatalities. The data source is the National Child Abuse and Neglect Data System (NCANDS), Administration on Children, Youth and Families, Administration for Children and Families (ACF), Children's Bureau. The National Center on Child Abuse and Neglect (NCCAN) established NCANDS in response to the Child Abuse Prevention and Treatment Act (Public Law 93-247), as amended, which called for the creation of a coordinated universal and case-specific national data collection and analysis program. In 1988, NCCAN embarked on a collaborative effort with the States to collect and analyze annual child abuse

and neglect data, on a voluntary basis, from Child Protective Services (CPS) agencies in the 50 States, the District of Columbia, the territories, and the Armed Services. Findings from NCANDS are based on aggregate data from 49 States and case-level data from 16 States.[248]

Maltreatment is defined as an act or failure to act by a parent, caretaker, other person, as defined under State law, which results in death, serious physical or emotional harm, sexual abuse or exploitation, or an act or failure to act that presents an imminent risk of serious harm. State definitions may include additional criteria.[249] The national information is prepared from State data reports of maltreatment from State child welfare agencies.

The numerator for the first subobjective is the number of persons aged 18 years and under found to be victims of maltreatment by State child welfare agencies. The actual question appearing on the survey is:

- Enter the number of children by disposition who were the subject of a CPS investigation or assessment _____

The national rate of children who were the subjects of reports was estimated to be 42.0 children per 1,000 children in the general population. Based on the number of child victims in the 41 reporting States (798,358), more than half of child victims (54.7 percent) were victims of neglect, while a quarter (24.5 percent) suffered physical abuse. Twelve percent were sexually abused. Child victims of psychological abuse or neglect or medical neglect accounted for 6.2 and 2.4 percent of all victims, respectively, while 11.0 percent were subjected to other types of maltreatment, such as "abandonment," "congenital drug addiction," and "threats to harm the child." (Percentages add up to more than 100 because children could have been victims of more than one type of abuse.)[250]

The numerator for the second subobjective is the number of reported child fatalities due to maltreatment among children aged 18 years and under. Child fatality due to maltreatment is defined as the death of a child as a result of abuse or neglect, because either (a) an injury resulting from the abuse or neglect of a child was the cause of the death, or (b) abuse or neglect were contributing factors to the cause of death. Data on child fatalities are collected from all States. Some State offices of CPS work closely with Health Departments or the coroner's office, whereas others rely more on their own records, including deaths reported to them by law enforcement.[251] The actual question appearing on the survey is:

- Enter the number of child victims who died as a result of child abuse or neglect _____

Forty-one States reported that there were 967 child maltreatment fatalities in 1997. Based on these numbers, it was estimated that there were 1,196 fatalities in the 50 States and the District of Columbia, a rate of 1.7 children per 100,000 children in the general population or 123 child fatalities per 100,000 victims of maltreatment.[252]

Violence or potential violence in the home is a primary, precipitating factor in some LGBT youth running away from home. These LGBT youth report histories of sexual abuse, physical abuse, and emotional abuse from parents, family members, guardians, and others in positions of power and responsibility.[253, 254, 255, 256] In addition, some LGBT youth are

probably more likely than the general population to refrain from reporting family violence for fear of disclosure and further harm to themselves and their families. Improving the cultural appropriateness of service agencies to which youth may report violence and enhancing the sense of safety these programs offer victims could improve the data and information available, hold perpetrators accountable, and increase understanding of this public health challenge.

15-34: Reduce the rate of physical assault by current or former intimate partners.

The data source for this objective is the National Crime Victimization Survey (NCVS), U.S. Department of Justice, Bureau of Justice Statistics. Sexual orientation data currently are not collected (DNC in the data template). The numerator is the number of persons aged 12 years or older who report being threatened or assaulted by a current or former spouse, boyfriend, or girlfriend.

NCVS uses a stratified, multistage cluster sample. Primary sampling units (PSUs) consist of counties, groups of counties, or large metropolitan areas. The 1994 survey sample households were drawn from the 1980-based sample design. Data are collected every year from a sample of approximately 50,000 households that include about 100,000 people aged 12 years and older. PSUs remain in the sample for a total of 3 years. A total of seven interviews are conducted at 6-month intervals during the 3-year process. NCVS counts incidents not reported to police and is one of two U.S. Department of Justice measures of crime in the United States. The survey contains a screening section with detailed questions and cues on victimizations and situations within which crimes may take place. Interviewers follow up positive responses and collect details about victimizations in incident reports. Demographic variables include age, gender, race, ethnicity, and income. Property crimes include data on age, race, ethnicity, and household size.[257]

Available data from 13 reporting centers throughout the United States indicate that intimate partner abuse occurs in 25 to 33 percent of same-sex relationships, generally equivalent to rates reported for opposite-sex relationships.[258] NCAVP reported 2,574 cases of domestic violence in LGBT relationships in 1998. However, there is evidence that violence in same-sex relationships maybe the "most overlooked" form of intimate violence[259] and that violence between same-sex partners may be as severe as that found between opposite-sex partners.[260]

15-35: Reduce the annual rate of rape or attempted rape.

The data source for this objective is the National Crime Victimization Survey (NCVS), U.S. Department of Justice, Bureau of Justice Statistics. Sexual orientation data currently are not collected (DNC in the data template).

This area is one for which there seems to be neither data nor research on LGBT populations. Obviously, this objective requires discussion as to the context, definitions, and mechanisms for proceeding. Given some of the alleged rates of alcohol abuse and use of other drugs, there are probably few LGBT individuals who would deny that rape or

attempted rape occurs within the LGBT populations. Stigma and myths surround this area of investigation, and prompt the need for solid research-based findings.

15-36: Reduce sexual assault other than rape.

Both females and males experience family and intimate violence and sexual assault. Perpetrators can be the same or of the opposite sex. Male victimization of females is more common in intimate partner violence and sexual assault.

In 1995, almost 5,000 females in the United States were murdered. In those cases for which the FBI had data on the relationship between the offender and the victim, 85 percent were killed by someone they knew. Nearly half of the females who knew the perpetrators were murdered by a husband, ex-husband, or boyfriend.[261] In 1994, more than 500,000 females were seen in hospital Emergency Departments (ED) for violence-related injuries, and 37 percent of those females were there for injuries inflicted by spouses, ex-spouses, or nonmarital partners.[262] Although most assault victims survive, they suffer physically and emotionally.

Violence against women is primarily partner violence. A national survey conducted from November 1995 to May 1996 estimates that approximately 1.5 million females and 834,700 males are raped and/or physically assaulted by an intimate partner annually in the United States. Seventy-six percent of the females who were raped and/or physically assaulted since age 18 were assaulted by a current or former husband, cohabiting partner, or date, compared with 18 percent of the males. Females are significantly more likely than males to be injured during an assault: 32 percent of the females and 16 percent of the males who were raped since age 18 were injured during their most recent rape; 39 percent of the females and 25 percent of the males who were physically assaulted since age 18 were injured during their most recent assault. About one in three females who were injured during a rape or physical assault required medical care.[263]

Estimates of abuse rates during pregnancy also are a concern. A 1996 literature review indicated that estimated proportions of women experiencing Intimate Partner Violence (IPV) during pregnancy ranged between 0.9 percent and 20.1 percent. The majority were between 4 and 8 percent. The proportion of pregnant women who had experienced IPV at any time in the past ranged between 9.7 percent and 29.7 percent.[264]

Males who are physically violent toward their partners are more likely to be sexually violent toward them, and are more likely to use violence toward children.[265] The perpetration of IPV is most common in adults who, as children or adolescents, witnessed IPV or became the targets of violence from their caregivers.[266]

Survey data from 1994 indicate that 407,190 females aged 12 years and older were victims of rape, attempted rape, or sexual assault.[267] Other surveys indicate that the problem is underestimated.[268] For example, the National Women's Study, in conjunction with estimates based on the U.S. Census, suggests that 12.1 million females in the United States have been

victims of forcible rape sometime in their lives. According to this study, 0.7 percent or approximately 683,000 of adult females experienced a forcible rape in the past year.[269]

Teen dating violence is a concern that may stem from childhood abuse or other experiences with violence. Battering in teen relationships is very different from IPV that occurs between adults. The issue of teen dating violence requires national attention and prevention efforts that need to continue focusing on adolescent violence within the larger context of family violence.

The nature of IPV and sexual violence makes such problems difficult to study. Consequently, much remains unknown about the factors that increase or decrease the likelihood that males will behave violently toward females, the factors that endanger or protect females from violence, and the physical and emotional consequences of such violence for females and their children.

The current data source for this objective is the National Crime Victimization Survey (NCVS), U.S. Department of Justice, Bureau of Justice Statistics. Sexual orientation data currently are not collected.

15-37: Reduce physical assaults.

In 1999, NCAVP reported 735 incidents of assault (without a weapon, with a weapon, and attempted assault with a weapon), abduction/kidnapping, bomb threats/bombings, and arson against individuals in the LGBT population. These include both hate-motivated and other acts of violence. In particular, it is important to ensure that DHHS and DOJ address bias-driven incidents committed by hate groups (25 in 1998; 17 in 1999 against LGBT individuals) or the police (72 in 1998; 30 in 1999).[270]

The current data source for this objective is the National Crime Victimization Survey (NCVS), U.S. Department of Justice, Bureau of Justice.

15-38: Reduce physical fighting among adolescents.

Sexual minorities are the most socially acceptable and widespread targets of violence by teenagers and young adults.[271] Several studies of violence against LGBT youth have found that they are much more likely than heterosexual youth to report having been targets of physical attacks and to have required medical attention as a result of such attacks.[272] In one study, up to half of LGBT students has been physically harassed.[273]

The current data source for this objective is the Youth Risk Behavior Surveillance System (YRBSS), CDC, National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP).

Services—RECOMMENDATIONS

- Federal, State, and community programs should strengthen and expand prevention and education programs and services related to violence—including, for example, bias and hate-related violence, anger management, conflict resolution training, domestic violence,

suicide, and substance abuse—through the public health and public school systems, social service agencies, criminal justice institutions, and the workplace by ensuring the inclusion of LGBT people.

- If self-identified LGBT people present with signs of physical violence, health care providers should assess, as with heterosexual clients, using a standardized instrument (e.g., Campbell's Danger Assessment) for forced sex, mental health status, previous undiagnosed head injuries, risk of suicide and/or homicide.[274]
- Health care providers should be aware of local, State, and national domestic violence referral sources for LGBT people, and where appropriate and available, link victims of violence to culturally appropriate social and mental health services for followup and aftercare.

Education and Training—RECOMMENDATIONS

- Schools should incorporate conflict resolution training and tolerance education into health and other antiviolence curricula beginning at the grade school level. DHHS, the U.S. Department of Education, and DOJ should collaborate on evaluating and improving existing curricula, supporting the dissemination of recommended curricula, and training teachers and other school personnel in the use of recommended curricula.
- DHHS, DOJ, State and local agencies, and private sector organizations should support the development and implementation of strategies to increase community awareness of bias crimes against LGBT individuals and families and to reduce such crimes at the community level.
- Federal, State and local agencies, and the private sector should support and strengthen training of health care, mental health, behavioral health, social services, and criminal justice personnel in the identification of LGBT-related violence, including hate-motivated crime and domestic violence, determination of factors related to the crime, and provision of prevention and intervention services, including but not limited to referral for culturally-appropriate post-trauma physical and mental health services.
- Federal, State and local agencies, and the private sector need to create services to address domestic violence within LGBT populations.
- An LGBT Intimate Partner Violence and Sexual Assault: A Guide to Training Materials and Programs for Health Care Providers should be written for distribution to all key stakeholders in health, law enforcement, and public safety. Included in the distribution should be the 36 model programs showcased in the already existing guide written in 1998 by the Centers for Disease Control and Prevention.[275]

Policy—RECOMMENDATIONS

- School systems should strengthen their antiviolence programs to include disciplinary procedures designed to reduce anti-LGBT violence; reduce or eliminate discrimination and violence against LGBT teachers, coaches, and other staff; and create "safe" environments that encourage involvement of LGBT parents and families with LGBT children in school boards and Parent/Teacher Associations.
- Key stakeholders in public policy should acknowledge that violence may disproportionately affect LGBT people, identify societal attitudes and barriers that may contribute to violent acts against LGBT people, and discuss efforts to prevent such violence.
- LGBT people should be involved in all subsequent national discussions of "defining" violence and ways to measure violent acts that include LGBT populations.
- Businesses should establish and enforce appropriate LGBT tolerance and antidiscrimination standards for the workplace.
- Faith-based initiatives at national, regional, State, and local levels should explicitly state that any violent act against LGBT people is not only unacceptable, but also illegal.
- The media should report anti-LGBT violence in its proper context—as a broader pattern of behavior that harms everyone.
- DHHS should work collaboratively with DOJ, State health offices, and State attorneys general to improve documentation of hate-motivated behavior against LGBT individuals and to strengthen Federal, State, and local law enforcement efforts.

Research—RECOMMENDATIONS

- DHHS with DOJ should increase support for data collection and analysis related to LGBT violence, including domestic violence and hate-motivated violence, with ample epidemiologic data to allow for design and implementation of effective prevention programs (e.g., demographic data on both survivors and perpetrators, changes in trends in the communities).
- DHHS with DOJ and other relative agencies should develop uniformity of definitions and measurement tools for violence perpetrated against and within LGBT populations. DHHS and DOJ jointly could explore conducting methodologic research.
- Given the possible small number of cases, a sentinel research system should be established so as to estimate statistically the incidence of violence and abuse of LGBT people across the lifespan.
- DHHS, other Federal agencies, and private foundations should support research to identify the patterns of hate crimes, criminal justice findings and outcomes (arrests, prosecutions and sentencing of hate crime offenders) by State and local jurisdiction.

Terminology

Attempted rape: Includes males and females, heterosexual and homosexual rape, and verbal threats of rape.

Homicide: Fatal injury intentionally caused to one human being by another.

Injury: Unintentional or intentional damage to the body resulting from acute exposure to thermal, mechanical, electrical, or chemical energy or from the absence of such essentials as heat or oxygen.

Intimate partner(s): Spouses, ex-spouses, boyfriends, girlfriends, and former boyfriends and girlfriends (includes same-sex partners). Intimate partners may or may not be cohabitating and need not be engaging in sexual activities.

Intimate partner violence: Actual or threatened physical or sexual violence or psychological and emotional abuse by an intimate partner.

Rape: Forced sexual intercourse, including both psychological coercion and physical force. Forced sexual intercourse means vaginal, anal, or oral penetration by the offender(s) and includes incidents of penetration by a foreign object. Also included are attempted rapes, male and female victims, and heterosexual and homosexual rape.

Sexual assault: A wide range of victimizations separate from rape and attempted rape. Included are attacks or attempted attacks of unwanted sexual contact between the victim and the offender that may or may not involve force; includes grabbing or fondling. Verbal threats also are included.

Unintentional injury: Injury that occurs without purposeful intent.

Violence: The intentional use of physical force or power, threatened or actual, against another person or against oneself or against a group of people, that results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation.

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Appendix A: Recommendations

Access to Quality Health Services

Services—RECOMMENDATIONS

- Private and public sector health care systems should create receptive environments for LGBT health care consumers. For example, health care forms should be inclusive rather than exclusive.
- The 1,200 school-based health care centers located in 45 States and the District of Columbia should offer targeted preventive interventions for LGBT and questioning youth.
- The National Coalition of LGBT Health and other interested organizations can create a "Health Care Report Card for LGBT Consumers."
- A national resource list of health plans, agencies, and professionals that are LGBT competent should be made available through the Internet.
- DHHS, in partnership with the health sector should collaborate on a web site that addresses LGBT health issues, including such information as LGBT health consumer rights and responsibilities, self-care, promotion of culturally appropriate standards of care for LGBT people, and a compendium of LGBT health information for professionals.
- DHHS, in partnership with professional organizations and other health care agencies already concerned with cultural competency in health care, should fund the expansion and evaluation of existing programs to promote sensitivity among health care providers to serve LGBT populations. The Gay, Lesbian, Bisexual and Transgender Health Access Training Project is ongoing in Massachusetts and the *Removing the Barriers to Accessing Health Care for Lesbians* was developed through funding from CDC's Division of Cancer Prevention and Control to the Mautner Project for Lesbians with Cancer in Washington, D.C.
- Appropriate social service agencies should include LGBT-sensitive support for informal family caregivers, including same-sex partners and close friends.

Education and Training—RECOMMENDATIONS

- Cultural competency training, specific to LGBT populations, should be a standard component of all health professional training curricula and made available to the health care workforce through continuing education institutes or other appropriate mechanisms.
- Models for training health care providers in LGBT-sensitive care should be collected in a database applicable to key stakeholders.
- Medical Boards and other groups that license or certify health care professionals should ensure that their examinations include questions on LGBT health care.

- Academic departments of health should encourage, if not require, an internship or a rotation at a community center or health center that serves LGBT people.
- Home care agencies should be trained to be culturally sensitive and respectful of the cultural differences among all elders, including LGBT.

Policy—RECOMMENDATIONS

- All health care accreditation organizations should specifically include language within their policies regarding access to health care services for LGBT populations.
- All Federal and other publicly funded health programs, including Medicare, should specifically have nondiscriminatory language related to sexual orientation and gender identity.
- DHHS, in partnership with organizations such as the American Association of Health Care Plans, the American Medical Association, the National Assembly of School-based Health Care, the American Public Health Association, National Association of State Medicaid Directors, and the National Association of Community Health Centers, should convene a task force of experts to discuss health care access for LGBT populations and issue recommended standards of care for adoption by appropriate health care programs.
- Confidentiality for LGBT people is critical and confidentiality guidelines and assurances must not only be communicated but also incorporated into all health care record keeping.
- Hospitals, nursing homes, assisted living facilities and any other health care facility should adopt policies that ensure that the families of LGBT people are treated as are the family members of heterosexual patients and residents.
- Medicaid spend-down protections, which provide income and asset protections to the husband or wife of a nursing home resident, should be expanded to cover the life partners of LGBT people who enter nursing homes.

Research—RECOMMENDATIONS

- Government and/or private funding should be directed to determining the barriers to access for LGBT populations as a whole as well as its component parts, including crosscutting variables such as race, age, ethnicity, and disability.
- Health care economists should be encouraged to develop an algorithm for determining the costs-benefits associated with sexual reassignment surgery and/or hormones so that health care insurers can make informed decisions.
- Health care researchers should be encouraged by public and private funders to identify LGBT individuals, if appropriate, within all studies relating to health care access.
- Government and/or private funding should be used to investigate the impact of domestic partnership policies on insurance coverage for LGBT populations.
- Research is critical in determining not only the causes of but also the resolutions to homophobia within the health care system.
- Data are needed to compare hospitalization rates for three ambulatory-care-sensitive conditions—pediatric asthma, uncontrolled diabetes and immunization-preventable pneumonia and influenza for LGBT adolescents, adults, and elders, respectively, with the total population.

Cancer

Services—RECOMMENDATIONS

All public health clinics and providers should participate in cultural competence training about sexual minority status and its effect on health and the provision of health care and related services. Federal funding for other types of provider situations should be contingent on the completion of cultural competency training.

- LGBT-friendly and, where necessary, LGBT-specific services should be provided in all areas of cancer care, including prevention and health behavior change.
- Existing lesbian cancer projects should be reviewed for their appropriateness as models for care for all sexual minority people.

Education and Training—RECOMMENDATIONS

- Health professions organizations should address sexual orientation and gender identity concerns in continuing medical education courses, clinical guidelines, risk assessment, and screening policies.
- Culturally appropriate interventions specific to LGBT health needs should be developed and made available to LGBT health centers, to other providers, and within the community itself.
- Preventive services screening programs, both current and future, should explicitly promote access for people of other sexual orientation or gender identity.

Research—RECOMMENDATIONS

- Additional research is needed to better understand disparities in cancer rates among LGBT populations and the degree to which potential disparities are associated with the lack of culturally appropriate prevention information and barriers to effective provider-patient communication.
- Population-based studies are needed to increase knowledge of breast and other forms of cancer among lesbians and to confirm hypotheses that obesity, alcohol consumption, nulliparity, and lower rates of breast cancer screening are risk factors for lesbians.
- Research is needed on how to target and market health education and health promotion programs successfully to diverse segments of the LGBT community.

Educational and Community-Based Programs

Services—RECOMMENDATIONS

- Community clinics, health maintenance organizations, and other primary care providers should become more knowledgeable about the different needs of LGBT patients and seek ways to make them more welcome in a clinical environment.
- Continuing education for physicians, nurses, technicians, and others who come in contact with LGBT patients in clinical settings should be available through professional organizations, continuing medical education programs, nursing education programs, and other venues to increase understanding and sensitivity.

- Primary care venues that welcome LGBT clients should post symbols or posters that indicate they are nondiscriminatory and patient-sensitive clinics.
- All forms used in school settings, worksites, health care venues, and other community organizations should be culturally sensitive and linguistically appropriate for LGBT individuals or parents.
- All types of managed care organizations, including health maintenance organizations, preferred provider organizations, point-of-service plans, and the hybrid of other financial and organizational structures, should devise a system for providing knowledge about providers who are LGBT or LGBT-friendly. This system must ensure the confidentiality of providers and consumers.

Education and Training—RECOMMENDATIONS

- Continuing education for other community-based services should be available for emerging service providers (e.g., fire, police, 911 teams) and community-service program staff (e.g., food banks, social security offices, emergency housing placement services).
- Health department staff should receive cultural competency and sensitivity training that includes information on LGBT populations and their health needs.
- Training provided to supervisors in both public and private sectors should include information on the health concerns of LGBT individuals along with sexual orientation and gender identity in cultural competency training.

Policy—RECOMMENDATIONS

- Schools must protect LGBT youth from harassment and violence.
- All health care accrediting organizations—such as the National Committee on Quality Assurance, the Joint Commission on Accreditation of Health Care Organizations, and the Council on Accreditation must include sexual orientation and gender identity as components of cultural competency.
- All Medicaid and Medicare regulations should reflect the inclusion of sexual orientation and gender identity within their beneficiary guidelines to ensure provision of care and appropriate reimbursement for medical and related services.
- Community-based organizations that receive Federal funding should be prohibited from discriminating against LGBT persons.

Research—RECOMMENDATIONS

- The National Profile of Local Health Departments survey instrument, administered at intervals by the National Association of City and County Health Officials, where appropriate should include questions related to sexual orientation and gender identity.
- Research is needed on culturally competent health promotion and education programs and materials for LGBT populations within the American Indian and Alaska Native populations.
- Analyses of the 2000 census data should yield more information about unmarried same-sex couples, thereby illuminating the demography of the gay and lesbian population.

- Specific research about LGBT persons is critical for generating baseline data for Healthy People 2010 population-based objectives.
- Longitudinal studies should be conducted to determine how sexual orientation and gender identity is manifested throughout the life cycle.

Health Communication

Services—RECOMMENDATIONS

- Clinical care providers for LGBT individuals should create opportunities to examine risk patterns as well as behaviors and options for risk reduction and to promote the adoption of health promotion practices through the establishment of safe and culturally responsive environments.
- Targeted health information should be delivered to high-risk and hard-to-reach LGBT individuals directly in their social contexts, including neighborhoods, socializing spaces, sexual environments, and workplaces.
- LGBT individuals identified as at risk should have access to individual and small group interventions founded on intervention research published in peer-reviewed health journals. These interventions should focus on relevant behavior patterns and should work to build motivation and skills to reduce harm associated with these behaviors.
- Community-level interventions targeted to various LGBT communities should be further developed to address large-scale patterns of risk and to influence health-supporting practices. These should include social marketing and electronically based forms of health communication.

Education and Training—RECOMMENDATIONS

- Health care providers of all disciplines should be provided with education and training on how to communicate with LGBT consumers and families in a culturally competent way and how to reduce barriers to effective communication.

Policy and Advocacy—RECOMMENDATIONS

- Health communication directed toward LGBT people should build upon the considerable health promotion literature and be founded on established principles predictive of successful outcomes.

Research—RECOMMENDATIONS

- Research is needed to determine if access to LGBT-specific health information improves health-seeking behaviors, increases access to care, enhances knowledge, and yields better health outcomes for LGBT consumers and families.
- At each level of intervention, a rigorous assessment, process monitoring, and outcome/impact measurement should be performed to assess the application of interventions previously tested with non-LGBT populations and subsets of the LGBT community not previously studied.
- Research is needed to determine the most appropriate health communication strategies for hard-to-reach LGBT populations such as those in rural areas, Native Americans, and persons with disabilities.

HIV/AIDS

Services—RECOMMENDATIONS

- Public and private-sector systems of care should implement comprehensive strategies to promote culturally competent, appropriate, and linguistically accessible HIV prevention messages to high-risk youth, particularly LGBT adolescents.
- Efforts are needed to better integrate prevention and treatment strategies for HIV/AIDS and primary care.
- There is a need for a national HIV prevention strategy for gay and bisexual men, the population at greatest risk for infection. Such a strategy should reflect the racial, ethnic, geographic, cultural, and age diversity of the gay and bisexual community and should be easily adaptable for population-specific marketing, including men of color, older gay and bisexual men, youth, gay and bisexual men in rural areas, and other diverse groups.
- There is a need to increase, through multiple measures, the percentage of individuals who know their HIV status.

Education and Training—RECOMMENDATIONS

- Health education materials need to be culturally specific to address the needs of transgender people and other sexual minority communities.[148, 149, 150]
- Cross-training is needed among all health care workers, especially those working with youth, acknowledging the interrelatedness of risky behaviors.

Policy—RECOMMENDATIONS

- Health departments need to form alliances with community-based organizations to address the epidemic at the local level by conducting needs assessments and funding community-based prevention and treatment strategies.
- Health insurance companies and managed care organizations should create incentives for health plans, providers, and provider organizations to develop targeted preventive interventions and accompanying early intervention services.

Research—RECOMMENDATIONS

- More data are needed on the incidence and prevalence of HIV infection in specific communities, the means by which individuals become infected, and how they identify themselves (LGBT, heterosexual, or otherwise).
- Additional studies are needed to better understand the potential risks associated with using recreational drugs, hormonal therapy (including transgender-related hormone therapy and anabolic steroid use among men), and other medications while on antiretroviral therapy.
- Research is needed to assess the long-term effects of combination anti-HIV drug regimens.
- Studies are needed to identify effective HIV prevention interventions for MSM (only 11 of 98 rigorous intervention studies in the United States have included MSM).

Immunization and Infectious Diseases

Services—RECOMMENDATIONS

- Public health, private health care providers, and STD clinics must all participate in programs to identify at-risk persons for HAV and HBV infection, including MSM and TSM, and to encourage vaccination.
- Providers should be expected to ask nonthreatening questions that identify individuals at risk, not just MSM and TSM, and they should offer the vaccine when they determine the individual is at risk.
- Individuals who are aware that they are at risk should be educated to understand that they share responsibility for requesting HAV and HBV vaccines.
- Providers and health plans should ensure that high-risk populations (e.g., persons over aged 65, persons with compromised immune systems due to chronic disease or disability or medications) receive the appropriate immunizations for pneumonia and influenza.

Education and Training—RECOMMENDATIONS

- New efforts are needed to reach physicians and other health care practitioners in all health care settings who provide health care to MSM and transgender persons so they can play an active role in educating patients about the risks of HAV and HBV infection as well as the availability of vaccinations.
- Curricula should be developed for physicians and other health care providers, as well as in health education and health promotion programs, on how to prevent, recognize, and treat HAV and HBV infection in high school and college students.

Policy—RECOMMENDATIONS

- Managed care organizations, insurance companies, and other health plans should provide insurance coverage or reimbursement for needed vaccines for high-risk populations, without cancellation penalties.
- Efforts must be made to ensure that LGBT individuals—including elders, children, and youth—who cannot afford to pay for needed vaccines have access to publicly funded services or affordable HAV and HBV vaccinations.

Research—RECOMMENDATIONS

- Additional research is needed to gain a better understanding of the risk and prevalence of HAV and HBV—not only among MSM and TSM but also among other LGBT populations.
- New studies are needed to explain why HAV and HBV vaccination rates among MSM and TSM are low.

Mental Health and Mental Disorders

Services—RECOMMENDATIONS

- Mental health and substance abuse services for LGBT consumers should be culturally competent and consumer-based to reflect the diversity of LGBT people.
- Effective services should be available for LGBT people who are in the process of acknowledging sexual orientation and gender identity. If age-appropriate, services are also needed for families and other significant individuals.
- Social, mental health, and substance abuse service providers should be sensitive to issues such as homophobia and internalized homophobia.
- A culturally appropriate and linguistically suitable hotline should be available, 24 hours a day, 7 days a week, to assist LGBT people and families who need assistance with mental health problems.
- Public-sector systems serving LGBT youth, including schools, should implement a comprehensive, wraparound approach to providing services.
- Given that mental health problems in children and adolescents generally precede the onset of substance abuse problems by approximately 6 to 8 years, policymakers and community leaders should support and establish substance abuse prevention activities that specifically target LGBT youth.

Education and Training—RECOMMENDATIONS

- Providers need to acquire basic knowledge of LGBT people (through curricula, inservice programs, or other educational opportunities) and their mental health needs. This understanding should reflect the diversity of different populations and the availability of community resources and referrals.
- Mental health care providers of all disciplines who serve children and adolescents and their families should be adequately trained to address sexual orientation and gender identity in clinical practice.
- Training programs for mental health, substance abuse, social service, and health care providers on LGBT issues should be developed and evaluated for effectiveness.

Policy—RECOMMENDATIONS

- Sexual orientation and gender identity information should be included as components of cultural competency training for managed care, Medicaid, Medicare, and Children's Health Insurance Program providers.
- Sexual orientation and gender identity should be included, whenever appropriate, in national surveys, evaluation studies, and surveillance systems.
- Licensing bodies for medicine, nursing, psychology, social work, and other health and mental health professions should include guidelines that prohibit discrimination based on sexual orientation and gender identity.
- Specific regulations should be developed to cease involuntary hospitalization of LGBT youth by parents and removal of LGBT youth from parent or guardian custody by child welfare agencies.
- The existing mental health consumer groups—such as On Our Own, the National Empowerment Center, the Consumer Managed Care Network, the Mental Health Consumers Association, United Seniors Health

Cooperative, and the Information Exchange—should include sexual orientation and gender identity within their special populations of concern.

- Existing accreditation organizations—such as the National Committee for Quality Assurance, the Council on Accreditation of Services for Families and Children, the Joint Commission on Accreditation of Healthcare Organizations, the Rehabilitation Accreditation Committee, and the Utilization Review Accreditation Commission—should include sexual orientation and gender identity as one of the cultural competence-related areas for accreditation.
- As most businesses and industries purchase health care benefits for their employees, groups such as the Washington Business Group on Health, the Pacific Business Group on Health, and the Employee Assistance Professionals' Association should sponsor regional meetings to discuss the mental health concerns of their LGBT employees.

Research—RECOMMENDATIONS

- New studies are needed to assess whether an elevated risk of suicide exists for LGBT populations.
- Research is needed to develop better screening tools to assess patients' sexual orientation, gender identity, and mental health needs.
- Additional research is necessary to generate new knowledge about LGBT youth and mental health services, including access to mental health services in comparison to non-LGBT youth and mental health services, specific mental health disparities, service utilization patterns, and outcomes.
- Research is needed to understand the healthy development of LGBT persons at all stages of life, including studies of how sexual orientation and gender identity develop. Such research should reflect the diversity of the LGBT community.
- Clinical and intervention research is needed to identify mental disorders that may be more prevalent among LGBT persons and to identify the most appropriate prevention and treatment strategies.
- Studies are needed that focus on comparisons *within* LGBT samples, such as similarities and differences based on sexual orientation, gender, gender identity, age, race/ethnicity, socioeconomic status, and geographic location.
- More clinical research focusing on the transgender population is needed, including followup psychosocial assessments for long-term outcomes for treatment of gender dysphoria, for gender reassignment, and for the relationship between the age at which an individual receives sex reassignment and long-term outcomes.

Nutrition and Weight

Services—RECOMMENDATIONS

- New efforts are needed to address body dissatisfaction and eating disorders among LGBT populations, with a strong emphasis on gay male and transgender adolescents. Specifically, school-based nutrition education programs must be LGBT-competent and relevant to LGBT youth who may be experiencing body dissatisfaction and eating disorders.
- LGBT-competent health care and support services must be made available to address nutrition, physical activity, and weight for lesbians with a high BMI, gay and bisexual men with weight or body image concerns, transgender individuals, persons living with HIV infection, and LGBT or questioning adolescents.

Education and Training—RECOMMENDATIONS

- Health care providers of all disciplines—but especially primary health care providers, dietitians, and nutritionists—need training on the specific nutritional needs of LGBT populations, such as lesbians with a high BMI, certain groups of gay and bisexual men, persons living with HIV infection, and LGBT or questioning adolescents. Such training should include a strong emphasis on delivering culturally competent and sensitive care.

Policy—RECOMMENDATIONS

- The U.S. Department of Health and Human Services and the U.S. Department of Agriculture should collaborate in designing, supporting, and evaluating a public health education campaign designed to increase awareness among LGBT populations about the Food Guide Pyramid and the recommendations of the Dietary Guidelines for Americans.

Research—RECOMMENDATIONS

- Sexual orientation and gender identity should be included as demographic variables in all relevant Federal and national data sets, including NHANES, BRFSS, the Continuing Survey of Food Intakes by Individuals, and the National Worksite Health Promotion Survey, as well as data sets administered by CDC and NCHS.
- Research is needed to examine the impact of self-esteem and body image, and their relationship to eating disorders within LGBT populations, especially among gay and bisexual males and MTF transgender individuals. Research also should look at the extent to which alienation, discrimination, and resultant stress may increase any propensity to eating disorders among all LGBT populations.
- Additional studies are needed to determine the specific causes of increased rates of obesity among lesbians and to determine if the long-term, potential health consequences of obesity in lesbians differ from women in the general population.
- Once sexual orientation and gender identity are added as demographic variables in national data sets, additional analyses will be needed to estimate the prevalence of poor nutrition and diet, obesity, physical inactivity, smoking, alcohol and drug use, and other risk factors commonly observed in LGBT populations as well as their association with heart disease, stroke, diabetes, and other negative health outcomes.
- Additional research is needed on the nutritional status of LGBT persons in hospitals, nursing homes, convalescent centers, and institutions; LGBT persons with physical, mental, and developmental disabilities in community settings; LGBT persons living on reservations and in correctional facilities; and LGBT youth and adults who are homeless. Data also are insufficient to develop targeted interventions for older LGBT persons who live independently.
- Research on the nutritional and dietary habits of transgender populations are needed to better understand the appropriate role of nutrition and diet in gender expression and reassignment.

Public Health Infrastructure

Data and Information Systems—RECOMMENDATIONS

- Establish guidelines within the Federal Government that recommend the collection of sexual orientation and gender identity data in all Federal, State, tribal, and local surveys that routinely collect population-based information regarding health, violence, or social issues.

- Support should be fostered for research to study how different ways of asking questions about sexual orientation, same-sex sexual behavior, attraction, and gender identity affect response rates and the validity of responses. Questions about methodology will continue to be discussed and should not be seen as a barrier to the immediate collection of data on sexual orientation and gender identity in population-based surveys.
- Methodological studies should ensure that racial, ethnic, and geographic differences in terminology and the definitions of sexual orientation and gender identity are accounted for when measuring health status indicators in LGBT communities.
- Demographic questions about sexual orientation and gender identity should be framed in national studies and surveys so as to provide widespread geographic and population-based information about prevalence of LGBT communities and their health status. Findings should be widely disseminated through all appropriate distribution methods, including through State, tribal, and local public health agencies.
- Federal, tribal, State, and local public health agencies must involve representatives from LGBT communities at all levels of decisionmaking, including soliciting input and participation of LGBT academics and other expertise in study sections, grant review committees, and advisory boards. The curriculum vitae of LGBT persons with specific areas of expertise should be provided to the organizations reviewing grant proposals and involved in other health planning and research activities.
- LGBT researchers should be encouraged to participate in extramural research programs.

Core Workforce and Organizational Competency—RECOMMENDATIONS

- DHHS should develop an office of LGBT health to provide overarching guidance and planning on LGBT health policy.
- DHHS should support further study of effective models of building institutional and specific personnel LGBT competency, including support for agencies working together across local and regional boundaries to develop effective models and to share knowledge and best practices. For example, the Massachusetts Department of Public Health supported the May 2000 Boston meeting of urban health officials addressing LGBT health.
- DHHS should encourage State, tribal, and local health agencies to implement standards of care for LGBT health consumers. The standards should be developed by a panel of experts that also includes appropriate stakeholders representing the diversity within LGBT populations.
- The Agency for Healthcare Research and Quality (AHRQ) should support research designed to improve the outcomes and quality of health care and broaden access to effective services for LGBT health care consumers.
- Public health agencies should develop appropriate policies, procedures, and requirements for contractors to ensure that services and products purchased are organized and delivered in a nondiscriminatory manner.
- Accrediting organizations such as the Joint Commission on Accreditation of Healthcare Organizations and the National Committee for Quality Assurance, along with such entities as Federal agencies involved in the delivery of publicly funded health care and related services (HRSA, SAMHSA, the Health Care Financing Administration, the Administration for Children and Families, and the U.S. Department of Housing and Urban Development), the American Public Health Association, and the National Association of County and City Health Officials should collaborate to develop cultural competency standards for organizational and personnel competencies that may be adopted by State, local, and tribal health agencies nationwide.

- The National Institute of Mental Health (part of the National Institutes of Health), the Center for Mental Health Services (part of SAMHSA), and ARHQ should fund research into standards and best practices of mental health care for LGBT people, including research on the impact of reparative therapy. SAMHSA with HRSA should review the need for developing a collaborative mental wellness initiative that includes all populations in disparity.
- Technical assistance in grant writing should be made available to all interested applicants. Such assistance could be made available through the Internet, the use of tutorials on CD-ROM, and other workshops organized at the regional level.
- All legally prohibited discrimination should include discrimination on the basis of sexual orientation or gender identity.
- State agencies charged with the regulation and oversight of nursing homes and long-term care facilities should develop and enforce compliance with standards of care for LGBT clients, including policies that recognize and affirm same-sex partners.
- Federal agencies providing publicly funded services to unserved populations and conducting data surveillance activities should communicate regularly with the field and regional offices regarding cultural competencies for all populations in disparity in access to needed services. For example, the agencies could disseminate an article on the importance and availability of LGBT competencies and guidelines, along with resources for additional information, technical assistance, and implementation strategies.
- The Centers for Disease Control and Prevention should fund the Association of Schools of Public Health to develop model curricula for public health students. CDC also should fund demonstrations and evaluations of LGBT-competent curricula.
- Accreditation bodies such as the Liaison Committee on Medical Education, the National Library of Medicine, and the Council on Education of Public Health should issue recommendations that address LGBT competency. They also should conduct surveys of schools of public health, nursing, and medicine, as well as emergency medical technician training programs, to determine which include LGBT competency in their curricula and to highlight case studies for dissemination throughout the medical field.
- DHHS should ensure that cultural sensitivity training is provided to all health care providers receiving Federal funds. Special attention should be given to identifying and evaluating studies that examine the effectiveness of training programs designed to promote transgender competencies, eliminate discrimination, and improve organizational competencies. Efforts to partner with the private sector and managed care plans should be an important part of this initiative.
- Existing cultural competency training modules should be reviewed by the Federal agencies, and a menu of appropriate technical assistance resources and training models should be made available to all publicly funded services programs, health departments, and health professionals to ensure that culturally competent care is provided for LGBT clients.
- Additional efforts are needed to increase the number of public health agencies that integrate LGBT-focused core competencies into orientation and inservice training.
- DHHS should provide incentives to increase the number of Federal, State, and local health departments that support community-based agencies providing LGBT competency training to the public health workforce.

The Law and Public Health—RECOMMENDATIONS

- DHHS with other Federal departments and agencies (e.g., U.S. Department of Education, U.S. Department of Housing and Urban Development, U.S. Department of Labor) should collaborate to determine how best to eliminate the effects of discrimination based on sexual orientation and gender identity.
- DHHS should direct its operating divisions and staff offices to review their policies, procedures, and practices to ensure that publicly funded services are being provided in a nondiscriminatory and culturally competent manner.
- Public health agencies at the State and local levels should review policies, procedures, and practices to ensure that publicly funded services for which they are accountable are being provided in a nondiscriminatory and culturally competent manner.
- The DHHS Office of Civil Rights should increase its efforts to enforce nondiscrimination protections, including meeting the requirements of the Americans with Disabilities Act.
- DHHS should review existing research and support new studies on the effect of legislation failing to prohibit discrimination on public health outcomes.
- Federal, State, tribal, and local health departments should adopt domestic partner benefits policies for employees and promote such policies on a wider basis as an access-to-care issue.
- Health agencies should incorporate guidelines to ensure equal consideration of same-sex partners of clients receiving treatment in all health care settings as part of their standards of care for LGBT people.

Sexually Transmitted Diseases (Infections)

Services—RECOMMENDATIONS

- "Sexual history" risk assessment tools that are culturally and linguistically appropriate need to be developed and widely disseminated.
- Additional efforts are needed to increase, at all potential sites for screening, the proportion of LGBT people screened for STDs and, if found positive, provided treatment services.
- There is a need for culturally appropriate STD prevention outreach for LGBT youth and youth questioning their sexual orientation.
- All STD media campaigns should be inclusive of all population sectors including LGBT youth and adults.

Education and Training—RECOMMENDATIONS

- Professional organizations of health care providers should address sexual orientation and gender identity concerns in continuing medical education courses, clinical guidelines, risk assessment, and screening policies.
- Health professions schools, including schools of medicine, nursing, physician assistants, public health, health educators, and others, should partner with all existing LGBT health centers for purposes of STD clinic staffing as well as management and professional training.
- All health care professionals should counsel their LGBT patients (or refer them to community-based organizations) regarding the risk of STDs and methods for reducing or preventing high-risk behaviors.

Counseling for STDs should be reimbursed without copayments or other financial disincentives by Medicaid programs, managed care organizations, or other health plans.

- Education is needed for LGBT individuals—especially youth—that condom usage provides no protection against hepatitis A and STDs transmitted by genital-oral contact.
- Health care providers and consumers must be made aware of the risks of HPV and how it is transmitted and prevented, including the need for routine Pap testing for WSW.

Policy—RECOMMENDATIONS

- STD-related performance measures specific to LGBT populations should be included in the Health Plan Employer Data Information Set (HEDIS) developed by the National Committee for Quality Assurance as well as in other health services performance measures of public and private health plans.
- Local health departments, with the assistance of the State health department, should consult with the LGBT community in determining how to provide high-quality, comprehensive STD-related clinical services.
- Health plans should provide for and cover comprehensive STD-related services, including screening, diagnosis, treatment, and counseling for plan members and their sex partners, regardless of the partners' insurance status.
- LGBT organizations should work with an independent group to serve as a catalyst for social change toward a new norm of healthy sexual behavior in the United States that would include a long-term national initiative to increase knowledge and awareness of preventing and treating STDs.

Research—RECOMMENDATIONS

- Research is needed to identify the incidence and prevalence of STDs within LGBT populations and to identify which sexual practices increase the risk of specific STDs.
- Sexual orientation and gender identity measures should be included within the CDC STD Surveillance System, the National Health and Nutrition Examination Survey, and CDC's National Center for HIV, STD, and TB Prevention.
- Specific data on the prevalence of anal neoplasia in men with a history of receptive anal sex should be collected, with special emphasis on individuals with anogenital HPV and HIV infection.

Substance Abuse

Services—RECOMMENDATIONS

- Health education and prevention-oriented materials on health risks related to substance abuse should be developed for and directed to LGBT youth.
- On college campuses, where binge drinking often occurs, LGBT students or local LGBT-friendly health clinics need to be included in health education and prevention programs aimed at reducing binge drinking.
- Providers should review how consumer data are collected for statistical purposes, program reporting requirements, and funding or reimbursement sources and should discuss with the data collection entities how best to collect baseline data on health needs and services usage by LGBT consumers.

Education and Training—RECOMMENDATIONS

- Mental health and substance abuse counselors should receive cultural competency training that includes addressing the health and other needs of LGBT youth and adults.
- Substance abuse and mental health providers, as well as LGBT persons, need to be made aware that people who meet the "disability" eligibility criteria in Medicare may be eligible for Medicare-covered alcohol and other drug treatment services.
- Culturally competent health education materials on low-risk drinking, or responsible alcohol use, and high-risk drinking need to be developed for and directed to the LGBT community.

Policy—RECOMMENDATIONS

- Federal and State funding for health services programs need to be linked to community-based prevention and treatment efforts; LGBT persons need to be included in the community-based planning process along with representatives from other underserved or unserved populations; and cultural competency guidelines need to be established so that individuals are not denied access to care based on their sexual orientation or gender identity.
- Community partnerships and coalitions should seek cultural competency training and technical assistance from LGBT organizations and service agencies so community planners may better understand and incorporate the health care needs of LGBT populations into planning efforts.
- Federal and State governments should develop demonstration projects that support community partnerships and coalitions that are convened to address the substance abuse prevention and treatment needs of LGBT communities.

Research—RECOMMENDATIONS

- Sexual orientation and gender identity should be included as demographic variables in national substance abuse surveys, such as NHSDA and the Monitoring the Future Study.
- Model programs for school youth education programs that address homophobia and drug abuse should be developed.
- Additional studies are needed to assess the drinking habits of midlife and older LGBT individuals.

Tobacco Use

Services—RECOMMENDATIONS

- Smoking prevention and cessation programs must be LGBT-competent, affordable, and accessible to LGBT individuals.
- LGBT-oriented community centers and other LGBT-affirming community-based organizations should be recognized as resources and included in developing, implementing, and evaluating culturally competent smoking cessation and prevention programs.

Education and Training—RECOMMENDATIONS

- Because clinical cessation guidelines may be used as a training tool for educating health care providers, LGBT-specific concerns regarding tobacco use and LGBT-competent prevention and treatment services should be reflected and addressed in such guidelines.
- Health care providers need training on how to provide culturally competent care to LGBT smokers and to adhere to guidelines on tobacco screening and treatment.
- Counter-advertising campaigns that promote health-positive messages should be conducted and targeted to LGBT populations. Such campaigns could be modeled after the "Truth" campaign and California Department of Health Services antismoking campaigns.

Policy and Advocacy—RECOMMENDATIONS

- LGBT individuals must have access to comprehensive, nondiscriminatory health insurance that covers smoking cessation products and services.
- LGBT communities must be educated about tobacco advertising and its role in promoting tobacco use.
- Health-positive environments for LGBT and questioning youth must be funded, supported, and sustained so that LGBT youth have healthier venues in which to socialize and "come out."

Research—RECOMMENDATIONS

- Sexual orientation and gender identity must be included in national and local data sets to study differences in smoking rates and treatment success.
- Data are needed on a variety of LGBT-specific tobacco-related issues so that culturally competent social marketing and public education campaigns, prevention activities, and cessation programs can be established and implemented.

Violence Prevention

Services—RECOMMENDATIONS

- Federal, State, and community programs should strengthen and expand prevention and education programs and services related to violence—including, for example, bias and hate-related violence, anger management, conflict resolution training, domestic violence, suicide, and substance abuse—through the public health and public school systems, social service agencies, criminal justice institutions, and the workplace by ensuring the inclusion of LGBT people.
- If self-identified LGBT people present with signs of physical violence, health care providers should assess, as with heterosexual clients, using a standardized instrument (e.g., Campbell's Danger Assessment) for forced sex, mental health status, previous undiagnosed head injuries, risk of suicide and/or homicide.[274]
- Health care providers should be aware of local, State, and national domestic violence referral sources for LGBT people, and where appropriate and available, link victims of violence to culturally appropriate social and mental health services for followup and aftercare.

Education and Training—RECOMMENDATIONS

- Schools should incorporate conflict resolution training and tolerance education into health and other antiviolence curricula beginning at the grade school level. DHHS, the U.S. Department of Education, and DOJ should collaborate on evaluating and improving existing curricula, supporting the dissemination of recommended curricula, and training teachers and other school personnel in the use of recommended curricula.
- DHHS, DOJ, State and local agencies, and private sector organizations should support the development and implementation of strategies to increase community awareness of bias crimes against LGBT individuals and families and to reduce such crimes at the community level.
- Federal, State and local agencies, and the private sector should support and strengthen training of health care, mental health, behavioral health, social services, and criminal justice personnel in the identification of LGBT-related violence, including hate-motivated crime and domestic violence, determination of factors related to the crime, and provision of prevention and intervention services, including but not limited to referral for culturally-appropriate post-trauma physical and mental health services.
- Federal, State and local agencies, and the private sector need to create services to address domestic violence within LGBT populations.
- An LGBT Intimate Partner Violence and Sexual Assault: A Guide to Training Materials and Programs for Health Care Providers should be written for distribution to all key stakeholders in health, law enforcement, and public safety. Included in the distribution should be the 36 model programs showcased in the already existing guide written in 1998 by the Centers for Disease Control and Prevention.[275]

Policy—RECOMMENDATIONS

- School systems should strengthen their antiviolence programs to include disciplinary procedures designed to reduce anti-LGBT violence; reduce or eliminate discrimination and violence against LGBT teachers, coaches, and other staff; and create "safe" environments that encourage involvement of LGBT parents and families with LGBT children in school boards and Parent/Teacher Associations.
- Key stakeholders in public policy should acknowledge that violence may disproportionately affect LGBT people, identify societal attitudes and barriers that may contribute to violent acts against LGBT people, and discuss efforts to prevent such violence.
- LGBT people should be involved in all subsequent national discussions of "defining" violence and ways to measure violent acts that include LGBT populations.
- Businesses should establish and enforce appropriate LGBT tolerance and antidiscrimination standards for the workplace.
- Faith-based initiatives at national, regional, State, and local levels should explicitly state that any violent act against LGBT people is not only unacceptable, but also illegal.
- The media should report anti-LGBT violence in its proper context—as a broader pattern of behavior that harms everyone.
- DHHS should work collaboratively with DOJ, State health offices, and State attorneys general to improve documentation of hate-motivated behavior against LGBT individuals and to strengthen Federal, State, and local law enforcement efforts.

Research—RECOMMENDATIONS

- DHHS with DOJ should increase support for data collection and analysis related to LGBT violence, including domestic violence and hate-motivated violence, with ample epidemiologic data to allow for design and implementation of effective prevention programs (e.g., demographic data on both survivors and perpetrators, changes in trends in the communities).
- DHHS and DOJ and other relative agencies should develop uniformity of definitions and measurement tools for violence perpetrated against and within LGBT populations. DHHS and DOJ jointly could explore conducting methodologic research.
- Given the possible small number of cases, a sentinel research system should be established so as to estimate statistically the incidence of violence and abuse of LGBT people across the lifespan.
- DHHS, other Federal agencies, and private foundations should support research to identify the patterns of hate crimes, criminal justice findings and outcomes (arrests, prosecutions and sentencing of hate crime offenders) by State and local jurisdiction.



Appendix B: Acronyms

FEDERAL AGENCIES AND THEIR COMPONENTS

AHCPR	Agency for Health Care Policy and Research (now AHRQ)
AHRQ	Agency for Healthcare Research and Quality (formerly AHCPR)
BHPr	Bureau of Health Professions (part of HRSA)
BLS	Bureau of Labor Statistics (part of DOL)
CDC	Centers for Disease Control and Prevention (part of DHHS)
CMHS	Center for Mental Health Services (part of SAMHSA)
CSAP	Center for Substance Abuse Prevention (part of SAMHSA)
CSAT	Center for Substance Abuse Treatment (part of SAMHSA)
DHHS	Department of Health and Human Services
DOEd	Department of Education
DOJ	Department of Justice
DOL	Department of Labor
DOT	Department of Transportation
GAO	General Accounting Office (investigative arm of Congress)
HCFA	Health Care Financing Administration (part of DHHS)
HHS	Health and Human Services (see DHHS)
HRSA	Health Resources and Services Administration (part of DHHS)
IHS	Indian Health Service (part of DHHS)
MCHB	Maternal and Child Health Bureau (part of HRSA)
NCCDPHP	National Center for Chronic Disease Prevention and Health Promotion (part of CDC)
NCES	National Center for Education Statistics (part of DOEd)
NCHS	National Center for Health Statistics (part of CDC)

NCHSTP	National Center for HIV, STD, and TB Prevention (part of CDC)
NCI	National Cancer Institute (part of NIH)
NHTSA	National Highway Traffic Safety Administration (part of DOT)
NIAAA	National Institute on Alcohol Abuse and Alcoholism (part of NIH)
NIDA	National Institute on Drug Abuse (part of NIH)
NIH	National Institutes of Health (part of DHHS)
NIMH	National Institute of Mental Health (part of NIH)
PHS	Public Health Service (see USPHS)
SAMHSA	Substance Abuse and Mental Health Services Administration (part of DHHS)
SSA	Social Security Administration
USPHS	U.S. Public Health Service (see also PHS)

ORGANIZATIONS AND OTHER TERMINOLOGY

AA	Alcoholics Anonymous
AAA	Area Agencies on Aging
AAHP	American Association of Health Plans (formerly GHAA)
AAPCC	American Association of Poison Control Centers
ACHA	American College Health Association
ACS	American College of Surgeons
ACU-I	Association of College Unions, International
ADA	Americans with Disabilities Act
ADHD	attention deficit/hyperactivity disorder
AEDS	Alcohol Epidemiologic Data System
AFSCME	American Federation of State, County, and Municipal Employees
AHECs	Area Health Education Centers
AIDS	acquired immunodeficiency syndrome
AIN	anal intraepithelial neoplasia
AJCP	American Journal of Community Psychology
ALF	American Legacy Foundation
AMA	American Medical Association

AMC	American Medical Center Cancer Research Center
AOD	alcohol and other drugs
APA	American Psychiatric Association
APEX/PH	Assessment Protocol for Excellence in Public Health
APHA	American Public Health Association
API	Asian and Pacific Islander
APIWC	Asian and Pacific Islander Wellness Center
ASAM	American Society of Addiction Medicine
ASHA	American School Health Association
ASIL	anal squamous intraepithelial lesions
ASIPT	Appointment Standardization Integrated Program Team
ASTDHPPHE	Association of State and Territorial Directors of Health Promotion and Public Health Education
ASTHO	Association of State and Territorial Health Officers
ATPM	Association of Teachers of Preventive Medicine
BBA	Balanced Budget Act (of 1997)
BMI	body mass index
BRFS	Behavioral Risk Factor Survey
BRFSS	Behavioral Risk Factor Surveillance System
BV	bacterial vaginosis
CAHPS	Consumer Assessment of Health Plans Study
CARF	Commission for Accreditation of Rehabilitation Facilities
CBO	community-based organization
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CHD	coronary heart disease
CHIP	Children's Health Insurance Program
CME	continuing medical education
COA	Council on Accreditation of Services for Families and Children
COBRA	Consolidated Omnibus Budget Reconciliation Act
COGME	Council on Graduate Medical Education
CPS	clinical preventive services

CRC	colorectal cancer
CSFII	Continuing Survey of Food Intakes by Individuals
CWLA	Child Welfare League of America
DMA	Division of Medical Assistance
DSH	disproportionate share hospital
DSM	Diagnostic and Statistical Manual of Mental Disorders
EAPA	Employee Assistance Professional Association
ECA	Epidemiologic Catchment Area
ED	(hospital-based) emergency department
EMS	emergency medical services
EMT	emergency medical technician
EMTALA	Emergency Medical Treatment and Active Labor Act (of 1986)
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
FACCT	Foundation for Accountability
FERRET	Federal Electronic Research and Review Extraction Tool
FFS	fee-for-service
FOBT	fecal occult blood test
FTM	female-to-male
FTMs	female-to-male transsexuals
GHAA	Group Health Association of America (now AAHP)
GID	gender identity disorder
GIDNOS	gender identity disorder not otherwise specified
GIS	geographic information system
GLAAD	Gay and Lesbian Alliance Against Defamation
GLBT	gay, lesbian, bisexual, and transgender
GLMA	Gay and Lesbian Medical Association
GLPTSA	Gay and Lesbian Parent Teacher Student Association
GLSEN	Gay, Lesbian, and Straight Education Network
GLYS	Gay and Lesbian Youth Support Project
GME	graduate medical education

GMHC	Gay Men's Health Crisis
HAART	highly active antiretroviral therapy
HAV	hepatitis A virus
HBIGDA	Harry Benjamin International Gender Dysphoria Association
HBV	hepatitis B virus
HCQA	Health Care Quality Alliance
HCSA	Hate Crimes Statistics Act
HCUP	Healthcare Cost and Utilization Project
HCV	hepatitis C virus
HEDIS	Health Plan Employer Data and Information Set
HIPAA	Health Insurance Portability and Accountability Act
HIV	human immunodeficiency virus
HMO	health maintenance organization
HPV	human papillomavirus
HRA	high resolution anoscopy
IDU	injection drug use
IDUs	injection drug users
IGLSS	Institute for Gay and Lesbian Strategic Studies
IOM	Institute of Medicine (part of National Academy of Sciences)
JAH	Journal of Adolescent Health
JAMA	Journal of the American Medical Association
JCAHO	Joint Commission for the Accreditation of Healthcare Organizations
JOH	Journal of Homosexuality
KS	Kaposi's sarcoma
LGBT	Lesbian, gay, bisexual, and transgender
LGBTQ	lesbian, gay, bisexual, transgender, and questioning
LLEGO	National Latina/o Lesbian, Gay, Bisexual, and Transgender Organization
LSD	lysergic acid diethylamide
MCO	managed care organization
MDMA	3,4-methylenedioxymethamphetamine (also known as “ecstasy”)

MDPH	Massachusetts Department of Public Health
MEPS	Medical Expenditure Panel Survey
MHPA	Mental Health Parity Act
MMPI	Minnesota Multiphasic Personality Index
MMWR	Morbidity and Mortality Weekly Report
MSA	metropolitan statistical area
MSM	men who have sex with men
MTF	male-to-female
MTFs	male-to-female transsexuals
NAADAC	National Association of Alcoholism and Drug Abuse Counselors
NACCHO	National Association of City and County Health Officials
NAEMT	National Association of Emergency Medical Technicians
NASBHC	National Assembly for School-Based Health Care
NASEMSD	National Association of State EMS Directors
NCAVP	National Coalition of Anti-Violence Programs
NCQA	National Committee for Quality Assurance
NCVS	National Crime Victimization Survey
NGC	National Guideline Clearinghouse
NHANES	National Health and Nutrition Examination Survey
NHIS	National Health Interview Survey
NHSDA	National Household Survey on Drug Abuse
NIHB	National Indian Health Board
NIS	Nationwide Inpatient Sample
NLGJA	National Lesbian and Gay Journalists Association
NLHCS	National Lesbian Health Care Survey
NMAC	National Minority AIDS Council
NMES	National Medical Expenditures Survey
NNDSS	National Notifiable Disease Surveillance System
NP	nurse practitioner
NPLHD	National Profile of Local Health Departments

NSFG	National Survey of Family Growth
NTAO	National Technical Assistance Office (part of AAHP)
NVSS	National Vital Statistics System
OASIS	Outcome and Assessment Information Set
PA	physician assistant
PATCH	Planned Approach to Community Health
PCCs	Poison Control Centers
PCP	Pneumocystis carinii pneumonia
PCP	primary care provider
PDN	priority data needs
PFLAG	Parents, Families, and Friends of Lesbians and Gays
PFP	Partnership for Prevention
PID	pelvic inflammatory disease
POS	point of service
PPO	Preferred Provider Organization
PRN	Practitioner Research Network
QueerTIP	Queer Tobacco Intervention Project
RWJF	Robert Wood Johnson Foundation
SAFE	Staff, Administration, and Faculty for Equality
SAGE	Senior Action in a Gay Environment
SASD	State Ambulatory Surgery Databases
SCHIP	State Children's Health Insurance Program (see CHIP)
SED	serious emotional disturbance
S/HMO	social health maintenance organizations
SID	State Inpatient Database
SMI	severe mental illness
SOC	Standard Occupational Classification
SOCs	standards of care
SPMI	serious and persistent mental illness
SSDI	Social Security Disability Insurance

SSI	Supplemental Security Income
STD	sexually transmitted disease
STDs	sexually transmitted diseases
STD-CSRS	STD Case Surveillance Reporting System
TB	tuberculosis
TRDRP	Tobacco-Related Disease Research Program
TSM	transgender persons who have sex with men
UCR	Uniform Crime Reporting
URAC	Utilization Review Accreditation Commission
VNA	Visiting Nurses Association
VPDs	vaccine-preventable diseases
WELCOA	Wellness Councils of America
WHI	Women's Health Initiative
WHO	World Health Organization
WPW	women who partner with women
WSW	women who have sex with women
YRBS	Youth Risk Behavior Survey



Appendix C: LGBT Definitions

Affectional orientation:

Emotional attraction to another person.

Androgyne:

Person who deliberately adopts characteristics of both genders or strives to attain a gender-neutral or nongender status.[1] (See also **Hermaphrodite**.)

Asexual:

Having no evident sex or sex organs (Webster's). In usage, may refer to a person who is not sexually active, or not sexually attracted to other persons.

Bear:

Slang for a gay man whose disposition is rooted in a subculture that emphasizes male secondary sexual characteristics such as beards and body hair growth,[2] and who is usually somewhat stouter than the average man.

Bias:

Prejudice; an inclination or preference, especially one that interferes with impartial judgment.[3]

Bisexual:

Man or woman with a sexual and affectional or emotional orientation toward people of both sexes.[4]

Closeted:

Not being open about oneself being gay or lesbian.[5]

Coming out:

Refers to the experiences of some, but not all, gay men and lesbians as they explore their sexual identity. There is no correct process or single way to come out, and some LGBT persons do not come out. The process is unique for each individual, and it is the choice of the individual. Several stages have been identified in the process: identity confusion, comparison, tolerance, acceptance, pride, and identity synthesis.[6]

Compulsive sexual behavior:

Sexual activity that is driven by stress, anxiety, or depression, rather than by sexual desire. Compulsive sexual behaviors often cause problems for persons who engage in them; problems include the potential for injury or illness, sexually transmitted diseases, and social or legal sanctions.[7]

Cross-dresser:

Person who dresses in clothing of the opposite sex for personal expression, emotional satisfaction, or erotic pleasure.[8]

Cross-gender hormone therapy:

Hormone medication used by transsexuals and other transgender persons to induce the physical characteristics of the sex with which they identify. Female-to-male hormone therapy utilizes testosterone; male-to-female hormone therapy utilizes estrogen, testosterone blockers, and progesterone.

Cultural competence:

Broadly based and diverse understanding of, and ability to respond and relate to, culturally specific nuances, communication styles, traditions, icons, experiences, and spiritual traditions of a given culture or cultures.[9]

Cultural practice:

Customs, habits, thinking patterns, and actions based on a set of beliefs, values, and traditions held by a specific group of people.

Discrimination:

The act of showing partiality or prejudice; a prejudicial act.[10]

Domestic partner insurance:

Health insurance benefits package (which may include medical, mental, dental, or long-term care insurance coverage) provided to an employee's unmarried partner as that insurance coverage would be made available to the employee's spouse.

Dominant culture:

The cultural values, beliefs, and practices that are most common, or that are most powerful and influential, within a given society.

Family:

Legally defined family is prescribed by legal statute or common law, specifically on the basis of blood relationship, legal marriage, or legal adoption.

Family of choice:

Persons or group of people an individual sees as significant in his or her life. It may include none, all, or some members of his or her family of origin. In addition, it may include individuals such as significant others or partners, friends, and coworkers.[11]

Family recognition benefit:

Benefit a person is eligible to receive as a result of being recognized as belonging to the family of another person. Ability to be included in a health insurance plan of a family member is one example of a family recognition benefit.

Female-to-male (FTM) transsexuals:

Individuals who have started, are in the process, or have partially or fully transitioned from female to male.[12] The FTM process does not necessarily include sex reassignment surgery.

Gay:

Term sometimes used to refer to a homosexual person of either sex. For example, some lesbians identify as "gay." However, "gay" most commonly refers to men who primarily have emotional and sexual attraction to men. Self-identified gay men do not necessarily have sex only with men, but occasionally may engage in sex with women.

Gender identity:

Person's sense of self as being either male or female. Gender identity does not always match biological sex; for example, a person may be born biologically male yet have a female gender identity.[13]

Gender-neutral:

Nondiscriminatory language to describe relationships—e.g. "spouse" and "partner" are gender-neutral alternatives to the gender-specific words "husband" and "wife."

Gender-variant:

Displaying gender traits that are normatively more typical of the opposite biological sex, within a given. "Feminine" behavior or appearance in men is gender-variant as is "masculine" behavior or appearance in women. Gender-variant behavior is culturally specific.

Gender role:

How "masculine" or "feminine" an individual acts. Society commonly has norms regarding how men and women should behave,[14] although the argument is made that dominant normative behavior is a dynamic, often evolving, process. (See also **Gender-variant**.)

Hate crime:

Hate crime legislation "defines a hate crime as an act committed on the basis of the actual or perceived race, color, religion, national origin, ethnicity, gender, disability, or sexual orientation of any person."[15]

Hermaphrodite (also may be referred to as intersex person):

Older, medical term for a person born with both male and female genitalia or reproductive organs. Today, "intersex" appears to be emerging as the preferred term in common usage, but some intersexed persons continue to refer to themselves as hermaphrodites.[16] The Intersex Society of North America believes that "hermaphrodite"is a stigmatizing and misleading term. The Society reports a growing momentum to eliminate the word "hermaphrodite" from medical literature and use only the word "intersex" in its place.[17] (See also **Androgyne**.)

Heterosexism:

Belief that heterosexuality is the only "natural" sexuality and that it is inherently healthier or superior to other types of sexuality.[18]

Heterosexual:

Individual with a primary sexual and affectional orientation or emotional attraction toward persons of the opposite sex. Heterosexuals are sometimes referred to as "straight."[19]

Homophobia:

Irrational fear or hatred of lesbian, gay, bisexual, or transgender people.

Homosexual:

Individual with a primary sexual and affectional orientation or emotional attraction toward persons of the same sex. Male homosexuals are often referred to as "gay," whereas female homosexuals are referred to as "lesbians."[20]

Internalized homophobia:

Internalized self-hatred that gays and lesbians struggle with as a result of heterosexual prejudice. Persons who experience internalized homophobia accept and believe the negative messages of the dominant group as they relate to gay men, lesbians,[21] bisexuals, and transgender people.

Intersexed:

Person having the characteristics of both male and female biological organs or genitalia. (See also **Hermaphrodite.**)

Lesbian:

A woman who has primary emotional and sexual attraction to other women. Sometimes lesbian women engage in sexual behaviors with men, even though the women self-identify as lesbian.[22]

LGBT:

Acronym for lesbian, gay, bisexual, and transgender.

LGBTQ:

Acronym for lesbian, gay, bisexual, transgender, and questioning. Questioning is commonly used to refer to adolescents. (See also **Questioning youth.**)

Male-to-female (MTF) transsexuals:

Individuals who have started, are in the process, or have partially or fully transitioned from male to female.[23] The MTF process does not necessarily include sex reassignment surgery.

Marginalized:

Excluded, ignored, or relegated to the outer edge of a group,[24] or society.

Men who have sex with men (MSM):

Men who engage in same-sex behavior, but who may not necessarily self-identify as gay.

Nonoperative transsexual:

A transsexual individual who has decided not to undergo sex reassignment surgery.[25]

Out or out of the closet:

Refers to varying degrees of being open about one's sexual orientation or gender identity.[26] (See also **Coming out.**)

Penile-inversion vaginoplasty:

In sex reassignment surgery, the creation of a vaginal cavity in a male-to-female transsexual using the skin of the penis turned inside out to line the vaginal cavity.

Questioning youth:

Young individual who may be experiencing lesbian, gay, bisexual, or transgender feelings or urges, but has not yet identified his or her sexual orientation or gender identity. LGBTQ is included in this population.

Reparative therapy (also called conversion therapy):

Attempt to change a person's sexual orientation from lesbian, gay, bisexual, or transgender to heterosexual.

Same-sex sexual orientation:

Having an erotic, physical, and emotional attraction to persons of one's own sex.

Self-identify:

To perceive and express one's internal reality or identity (as in sexual orientation or gender identity), as opposed to external factors and others' interpretations of them.[27]

Sex reassignment surgery:

Surgery performed on transsexuals to create genitalia resembling those of the sex with which the person identifies. In male-to-female transsexuals, this means removal of the penis and testes and creation of a vulva and vagina. In female-to-male transsexuals, this means removal of the uterus, tubes and ovaries, and often creation of a penis, testes, and scrotum.

Sex workers:

Individuals (either male or female) who work as prostitutes, hustlers, or escorts and are in the business of providing sex for money, drugs, or housing.[28]

Sexual identity:

What people call themselves with regard to their sexuality. Labels include "lesbian," "gay," "bisexual," "bi," "queer," "questioning," "undecided" or "undetermined," "heterosexual," "straight," and "asexual." Sexual identity evolves through a multistage developmental process, which varies in intensity and duration depending on the individual. Our sexual behavior and how we define ourselves (our identity) is usually a choice.[29] Sexual identity also refers to a person's erotic and affectional response to another with respect to gender: heterosexual, lesbian, gay, or transgender.

Sexual identity formation:

The process of coming to recognize one's attraction to members of one or both sexes and to define or label oneself on the basis of that attraction.

Sexual minority:

Refers to lesbian, gay, bisexual, transgender, and questioning people as a minority in a predominantly heterosexual total population.

Significant other:

Life partner, domestic partner, lover, boyfriend, or girlfriend. Because gays and lesbians are not allowed to marry legally in the United States (although gay and lesbian marriages are allowed in some European countries), "significant other" is often equivalent to the term "spouse" for lesbian, gay, bisexual, and transgender people.[30]

Sodomy laws:

State statutes (which vary by State) that prohibit contact between the mouth or anus of one person and the sexual organs of another person, consensual or otherwise.[31]

Transgender person:

Person whose gender identity or gender expression is not congruent with his or her biological sex. Transgender persons usually live full or part time in the gender role opposite to the one in which they were born. "Transgender" sometimes may be used as an umbrella term encompassing transsexuals, transvestites, and cross-dressers.

Transgenders who have sex with men (TSM):

Transgender people who engage in sex with men.

Transphobia:

Irrational fear or hatred of transgender or transsexual individuals.[32]

Transsexual:

Individual whose gender identity is that of the opposite sex. There are female-to-male and male-to-female transsexuals. A transsexual may or may not have had sex reassignment surgery.

Vaginoplasty:

In sex reassignment surgery, the creation of a vaginal cavity in a male-to-female transsexual. (See also **Penile-inversion vaginoplasty.**)

Women who have sex with men (WSM):

Women who engage in sex with men, but may not necessarily identify as heterosexual.

Women who have sex with women (WSW):

Women who engage in same-sex behavior, but may not necessarily identify as lesbian.

Women who partner with women (WPW):

Women who form long-term or committed relationships with other women, often involving cohabitation. May or may not involve same-sex behavior.

Additional definitions and links:

Wizard's Gay Slang Dictionary: http://www.hurricane.net/~wizard
GayProud: http://www.gayproud.org

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[8] Sember, R.; Lawrence, A.; and Xavier, J. Lesbian, gay, bisexual, and transgender health: Findings and concerns. *Journal of the Gay and Lesbian Medical Association* 4(3):37, 2000.

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[10] Neufeldt, V., ed. *Webster's New World Dictionary of American English, Third College Edition*. 1991, 393.

[11] DHHS, SAMHSA. *A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals*. Rockville, MD: SAMHSA, 2000, A-2.

[12] Transgender Nation.

[13] DHHS, SAMHSA. *A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals*. Rockville, MD: SAMHSA, 2000, A-2.

[14] JRI Health.

[15] DHHS, SAMHSA, Center for Substance Abuse Prevention. *Substance Abuse Resource Guide: Hate Crimes*. Rockville, MD: SAMHSA, National Clearinghouse for Alcohol and Drug Information, DHHS Publication No. (SMA) 00-3445, 2000, 11.

[16] DHHS, SAMHSA. *A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals*. Rockville, MD: SAMHSA, Page A-2. 2000.

[17] Intersex Society of North America. http://www.isna.org.

[18] DHHS, SAMHSA. *A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals*. Rockville, MD: SAMHSA, 2000, A-2.

[19] Ibid.

[20] Ibid.

[21] Ibid.

[22] Ibid.

[23] Transgender Nation.

[24] Neufeldt, V., ed. *Webster's New World Dictionary of American English, Third College Edition*. 1991, 827.

[25] DHHS, SAMHSA. *A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals*. Rockville, MD: SAMHSA, 2000, A-2.

[26] Ibid.

[27] Gender Web Project. Transgender, Gay, Lesbian and Bisexual Glossary and Acronym List. 1994. Retrieved January 14, 2001. http://www.genderweb.org/general/tlbgglos.html.

[28] DHHS, SAMHSA. *A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals*. Rockville, MD: SAMHSA, 2000, A-3.

[29] Blumenfled, W.J. *Adolescence, Sexual Orientation and Identity: An Overview.* OutProud, Be Yourself. Available online at http://www.outproud.org/article_sexual_identity.html.

[30] DHHS, SAMHSA. *A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals*. Rockville, MD: SAMHSA, 2000, A-3.

[31] Ibid.

[32] Ibid.

Appendix D: Resources

FEDERAL RESOURCES

FIRSTGOV

Internet gateway to the entire Federal Government, with search engine and hot links sorted by interest areas: www.firstgov.gov

U.S. Department of Health and Human Services (DHHS)

Internet gateway to DHHS, with search engine, links to agencies, news, opportunities, and related sites: www.dhhs.gov. This Web site provides access to the individual DHHS agencies.

The DHHS Agencies:

The Secretary of Health and Human Services (OS)

Advises the President on health, welfare, and income security plans, policies, and programs of the Federal government. The Secretary administers these functions through the Office of the Secretary and the Department's 12 operating divisions, including a budget of $376 billion and a workforce of 59,000 employees.

Administration for Children and Families (ACF)

Responsible for some 60 programs which provide services and assistance to needy children and families, administers the new State-Federal welfare program, Temporary Assistance to Needy Families, administers the national child support enforcement system, and the Head Start program, provides funds to assist low income families in paying for child care, and supports state programs to provide for foster care and adoption assistance.

Administration on Aging (AOA)

Supports a nationwide aging network, providing services to the elderly, especially to enable them to remain independent. AoA supports some 240 million meals for the elderly each year, including home-delivered "Meals on Wheels," helps provide transportation and at-home services, supports ombudsman services for elderly, and provides policy leadership on aging issues.

Agency for Healthcare Research and Quality (AHRQ)

Supports crosscutting research on health care systems, health care quality and cost issues, and effectiveness of medical treatments.

Agency for Toxic Substances and Disease Registry (ATSDR)

Works with states and other federal agencies to prevent exposure to hazardous substances from waste sites. The agency conducts public health assessments, health studies, surveillance activities, and health education training in communities around waste sites on the U.S. Environmental Protection Agency's National Priorities List.

Centers for Disease Control and Prevention (CDC)

Provides a system of health surveillance to monitor and prevent outbreak of diseases. With the assistance of states and other partners, CDC guards against international disease transmission, maintains national health statistics and provides for immunization services and supports research into disease and injury prevention.

Food and Drug Administration (FDA)

Assures the safety of foods and cosmetics, and the safety and efficacy of pharmaceuticals, biological products and medical devices.

Health Care Financing Administration (HCFA)

Administers the Medicare and Medicaid programs, which provide health care to America's aged and indigent populations, about 1 in every 4 Americans, including nearly 18 million children and nursing home coverage for low income elderly. HCFA also administers the new Children's Health Insurance Program through approved state plans that cover more than 2.2 million children.

Health Resources and Services Administration (HRSA)

The Access agency: helps provide health resources for medically underserved populations. HRSAsupports a nationwide network of 643 community and migrant health centers, and 144 primary care programs for the homeless and residents of public housing, serving 8.1 million Americans each year. HRSA also works to build the health care workforce and maintains the National Health Service Corps, oversees the Nation's organ transplantation system, works to decrease infant mortality and improve child health and provides services to people with AIDS through the Ryan White CARE Act programs.

Indian Health Service (IHS)

Supports a network of 37 hospitals, 60 health centers, 3 school health centers, 46 health stations and 34 urban Indian health centers to provide services to nearly 1.5 million American Indians and Alaskan Natives of 557 federally recognized tribes.

National Institutes of Health (NIH)

With 17 separate institutes, is the world's premier medical research organization, supporting some 35,000 research projects nationwide in diseases like cancer, Alzheimer's, diabetes, arthritis, heart ailments and AIDS.

Substance Abuse and Mental Health Services Administration (SAMHSA)

Works to improve the quality and availability of substance abuse prevention, addiction treatment, and mental health services.

Social Security Administration (SSA)

Became an independent agency on March 31, 1995.

FOUNDATIONS AND FUNDING RESOURCES

American Legacy Foundation

1001 G Street, NW, #800, Washington, DC 20001
202-454-5555 E-mail: info@americanlegacy.org
www.americanlegacy.org
Established in November 1998 as a result of the Master Settlement Agreement (MSA) between a coalition of Attorneys General in 46 states and 5 U.S. territories and the tobacco industry. Funds cutting edge research, marketing and education programs that tell the truth about tobacco use. LGBT populations are a priority for funding.

Astraea National Lesbian Action Foundation

116 East 16th Street, 7th Floor, New York, NY 10003
212-529-8021 E-mail: info@astraea.org
http://www.astraea.org
National nonprofit public charity whose purpose is to advance the economic, political, educational and cultural well-being of lesbians. Educates individuals about money, power and giving. Dedicated to expanding the community of donors supporting lesbian issues and to raise and distribute funds to organizations, individuals and projects. Programs benefit lesbians, gay men and all women and girls both in the United States and internationally and work to eliminate racism, ageism, sexism, heterosexism, economic exploitation and anti-Semitism.

Gill Foundation

2215 Market Street, Suite 205, Denver, CO 80205
303-292-4455 E-mail: info@gillfoundation.org
www.gillfoundation.org
Serves as a catalyst and provides resources for communities in pursuit of justice and equality, while building awareness of the contributions gay men and lesbians make to American society. Through grantmaking activities, technical assistance and other special programs, the Foundation invests in organizations serving the needs of LGBT people, and in community programs designed to improve the quality of life for everyone.

Lesbian Health Fund

A program of the Gay and Lesbian Medical Association
459 Fulton St., Suite 107, San Francisco, CA 94102

415-255-4547 E-mail: info@glma.org
www.glma.org/programs/lhf/index.html
Dedicated to improving the health of lesbians and their families through research grants.

National Health Foundation

515 S. Figueroa St., #1300, Los Angeles, CA90071
213-538-0700 www.nationalhealthfdt.org
Independent, charitable, tax-exempt, 501(c)(3) corporation dedicated to improving and enhancing the health of the underserved by developing and supporting innovative programs that can become independently viable, systemic solutions to gaps in healthcare access and delivery, and that have the potential to be replicated nationally.

Robert Wood Johnson Foundation

PO Box 2316, Princeton, NJ 08543
www.rwjf.org
Largest U.S. foundation devoted to improving the health and health care of all Americans. Concentrates grantmaking in three areas: to assure that all Americans have access to basic health care at a reasonable cost; to improve care and support for people with chronic health conditions; and to promote health and prevent disease by reducing the harm caused by substance abuse — tobacco, alcohol, and illicit drugs. Gives preference to applicants that are public agencies or are tax-exempt under Section 501(c)(3) of the Internal Revenue Code.

COMMUNITY HEALTH CENTERS SERVING THE LESBIAN, GAY, BISEXUAL, AND TRANSGENDER COMMUNITY

Callen-Lorde Community Health Center

356 West 18th Street, New York, NY 10011
212-271-7200 www.callen-lorde.org
Offers primary health care, including medical services, case management, health promotion, support groups, lesbian health services, HIV/AIDS primary care and special programs reaching at-risk teens and transgendered individuals.

Chase Brexton Health Services

1001 Cathedral Street, Baltimore, MD 21201
410-837-2050 www.chasebrexton.org
Offers comprehensive primary care services, including but not limited to medical services, mental health, addictions counseling, pediatrics, health promotion, case management, preventative health care, STD clinics and HIV/AIDS primary care.

Fenway Community Health

7 Haviland Street, Boston, MA 02115
617-267-0900 888-242-0900 (toll free) 617-927-6460 (Spanish) 617-859-1256 (TTY) 888-340-4528 (Helpline); www.fenwayhealth.org
Offers comprehensive primary medical care, mental health, and addiction services, including acupuncture detoxification, to the LGBT communities of greater Boston and New England. A full spectrum of HIV/AIDS clinical services is offered. Additional programs include health promotion and wellness, lesbian cancer support groups, violence recovery services, lesbian and gay family and parenting programs, research and training. Clinical departments have bilingual/bicultural Spanish capacity, and ASL interpretation is offered.

Hartford Gay and Lesbian Health Collective

1841 Broad Street, Hartford, CT 06114
860-278-4163 www.hglhc.org
Provides comprehensive education, support, advocacy and specific medical services to meet the health care needs of lesbians, gay men and bisexuals in the greater Hartford, Connecticut area, with a strong focus on wellness and prevention work.

Howard Brown Health Center

4025 N. Sheridan Road, Chicago, Illinois 60613
773-388-1600 www.howardbrown.org
Howard Brown Health Center, located in downtown Chicago, offers a continuum of primary care services, with a focus on addressing the needs of the LGBT community. Medical care, comprehensive HIV/AIDS care, STD services and a women's health program, mental health counseling and support services, prevention and wellness programs are also available.

Lambda Medical Group

Los Angeles Gay and Lesbian Center
Museum Square Building, 5757 Wilshire Blvd,
Los Angeles, CA
877-4LAMBDA (877-452-6232) www.laglc.org

Lambda offers traditional family practice services, including wellness and prevention programs, Ob-Gyn, and HIV/AIDS treatment. HIV/AIDS services are available at the Jeffrey Goodman Special Care Clinic, while Lesbian health programs are located with the Audre Lorde Lesbian Health Clinic. Adolescent HIV services are provided at the Pedro Zamora Youth HIV Clinic. In addition to primary medical care, the Lambda group also offers mental health and domestic violence services.

Lyon-Martin Women's Health Services

1748 Market St., #201, San Francisco, CA 94102
415-565-7667 www.sfccc.org/clinics/lmwhs.htm
Lyon-Martin Women's Health Services provides primary care, gynecology, primary care for HIV positive women, breast cancer early detection screening, support groups, case management, prevention education, nutrition counseling, smoking cessation classes, and substance abuse education not only for lesbians, but bisexual and transgendered women and girls. Parenting services for lesbian and bisexual parents offer legal, medical and social services information through forums and workshops. Services are available in Spanish as well as English.

Montrose Clinic

215 Westheimer, Houston, TX 77006
713-830-3000 www.montroseclinic.org
Montrose Clinic is located in Houston, Texas, and is the city's only health clinic serving the lesbian and gay community. As part of the Clinic's primary care services, it offers anonymous and confidential HIV testing, women's health services, dermatology, nutrition consultation, optometry and ophthalmology screening, and STD and Hepatitis C screening services. A community services division provides education, case management and outreach. A research division, Houston Clinical Research Network, provides community based HIV drug research through clinical trials.

Outer Cape Health Services

49 Harry Kemp Way, Provincetown, MA 02657
508-487-9395
Outer Cape Health is a free standing community health center with clinical sites in Provincetown, Wellfleet, and Orleans, Massachusetts, with a long history of serving the area's gay and lesbian population. Primary care services include medical, nutrition, laboratory, and x-ray services. Also offers case management, referrals, and health promotion programs.

Whitman Walker Clinic

1407 S Street, NW, Washington, DC 20009
202-797-3500 202-365-5225 (24-Hour Line)
202-939-7814 (TDD)
202-328-0697 (En Español) www.wwc.org
Whitman Walker Clinic, a volunteer-based lesbian and gay community health organization serving the Washington, DC metropolitan area, provides health care services to the LGBT community in the greater District of Columbia area, with four service delivery sites, two in the District, and one each in Virginia and Maryland. Services include HIV/AIDS care and treatment, mental health services, lesbian and gay health wellness programs, a lesbian and gay hotline, and AIDS education and prevention programs. A special HIV and STD prevention initiative targets the Latino community through outreach and education services.

LGBT COMMUNITY CENTERS

The LGBT Community Centers section of the Resource Guide was produced by Richard Burns and Paul Fricken, Lesbian and Gay Community Services Center - New York, for the National Association of Lesbian, Gay, Bisexual and Transgender Community Centers - www.gaycenter.org.

ALASKA

Anchorage Organizing Committee

907-278-4784
Their vision is to create a physical community center in Anchorage and a virtual one for the whole state.

ARIZONA

Northern Arizona Rainbow Community Center

1300 South Milton Rd, Suite 221, Flagstaff, AZ 86001
520-526-5419 E-mail: arcc12000@aol.com
Information/referral switchboard, resource/referral database, group meeting space, office space for LGBT organizations/allies, community information packets, regional LGBT calendar. Monthly newsletter: Rainbow Reporter.

Valley of the Sun Gay and Lesbian Community Center

24 West Camelback Road, Suite C, Phoenix, AZ 85013
602-265-7283 E-mail: lmiller@phxcenter.org
www.phxcenter.org
Lesbian and Gay Community Switchboard and Arizona AIDS Information Line; youth groups, men's/women's/seniors' suport groups; antiviolence project; recovery community support project; cultural programs.

Wingspan

300 E. 6th Street, Tucson, AZ 85705
520-624-1779 E-mail: wingspan@wingspanaz.org
www.wingspanaz.org
Adult and youth support groups, meeting spaces, information and referral phone line, lending library, free and anonymous HIV testing, Pride Law Center, and Domestic Violence Project. Bimonthly newsletter: Wingspan.

CALIFORNIA

Inland Empire Gay and Lesbian Center

909-882-4488
Hotline, peer support and a speakers bureau.

L. A. Gay and Lesbian Center

1625 N. Schrader Blvd., Los Angeles, CA 90028
323-993-7600 E-mail: info@laglc.org www.laglc.org
Counseling, addiction recovery, policy and public affairs, youth services, homeless youth shelter, legal services, antiviolence project, AIDS/HIV medical clinic, pharmacy, Audre Lorde Lesbian Health Clinic, anonymous HIV testing site, HIV prevention education, Pedro Zamora Youth HIV Clinic.

Additional facilities of the Los Angeles Gay and Lesbian Center:

California AIDS Clearinghouse: 323-845-4180 Jeff Griffith Gay and Lesbian Youth Center: 323-461-8163 Youth talk line: 800-773-5540 Lambda Medical Group: 877-4-LAMBDA The Village at Ed Gould Plaza: 323-860-7302

Lambda Community Center

920 20th Street, Suite 117, Sacramento, CA 95814
916-442-0185 E-mail: LAMBDACENTER98@hotmail.com
AIDS education and prevention, youth program, health education for lesbians, Lambda Players Theatre Group, AIDS/HIV support groups, Triangle Cafe, library and resource center, case management, Lambda AIDS response. Quarterly newsletter: At The Center.

National Deaf Queer Resource Center

E-mail: info@deafqueer.org www.deafqueer.org
Resources, information and referrals. Weekly newsletter: FLASH.

Northcoast Lesbian, Gay, Bisexual and Transgender Alliance

235 4th Street, Suite A, Eureka, CA 95501
707-445-9760 E-mail: darncat@reninet.com
www.reninet.com/darncat
Drop-in space, community resource listings, assistance with welfare and public health services, support groups, outreach, dances, job bank, lending library, and art gallery. Monthly newsletter: GALA News.

Pacific Center for Human Growth

2712 Telegraph Avenue, Berkeley, CA 94705
510-548-8283 510-548-2192 (Counseling Request Line)
E-mail: info@pacificcenter.org www.pacificcenter.org
LGBTQ community space; individual/family/couples counseling; HIV counseling/support groups/outreach and prevention; educational outreach and speakers bureau; peer support groups; information and referral; volunteer programs; and youth services. Quarterly newsletter: Pacific Currents.

Pacific Pride Foundation

126 E. Haley Street, Suite A10, Santa Barbara, CA 93101
805-963-3636 E-mail: Pride@silcom.com
Sponsor annual Pride and AIDS Walk events. HIV counseling, youth groups and support groups. Monthly newsletter: The Bulletin.

Rainbow Community Center of Contra Costa County

2118 Willow Pass Road, Suite 500, Concord, CA 94520
925-992-0090 E-mail: board@rainbowcc.org
www.rainbow.cc.org

Social activities, peer support groups, and educational programs. Bimonthly newsletter: Prism.

San Francisco Community Center Project

1800-1810 Market Street, San Francisco, CA94102
415-437-2257 E-mail: sfgaycent@aol.com
www.sfgaycenter.org
Planning began in 1994. Center is under construction.

Solano Pride Center

934 Missouri Street, Suite T, Fairfield, CA 94533
707-246-6660 E-mail: barmayjr42@cs.com
Solanopride.org
Youth group (ages 13-21), community outreach, adult services, information and referral line. Publish bimonthly newsletter.

Spectrum Center for Gay, Lesbian, and Bisexual Concerns

1000 Sir Frances Drake Blvd, #10, San Anselmo, CA 94960
415-457-1115 E-mail: spectrumLG@aol.com
www.SpectrumMarin.org
Support groups for all ages, social activities, speakers bureau, Annual Marin Pride Festival. Monthly newsletter: Spectrum Dispatch.

Stonewall Alliance Center

341 Broadway, Suite 416, Chico, CA95928
530-893-3336 E-mail: Center@stonewallchico.org
www.stonewallchico.org
Information and referral, Harlen M. Adams Memorial Lending Library, youth program (ages 13 to 25), Pride Fest "Chico Freedom Fest," Social Services Rainbow Alliance and Business Alliance, support groups, AIDS Panels of Remembrance, coalition with the Butte Health Dept. for HIV testing, Partner Abuse Prevention Program (PAPP). Monthly newsletter: CenterStone.

The Billy DeFrank Lesbian and Gay Community Center

938 The Alameda, San Jose, CA 95126
408-293-3040 E-mail: defrank@defrank.org
www.defrank.org
Information and referral, voter registration and mobilization, peer counseling, youth services, social/recreational services mental health program, addiction outreach program, volunteer resources, community drop-in, gay bingo, and meeting space. Monthly newsletter: Community Center News.

The Diversity Center

1328 Commerce Lane, Santa Cruz, CA95060
831-425-5422 E-mail: info@diversitycenter.org
www.diversitycenter.org
Annual parade and celebration; diversity outreach committee; Santa Cruz Uniting Trans Men; Santa Cruz Youth Task Force; men's, women's, and coming out support groups; social events; and La Gazette Women's Newspaper. Monthly newsletter: Manifesto.

The Edge

39160 State Street, Fremont, CA 94538-1436
510-790-2887 E-mail: theedgefremont@aol.com
Meeting space, drop-in space, community announcement bulletin boards, housing referral boards, gay men's support group, gay men of color support group, women's support group, men's social group, lesbian social group, and HIV education and prevention services.

The Gay and Lesbian Community Center of Greater Long Beach

2017 E. 4th Street, Long Beach, CA 90814-1001
562-434-4455 www.centerlb.org
Support and rap groups, hate crimes hotline, legal, psychological and unemployment counseling, community activities programs, information and referral, twelve step programs, and AIDS/HIV case management and client advocacy. Monthly newsletter: Center Post.

The Gay and Lesbian Community Services Center of Orange County

12832 Garden Grove Blvd., Suite A, Garden Grove, CA 92843
714-534-0862 E-mail: administration@centeroc.org
www.centeroc.org
Mental health services, special interest groups, youth services, information and referral, AIDS education and HIV support services and testing. Bimonthly newsletter: Center Connections.

The Lesbian and Gay Men's Community Center

3909 Centre Street, San Diego, CA 92103
619-692-2077 619-692-3282 (TTY)
E-mail: iedthecentersd@usa.net www.thecentersd.org
HIV prevention, youth services, antiviolence project, lesbian health, disabled services, coming out groups, LGBT counseling, HIV mental health. Bimonthly newsletter: CenterPiece, available online. Satellite center at 150 Valpreda, Suite 201, San Marcos: 760-744-0220.

The Wayne McCaughan Community Pride Center

1306A Higuera Street, San Luis Obispo, CA93401
805-541-4252
Education, outreach, referrals and a library. Bimonthly newsletter: GALA News and Reviews.

Ventura County Rainbow Alliance

3503 Arundell Circle, Suite A, Ventura, CA 93003
805-339-6340 E-mail: LAConstrux@aol.com
www.glccventura.com
AIDS Project Ventura County; breast cancer early detection program; alcohol and drug program; HIV/STD prevention, testing and counseling; Youth Empowerment Project; Lesbigay Student Scholarship Fund; annual community service awards; mental health counseling and referral; addiction recovery; social services/outreach/legal/financial clinics. Monthly newsletter: Out and About.

COLORADO

Aspen Gay and Lesbian Community Fund

215 North Garmisch, Aspen, CO 81611
970-925-4123 E-mail: aspengay@rof.net
www.gayskiweek.com
Resources and referrals for Aspen and Roaring Fork Valley, links to AIDS services, HIV prevention and education, youth diversity and tolerance training, speakers bureau, social activities. Monthly newsletter: Community News.

Gay, Lesbian and Bisexual Community Services Center of Colorado

234 Broadway, Denver, CO 80203
303-733-7743 E-mail: glbcscc@aol.com
www.coloradoglbt.org
Youth services, community support programs, Pridefest, Mountain State G/L film festival, Lesbian Cancer support services, Health and Wellness Programs, HIV testing, hepatitis vaccinations, HIV prevention programs, movies and cultural programing. Bimonthly newsletter: Centerlines.

Pikes Peak Gay and Lesbian Community Center

125 North Parkside, Colorado Springs, CO 80909
719-471-4GAYS (4429) E-mail: mail@ppglcc.org
www.ppglcc.org
Resource and information line, office space for other organizations, PrideFest, Business Directory. Monthly newsletter: Community Vision.

The Lambda Community Center

149 West Oak, Suite #8, Fort Collins, CO 80524
970-221-3247 970-221-3247 (Information Services and TTY) E-mail: lambda@lambdacenter.org
www.lambdacenter.org
Lambda Library and Archives; men's, women's and youth groups, Lambda University Educational Series; Lambda Business Council; information and referral. Monthly newsletter: Lambda Lines.

CONNECTICUT

Gay and Lesbian Community Center

1841 Broad Street, Hartford, CT 06114
860-724-5542
AA recovery programs, health services, recreational programs, educational forums, and a theatre company. Monthly newsletter.

New Haven Gay and Lesbian Community Center

50 Fitch Street, New Haven, CT 06515
203-387-2252 E-mail: fgdmyo@aol.com
www.nhglcc.org
Coming out group, gay fathers' group, gay men's rap group, lesbian rap group, movie night, Living Positively, lesbian coparenting group, Course in Miracles, and drop-in hours. Bimonthly newsletter: NHGLCC News.

Triangle Community Center

P.O. Box 4062, East Norwalk, CT 06855
203-853-0600 E-mail: tccenter@aol.com
members.aol.com/tccenter
Discussion groups, resouce room of books and periodicals, meeting space, and a community directory. Monthly newsletter: News and Views.

FLORIDA

Compass

1700 North Dixie Highway, West Palm Beach, FL 33407
561-833.3638 E-mail: compasswpb@aol.com
Support and social programs for youth 14-18 and parents; HIV prevention and education; lending library; HIV/AIDS case management services. Quarterly newsletter: Compass Direction.

Cosmopolitan Center of Miami

701 Lincoln Rd Fl 2, Miami, FL 33139-2879
305-759-5210
Bimonthly newsletter: Cosmopolitan Clarion.

Gay and Lesbian Community of Greater Fort Lauderdale

P.O. Box 70518, Fort Lauderdale, FL 33307-0518
954-563-9500 E-mail: GLCCFTL@aol.com
www.glccftl.org
Information, referral and peer support switchboard and hotline; mainstream outreach program (GLOW); voter registration; meeting space; support groups; free HIV testing; gays and lesbians with children; older men's talk group; youth group; women's group; and generation x group. Monthly newsletter: The Center Voice.

Gay, Lesbian and Bisexual Community Center of Central Florida

934 N. Mills Avenue, Orlando, FL 32803-3230
407-228-8272 E-mail: info@glbcc.org www.glbcc.org
Community and business support and advocacy, family and youth services including advocacy, crisis intervention, peer counseling and education, bisexual/transgender support services, information and referral, 24-hour gay info line, outreach/education services, speakers bureau. Monthly newspaper: The Triangle.

The Center of Tampa

4265 Henderson Boulevard, Suite B, Tampa, FL 33629
813-287-2687 E-mail: tampacenter@mindspring.com
www.tampacenter.org
Support groups for lesbians, gay men, LGBTQ youth, transgender individuals, gay parents, and coming out; Community information and referral; organizations support and assistance with startup. Bimonthly newsletter: The Center Voice.

The Family Tree

423 East Virginia Street, Tallahassee, FL 32301
850-222-8555 E-mail: familytree1999@hotmail.com
www.familytreecenter.org
Telephone information and referrals, social and recreational events, peer counseling, support groups, community education, publicity outreach, resource library, youth group. Monthly newsletter: Branching Out.

The Gay and Lesbian Community Center

1075 Duval Street, Duval Sq. C-14, Key West, FL 33041-0071
305-292-3223 E-mail: info@glcckeywest.org
glcckeywest.org
Forty-Niners (Senior gays), AIDS support group, social, sports. Quarterly newsletter: The Center.

GEORGIA

The Atlanta Gay and Lesbian Center

159 Ralph McGill Blvd, Suite 600, Atlanta, GA30308
404-523-7500 E-mail: jpetty@aglc.org www.aglc.org
Support/discussion groups; clinic testing and immunization; library with 3,000+ volumes; helpline; various social and cultural programs.

HAWAII

Gay and Lesbian Community Center

2424 S. Beretania Street, Honolulu, HI 96826
808-951-7000 E-mail: glcc-news@juno.com
www.glcc-hawaii.org
Meeting space; spirituality support groups; coming out support groups for men, women, and youth; speakers bureau; library. Quarterly newsletter: Outlook.

IDAHO

The Community Center: Resources for Gay and Lesbian People

919A N. 27th, Boise, ID 83702
208-336-3870 E-mail: tcc@micron.net
Hotline and Information and Referral 208-336-3870. Publish the gay and lesbian newspaper for Idaho: Diversity.

ILLINOIS

Church of the Open Door Community Center

5954 South Albany Avenue, Chicago, IL 60629
773-778-3030
Employment services; crisis counseling; counseling; prison outreach; antiviolence actions; voter registration; health advocacy; credit and budget counseling; men's group; community organizing and leadership development; space sharing for nonprofits; multimedia information and education materials focused on the African American LGBT and wider communities.

Horizons Community Services

961 W. Montana Street, Chicago, IL 60614-2408
773-472-6469 E-mail: Rogerd@horizonsonline.org
www.horizonsonline.org
Lesbian and Gay Helpline, Anti-Violence Project 24 Hour Crisis Hotline, youth services, ED and support services, psychotherapy, speakers service and legal services. Quarterly newsletter: The Horizon.

Quad Citians Affirming Diversity

1705 2nd Avenue, #508, Rock Island, IL 61201
309-786-2580 E-mail: qcadmen@aol.com
home.revealed.net/qcad
Youth and adult drop-in and support; technical assisstance; community education. Monthly newsletter: QCAD News.

INDIANA

The Diversity Center

Chris Gonzolez Library and Archive
723 Massachusettes Avenue, Indianapolis, IN 46204
317-639-4297 E-mail: diversity@gayindy.org
www.gayindy.org
The Marion County Board of Health anonymous and confidential HIV testing, FDA HIV/AIDS Drug Fraud Task Force.

Up the Stairs Community Center

3426 Broadway, Fort Wayne, IN 46807
219-744-5430 E-mail: uts2k@hotmail.com
Archives and resource library, Community AIDS Action Team, Social Action Committee, bisexual/transgender group, Horizons Youth Group, Promote the Vote, Friday Night Drop-In, Pride Fest Committee. Monthly newspaper: The Rainbow Reader.

IOWA

Gay and Lesbian Resource Center

1165 25th Street, Des Moines, IA 50311
515-277-7884 www.glrc-dsm.org
3,500+ library and video collection, Web site, speakers bureau, media response, organizational meeting space, phone line, artists gallery, youth space, drop-in center. Newsletter published monthly.

Gay and Lesbian Resource Center of Cedar Rapids

1056 5th Avenue, South East, Cedar Rapids, IA 52403
319-366-2055 E-mail: crglrc@crglrc.org
www.crglrc.org
Lending library, resource and referral, social functions, advocacy, speakers bureau, workshops, phone line, support groups. Monthly newsletter: The Resource Line.

The Center - Wichita

316-262-3991
Lesbian, Gay, Bi, AA Meetings; The Kansas Gay and Lesbian Archives; weekly coffee house; weekly lesbian coming out support group; Wichita Gay and Lesbian Alliance; HIV/AIDS Clothes Closet; community information center. Monthly newsletter.

LOUISIANA

Lesbian and Gay Community Center of New Orleans

2114 Decatur Street, New Orleans, LA70116
504-945-1103 E-mail: lgccno@aol.com
www.lgccno.homepage.com
Hate Crimes Intervention Project; youth group; coming out support group; 20-something group; meeting space;

information and referral. Monthly newsletter: The Center Line.

The Lambda Center

1733 Florida Blvd, Baton Rouge, LA 70802
225-346-0670 E-mail: info@lambdabr.org
www.lambdabr.org
Teen group; men's group; monthly community breakfast; PFLAG; GLSEN; socials; referrals; speakers bureau; Annual Fallfest (pride celebration). Bimonthly newsletter: Lambda Letter.

MAINE

Gay and Lesbian Community Services Center of Northern Maine

568 Main Street, Caribou, ME 04736
207-498-2088
A hotline – including HIV prevention education and counseling; education; information and peer support for the LGBT communities of Maine, and their families; various other social activities.

The Diversity Center

888-216-2034 ext. 7299 E-mail: pinkpride@hotmail.com

MARYLAND

Gay and Lesbian Community Center of Baltimore

241 W. Chase Street, Baltimore, MD 21201
410-837-5445 E-mail: office@glccb.org
www.glccb.org
Switchboard referral service; youth and young adults program; Womonspace; People Like Us; various social, support, and outreach groups; community outreach; health outreach; and Pride celebration. Semimonthly publication: Baltimore Gay Paper.

MASSACHUSETTS

Boston Center for Lesbians and Gay Men

80 Chandler Street, Boston, MA 02116
617-426-1316

LGBT Community Center Project of Western Massachusetts

413-582-0743 E-mail: valleyctr@hotmail.com
www.queerhamp.org
Virtual community center Web site, community resource listings, monthly book club. Committees: programming and development, fundraising, and public relations and networking. Bimonthly newsletter: The Community News.

Pride Zone

34 Maplewood Shops, Northampton, MA01060
413-584-1116
Youth Alliance, game night, 24-hour advisor, monthly social events, Western Massachusetts Pride Rally, Trans Support Group, Youth of Queer Parents Group.

MICHIGAN

Affirmations Lesbian and Gay Community Center

195 West Nine Mile Road, Ferndale, MI 48220
248-398-7105 E-mail: affirmationslgbt@juno.com
www.comnet.org/affirmations
Social services, advocacy and education. Monthly newsletter: Affirmations.

Kalamazoo Gay and Lesbian Resource Center

629 Pioneer Street, Kalamazoo, MI 49008-1801
616-349-4234 E-mail: KGLRC@aol.com
www.kglrc.org
Information and referral line and a youth group. Quarterly newsletter: The Resource Center News.

Karibu House

Detroit, MI
313-863-8803 E-mail: karibuhouseinc@aol.com

Lesbian and Gay Community Network of Western Michigan

909 Cherry Street, SE, Grand Rapids, MI 49506
616-458-3511 616 458-4691 (TTY)
Weekly support groups, annual Pride Celebration, lending library, drop-in center and meeting space, resource directory, information and referral services, Stop the Violence Hotline for reporting bias incidents,

speakers bureau, HIV/AIDS prevention programs, and various social and educational activities throughout the year. Monthly newsletter: The Network News.

Washtenaw Rainbow Action Project

325 Braun Court, Ann Arbor, MI 48107
734-995-987 E-mail: wrap@wrap-up.org www.wrap-up.com
Works on public policy concerns such as nondiscrimination policies; liaisons and cooperates with other groups; offers educational presentations; provides meeting space for local groups; disseminates information; provides social programming; organizes special events, such as National Coming Out Day rally, march and street party. Monthly newsletter: WRAP-Up.

MINNESOTA

AURORA: A Northland Lesbian Center

32 East 1st Street, Duluth, MN 55802
218-722-4903
Resource center, lesbian library, referral, Women Music Fest. Monthly newsletter.

Northland Gay Men's Center

8 N. 2nd Ave. East, Suite 309, Duluth, MN 55802
218-722-8585 E-mail: ngmc@cpinternet.com
cpinternet.com/~ngmc
Discussion groups, lending library, canoeing, camping, day trips, community action, mentoring, dances, education, and speakers bureau. Quarterly newsletter: GAYRIGHTER.

OutFront Minnesota

310 East 38th Street, Room 204, Minneapolis, MN 55409
612-822-0127 800-800-0350 E-mail: outfront@outfront.org www.outfront.org
24-hour info line, domestic violence intervention, antiviolence advocacy, legal advocacy, education and training, community development, and public policy.

MISSOURI

Gay and Lesbian Community Center of the Ozarks

518 E. Commercial, Springfield, MO 65801
417-869-3978 E-mail: GLODir@aol.com
www.ozarksforum.net/GLO
Rap groups, HIV+ Affinity Group, youth group, Cafe GLO (Open Mike Night), GLO Film Society. Monthly newsletter: The GLO Newsletter.

Lesbian and Gay Community Center

The Supreme Bean Coffee Shop, 1615 W. 39th Street, Kansas City, MO
E-mail: lgcc@kc-lgcc.org www.kc-lgcc.org
Currently meeting upstairs at The Supreme Bean Coffee Shop.

MONTANA

Western Montana Gay and Lesbian Community Center

615 Oak Street, Missoula, MT 59801
406-543-2224 E-mail: wmglcc@gaymontana.com
www.gaymontana.com
Healthy Lifestyles Program (HELP), a lending library, support groups, resource center.

NEBRASKA

Panhandle Gay and Lesbian Support Services

308-635-8488
Provide services to 11 counties in Nebraska panhandle through social functions, support and education.

Rainbow Outreach Resource Center

1719 Leavenworth Street, Omaha, NE 68102
402-341-0330 www.rocc.org
24-hour phone line, library, education, information and referral, social activities, meeting space for eastern NE/western IA. Publish a quarterly newsletter.

NEVADA

A Rainbow Place

263 Keystone Avenue, Reno, NV 89503
775-329-3034 E-mail: ARainbowPlace@aol.com
Community library, 24-hour information hotline, antiviolence project, meeting space, youth support services, suicide prevention program, leadership building, peer support groups, political engagement; voter registration, education, lobbying,

health/counseling service referral network, public education. Quarterly Newsletter: Nevada OUTpost.

The Gay and Lesbian Community Center of South Nevada

912 East Sahara Avenue, Las Vegas, NV 89104
702-733-9800
Youth mentoring, HIV prevention, community resource services. Bimonthly newsletter: The Center Line.

NEW JERSEY

Gay and Lesbian Community Center of New Jersey

626 Bangs Avenue, Asbury Park, NJ 07712
732-774-1809
Email newsletter.

The Pride Center of New Jersey

211 Livingston Avenue, New Brunswick, NJ 08901
732-846-2232 E-mail: info@pridecenter.org
www.pridecenter.org
Statewide info line, HIV counseling and testing, roommate/apartment services, monthly coffee house, over 20 programs including coming out support groups, Al-Anon, Latinos Unidos, Long Yang Club, Out There, Under the Rainbow, and others.

NEW YORK

Capital District Gay and Lesbian Community Center

332 Hudson Avenue, Albany, NY 12210
518-462-6138 E-mail: cdglcc@aol.com
www.thedigitalvillage.com/cdglcc
Support groups; programming throughout the Capital District; and a 24-hour information line. Monthly newsletter: Community.

Community House of Long Island

751 Long Island Avenue, Deer Park, NY
631-242-9727 E-mail: info@choli.org www.choli.org
Major programs and services are in the formation stages. Projects include a diversity program, Promote the Vote, Project on Domestic Violence with Gay and Lesbian Couples; groups include HIV+ Group, Latinos and Hispanics, LIFE, GOAL, The Bears, The LGBT Network Committee, Gay Democrats of Suffolk County, SAGE, and more.

Gay Alliance of the Genesee Valley

179 Atlantic Avenue, Rochester, NY 14607
716-244-6335 E-mail: rgelder@gayalliance.org
www.gayalliance.org

Pride Community Center of Central New York

745 North Salina Street, Syracuse, NY 13208
315-426-1650
Resource and referral center, phone info line, drop-in center, reading/lending library, meeting space for organizations, Friday night movies. Quarterly newsletter: Pride Inside.

Queens Lesbian and Gay Community Center

c/o Queens Borough Hall
120-55 Queens Boulevard, Rom 325, Kew Gardens, NY 11424
718-261-7068
Meeting space for Queens groups, library/media resource center, social events, domestic violence counseling with Anti-Violence Project, legal clinic, gender identity series, youth group.

The Audre Lorde Project

85 South Oxford Street, 3rd Floor, Brooklyn, NY 11217
718-596-0342 E-mail: alpinfo@alp.org www.alp.org
Quarterly newsletter: The Missive.

The Lesbian and Gay Community Services Center

208 West 13th Street, New York, NY 10011
212-620-7310 E-mail: info@gaycenter.org
www.gaycenter.org
Meeting space for over 300 groups; alcoholism and substance abuse recovery counseling; AIDS bereavement program; creative arts programming for young people; support services for the transgender/transexual community; mediation services; information and referral; and more. Bimonthly newsletter: Center Voice and monthly calendar: Center Happenings.

The Loft - The L&GCSC of the Lower Hudson Valley

180 East Post Road, White Plains, NY 10601
914-948-4922 914-948-2932 E-mail: info@loftgaycenter.org
www.loftgaycenter.org
Weekly rap groups run by loft peer support services, as well as other special discussion groups, Sobriety at The LOFT, Al-Anon, social events and groups, Positively Expressed (HIV+ group), various socials, dances, speakers, authors/book signings, and other events. HIV testing available by appointment. Newsletter 10 times per year: LOFT Community New (Cnews).

NORTH CAROLINA

OutCharlotte Organizing Committee

704-563-2699 E-mail: communitycenter@aol.com
www.outcharlotte.org

Triangle Community Works!

814 Dixie Trail, Raleigh, NC 27607
919-821-0055
Gay and Lesbian Helpline, A Safer Place Youth Network, resource library, Medical Provider Resource Project, Bisexual Discussion Group. Bimonthly newsletter: Community Works!

OHIO

Lesbian/Gay Community Service Center of Greater Cleveland

6600 Detroit Avenue, Cleveland, OH 44102
216-651-5428 1-888-GAY-8761 E-mail: thecenter@earthlink.net www.lgcsc.org
Hotline; The Living Room (A drop-in center for people living with HIV/AIDS); youth program; Presence and Respect for Youth In Sexual Minority (PRYSM), Safe Schools Are For Everyone (SSAFE), a speakers bureau and resource center. Quarterly newsletter: The Center Attraction.

Pride Center of Greater Youngstown

330-747-7433 E-mail: youngstownpride@hotmail.com
hometown.aol.com/thepridecenter
Maintains a Web site and an informational phone line; social events safe for LGBT people; Coffee Klatches; Liason with LGBT groups in the area.

Stonewall Columbus Community Center

1160 N. High Street, Columbus, OH 43201
614-299-7764 E-mail: stonewall@stonewall-columbus.org www.stonewall-columbus.org
Support groups, referrals, free meeting space, copies and fax services, mailbox rentals, office space rental (when available), Lavendar Listings - annual business directory. Monthly newsletter: Stonewall Journal.

The Dayton Lesbian and Gay Center

200 Delaware Avenue at Faith UCC, Dayton, OH 45405
937-676-2274
Women's Forum, Men's Forum, Monthly Community Nite Series, Pride Events, 24-hour automated hotline. Quarterly newlsetter.

The Gay and Lesbian Community Center of Greater Cincinnati

4119 Hamilton Avenue, Cincinnati, OH 45223
513-591-0200 513-651-0070 (Information and referral switchboard)
E-mail: mail@glbtcentercincinnati.com
www.glbtcentercincinnati.com
Library and archives, meeting space, community calendar of events, community resource area for copying, faxing and work on personal computer; Cincinnati Youth Group, Coalition, Men's Support Group, Pride Committee. Quarterly newsletter: Outlooks.

The Pride Center

71 North Adams Street, Akron, OH 44302-2254
330-275-5900 E-mail: akpride007@hotmail.com
www.rainbow-akron.com/aapc/
Social, educational, support and disussion groups for LGBT communities. Meeting/event space for AA, Stonewall Akron, NEON, Equality Begins at Home, Out In Akron, and various LGBT churches. Lending library; and resource and information distribution. Monthly newsletter: The Pride Center.

OKLAHOMA

Herland Sister Resources

2312 N.W. 39th Street, Oklahoma City, OK 73112
405-521-9696 E-mail: herland@mailroom.com
www.herlandsisters.org

Cultural programming, semiannual retreat for women, meeting space for various groups. All services oriented for women although men may participate in any program or service not specifically designated as "women only." Bookstore, library, and coffee house. Monthly newsletter: Herland Voice.

The Center

2135 NW 39th Street, Oklahoma City, OK 73112
405-524-6000
Pride merchandise store, meeting space for community organizations, substance abuse groups, coming out groups, annual Pride events. Monthly newsletter: The Pride Center News.

The Pride Center -Tulsa Oklahomans for Human Rights

1307 East 38th Street, Tulsa, OK 74105
918-743-4297 E-mail: pride_center@yahoo.com
Pride merchandise store, meeting space for community organizations, substance abuse groups, coming out groups, annual Pride events coordination (including HIV prevention programs that are now operated as a separate agency). Monthly newsletter: The Pride Center News.

OREGON

Abdill-Ellis Lambda Community Center

The Fourth Street Studio, 281 Fourth Street, Ashland, OR 97520
541-488-6990 E-mail: info@abdellis.org
www.abdellis.org
Lending library; business directory; info and referral; Southern Oregon outreach to lesbians and gay men; HIV/AIDS prevention education; movie night; social and support groups. Monthly newsletter: Prizm.

Lesbian Community Project

1001 East Burnside Street, Portland, OR 97214
503-233-3913 E-mail: lcppdx@hotmail.com
www.teleport.com/~lcppdx
Lesbian Health Project; The Oregon Lesbian Conference; voter registration; For Love and Justice - A Walk Against Hate; safer sex workshops; coming out series; presentations to high school and college classes and business and social service organizations, churches and other groups; and some thirty other programs and services. Monthly newsletter.

North Coast Pride Network

10 6th Street, Suite #209, Astoria, OR 97103
503-338-0601 E-mail: ncpn@pacifier.com
LGBT social, quarterly newsletter "OUT on the Coast," information about events and community service activities.

Phoenix Rising

424 Burnside, Portland, OR 97214
503-872-9664 E-mail: safetnet@aol.com
Youth drop-in center for LGBT and questioning youth, youth support groups, youth leadership training, HIV/STD (Youth Against AIDS) prevention, outreach and education. Seniors Community Resource Guide. Triannual newsletter: Phoenix Flyer.

PENNSYLVANIA

Gay and Lesbian Community Center of Pittsburgh

5808 Forward Avenue, Pittsburgh, PA 15217-2302
412-422-0114 412-422.1633 (Youthline)
E-mail: center@glccpgh.org www.glccpgh.org
Youthline hours: 3pm-6pm on Saturdays, youth services, information and referral support through phone line, lending library and meeting space. Quarterly newsletter: Gay and Lesbian Community Center Newsletter.

William Way Community Center

1315 Spruce Street, Philadelphia, PA 19107-5601
215-732-2220 E-mail: wwcenter@yahoo.com
www.waygay.org
Peer counseling, front desk information and referral, library, archives, support groups, coffee houses, seminars, social events, town meetings. Bimonthly newsletter: William Way Community Center News and Notes.

TENNESSEE

Gay and Lesbian Resource Center

1040 Murfeesboro Pike, Suite 105, Nashville, TN 37217
877-499-GLRC (4572) 877-480-TENN (8366) (24 hour crisis intervention)
E-mail: info@glrgtn.org www.glrctn.org
Case management for disabled and mentally challenged; walkin crisis counseling and assistance with food, prescriptions, and utilities; coming out support for

men aged 18-25; Transistional Living Program, emergency housing for homeless people and victims of domestic abuse. Newsletter: Freeality.

LGBT Center

703 Berry Road, Nashville, TN 37204
615-297-0008 E-mail: info@nashcenter.org
www.nashcenter.org
Education, community building, strategic development, counseling/care providing, and outreach. Switchboard services include referrals, information and peer counseling. Bimonthly newsletter: Center Intrigue.

Memphis Gay and Lesbian Community Center

901-324-4297 E-mail: mglcccalendar@yahoo.com
www.memphisgayweb.org
Town Hall meeting, potluck dinner, Gay and Lesbian Film Festival, Pride Weekend Party. Web site provides community calendar and directory. Switchboard provides information about groups, business, and counseling.

TEXAS

Austin Gay and Lesbian Community Services

E-mail: aglcs@email.com www.austincenter.org
Access to an Austin area calendar of events, an e-mail subscription list, a Resource Guide and Business Directory. This is a cyber center.

Gay and Lesbian Community Center of San Antonio

3126 N. Saint Mary's, San Antonio, TX 78212
210-732-4300
HIV/AIDS testing, counseling, information and referrals, HIV Support Plus Club, psychological counseling, monthly calendar, social mixers, youth groups, lending library, meeting space rental, Virtual G and L Chamber of Commerce. Monthly newsletter: The Calendar.

Houston Lesbian and Gay Community Center

803 Hawthorne, Houston, TX 77006
713-524-3818
Meeting space, community information, office space for community organizations. Monthly newsletter.

John Thomas Gay and Lesbian Community Center

2701 Reagan Street, Dallas, TX 75219
214-528-9254 E-mail:
glccdallas@resourcecenterdallas.org
www.resourcecenterdallas.org
Speakers bureau; switchboard; special events and fun classes; 10% Youth; meeting space for 60+ groups; Lesbian Health Commandos; Phil Johnson Historic Archives and Research Library; and AIDS Resource Center Division. Community newsletter in development. Monthly AIDS Update published by AIDS Resource Center.

LAMBDA LGBT Community Services

216 S. Ochoa, El Paso, TX 79901
915-562-4297 E-mail: admin@lambda.org
www.lambda.org
National Hate Crimes Documentation Network (www.HCDN.org), HIV/AIDS prevention and testing, meeting and office space for community organizations, library/archives, regional calendar and e-mail lists, counseling, community information, weekly movie nights, youth dances, information and referrals, concerts, annual Pride events. Monthly newsletter.

UTAH

The Lesbian and Gay Community Center of Utah

361 North-300 West, Salt Lake City, UT 84103
801-539-8800 E-mail: pwolfe@glccu.com
www.glccu.com
Lending library, referrals, group meetings, bulletin boards, art center, youth programs, drop-in center, meeting space, and a coffee shop called The Stonewall Coffee Company.

VERMONT

R.U.1.2. Community Center

802-860-RU12 (7812) E-mail: thecenter@ru12.org
www.ru12.org
Monthly potluck, bimonthly coffeehouse, cosponsor other events. Quarterly newsletter: From The Center.

VIRGINIA

Shenandoah Valley Gay and Lesbian Association

540-574-4636
Resource information, a calendar of events, social and educational support services. Monthly newsletter and calendar of events.

WASHINGTON

Lesbian Resource Center

2214 South Jackson Street, Seattle, WA 09144
206-322-3965 www.lrc.net/
Resources, referrals, library, rap groups, emergency fund. Lesbian Neighborhoods Project—grassroots organizing and training in individual neighborhoods. Antioppression program—regular trainings (antiracism, anticlassism) offered to community and other organizations. Monthly newsletter: Lesbian Resource Center News.

Queen City Community Development

1161 11th Avenue, Seattle, WA 98122
206-323-2227 E-mail: info@seattlegayculture.org
www.seattlegayculture.org
60 units of mixed income senior housing, 50,000 square feet of nonprofit offices including day care, senior center, adult day health and family center plus conference center and multipurpose spaces.

Rainbow Center

1501 Pacific Avenue, Suite 310-D, Tacoma, WA 98402
253-383-2318
Distribution center and bulletin boards, information and referral and voice mail services, partnership program for LGBT groups to use center as a home base for meetings, events, etc. Monthly community events calendar.

Rainbow Regional Community Center

206 1/2 East Wellesley, Spokane, WA 99207
509-489-1914 E-mail: info@rainbowcenter.org
www.rainbowcenter.org
Various support groups; meeting facilitators; fiscal sponsorships; voice mail for other LGBTQ groups; lending library; Pride Store; educational outreach; intimate partner abuse referral system; community contacts and networking assistance. Quarterly newsletter.

Outreach

600 Williamson Street, Suite P-1, Madison, WI 53703
608-255-8582 E-mail: outreach@outreachinc.com
www.outreachinc.com
Peer counseling; support groups; information; referrals; education services; youth services; lending library; advocacy; The Directory: A Guide to Businesses and Organization Serving Madison's LGBT Communities; The Calender and Guide. Quarterly Newsletter: Equal Time.

The Milwaukee LGBT Community Center

170 South Second Street, Milwaukee, WI 53204
414-271-2656 E-mail: execdirector@mkelgbt.org
www.mkelgbt.org
Community development – office space, meeting rooms, technical assistance; youth programming – drop-in, mentoring, tutoring, speakers bureau, social activities; community outreach and education – library, speakers bureau, hotline, Web site; advocacy—"Promote the Vote" voter registration and mobilization, neighborhood organizing, statewide efforts.

PROFESSIONAL ORGANIZATIONS (see NATIONAL LGBT ORGANIZATIONS)

American Federation of State, County and Municipal Employees, AFL-CIO

1625 L Street, NW, Washington, DC 20036-5687
202-429-1000 202-659-0446 (TTY) www.afscme.org
One of the union leaders in demanding equal rights for all employees.

American Libraries Association

Gay and Lesbian Roundtable
http://calvin.usc.edu/~trimmer/ala_hp2.html
A unit of the American Library Association, the GLBTRT was founded in 1970 as the Task Force on Gay Liberation. Considered to be the nation's first LGBT professional organization.

American Psychological Association Committee on Lesbian and Gay Concerns

750 First Street, NE #100, Washington, DC 20002-4242
202-336-5500 202-336-6041 www.apa.org/pi/lgbc
Both an advocacy and membership group, the Committee encourages objective and unbiased research in areas relevant to LGBT adults and youths, and the social impact of such research, examines the consequences of inaccurate information and stereotypes about LGBT adults and youths in clinical practice, and develops educational materials for distribution to psychologists and others. Also furthers the cause of civil and legal rights of LGBT psychologists within the profession.

American Public Health Association Lesbian, Gay, Bisexual and Transgender Caucus of Public Health Workers

800 I St NW, Washington, DC 20001
www.apha.org www.stophiv.pitt.edu/~lgbtc/
Forum for public health workers and professionals interested in LGBT issues. Committed to combating discriminatory practices in health organizations and systems. Web site includes two papers: The Need for Acknowledging Transgendered Individuals within Research and Clinical Practice and The Need for Public Health Research on Gender Identity and Sexual Orientation. Site also includes links to Web sites related to support and funding information and other LGBT sites.

American School Health Association

P.O. Box 708, Kent, Ohio 44240
330-678-1601 E-mail: asha@ashaweb.org
www.ashaweb.org/
Mission of the Association is to protect and improve the well-being of children and youth by supporting comprehensive school health programs, including school health education, school health services and school health environments. Also works to support and integrate school counseling, psychological and social services, food services, physical education programs and the combined efforts of schools, other agencies and families to improve the health of school-aged youth and school personnel.

Association for Worksite Health Promotion

60 Revere Drive Suite 500, Northbrook, Illinois 60062
847-480-9574 E-mail: awhp@awhp.organization
www.awhp.org
Provides a network of worksite health promotion professionals willing to share the methods, processes and technologies necessary to initiate a successful health promotion program.

Association of Gay and Lesbian Psychiatrists

4514 Chester Ave., Philadelphia, PA 19143-3707
215-222-2800 www.aglp.org
Professional organization of psychiatrists, psychiatry residents, and medical students that serves as a voice for the concerns of lesbians and gay men within the psychiatric community. Committed to fostering a more accurate understanding of homosexuality, opposing discriminatory practices against gay men and lesbians, and promoting supportive, well-informed psychiatric care for lesbian and gay patients.

Association of Nurses in AIDS Care

11250 Roger Bacon Drive, Suite 8, Reston, VA 20190-5202
800-260-6780 703-925-0081 E-mail: AIDSNURSES@aol.com www.anacnet.org
Committed to fostering the individual and collective professional development of nurses involved in the delivery of health care to persons infected or affected by the HIV, and to promoting the health, welfare, and rights of all HIV infected persons.

Gay and Lesbian Medical Association (GLMA)

459 Fulton St. Suite 107, San Francisco, CA 94102
415-225-4547 E-mail: info@glma.org www.glma.org
Working to end homophobia in health care. Represents the interests of LGBT physicians and medical students, as well as millions of LGBT patients throughout North America who seek equality in health care access and delivery. Web site contains the full text of this Healthy People 2010 Companion Document, the January 2000 white paper, "LGBT Health: Findings and Concerns," comprehensive information on LGBT health in the United States, links to other LGBT and health organizations, and the nation's largest online LGBT heath care provider referral program.

National Assembly on School-based Health Care

666 11th St., NW, Suite 735, Washington, DC 20001
888-286-8727 202-638-5872 E-mail:
info@nasbhc.org www.nasbhc.org
Dedicated to promoting accessible, quality school-based primary health and mental health care for children and youth through interdisciplinary and collaborative efforts. Provides community, state, and national advocacy, information and knowledge exchange, networking opportunities, and technical assistance.

National Association of School Nurses

P.O. Box 1300, Scarborough, ME 04070-1300
207-883-2117 www.nasn.org
Improves the health and educational success of children and youth by developing and providing leadership to advance school nursing practice.

National Association of Social Workers

National Committee on Lesbian, Gay and Bisexual Issues
750 First St. NE, Suite 700, Washington, DC 20002-4241
202-408-8600 www.socialworkers.org
Membership organization that promotes, develops, and protects the practice of social work and social workers. Committed to enhancing the effective functioning and well-being of individuals, families, and communities through its work and through its advocacy.

Partnership for Prevention

1233 20th St. NW, Suite 200, Washington DC 20036
202-833-0009 E-mail: info@prevent.org
www.prevent.org
Dedicated to increasing the resources for and knowledge about effective disease prevention and health promotion policies. Analyzes information and convenes experts and decision makers from various sectors to identify strategies to improve the science and practice of prevention. Advocates for policies and programs that reduce the nation's burden of preventable disease, injury, and death.

Wellness Councils of America

9802 Nicholas St., Suite 315, Omaha, NE 68114
402-827-3590 E-mail: wellworkplace@welcoa.org
www.welcoa.org
Dedicated to improving the health and well-being of Americans everywhere—especially through activities at the worksite.

NATIONAL LGBT ORGANIZATIONS (see PROFESSIONAL ORGANIZATIONS)

Alternatives to Marriage Project

http://www.unmarried.org/
A national organization for unmarried people, including people who choose not to marry, are prevented from marrying, or are among the majority of people who live together before marriage. Work for greater understanding and acceptance of unmarried people.

BiNet, USA

www.binetusa.org
Also known as the Bisexual Network of the USA, this is a national organization. Dedicated to collecting and distributing information regarding bisexuality; facilitating the development of bisexual community and visibility; working for the equal rights and liberation of bisexuals and all oppressed peoples; eradicating all forms of oppression inside and outside the bisexual community.

Bisexual Resource Center

P.O. Box 1026 Boston, MA02117-1026
617-424-9595 www.biresource.org
Focusing on research and education, the center also serves as a support network and provides a public forum for the discussion of bisexuality.

Children of Lesbians and Gays Everywhere (COLAGE)

3543 18th St., #1, San Francisco, CA94110
415-861-KIDS (5437) E-mail:
colage@colage.organization www.colage.org
Mission is to foster the growth of daughters and sons of lesbian, gay, bisexual and transgender parents of all racial, ethnic, and class backgrounds by providing education, support and community on local and international levels, to advocate for our rights and those of our families, and to promote acceptance and awareness in society that love makes a family.

Families Like Ours, Inc.

P.O. Box 3137, Renton, WA 98056-3137
425-793-7911 Washington Office 480-699-2897 Arizona Office www.familieslikeours.org
Online virtual community where alternative family parents (adoptive and birth parents) and parents-to-be will find resources, tools, and support.

Family Pride Coalition

P.O. Box 34337, San Diego, CA92163
619-296-0199 E-mail: pride@familypride.organization www.familypride.org
Mission is to advance the well-being of lesbian, gay, bisexual and transgendered parents and their families through mutual support, community collaboration, and public understanding.

Gay and Lesbian Alliance Against Defamation (GLAAD)

1825 Connecticut Avenue NW, 5th Floor, Washington, DC 20009
202-986-1360 1-800-GAY-MEDIA (1-800-429-6334)
E-mail: glaad@glaad.organization www.glaad.org
Dedicated to promoting and ensuring fair, accurate, and inclusive representation of individuals and events in all media as a means of eliminating homophobia and discrimination based on gender identity and sexual orientation.

Gay and Lesbian Victims' Assistance Hotline

800-259-1536
Assists all victims of antigay incidents and provides a centralized source of information and documentation.

Gay and Lesbian Association of Retiring Persons (GLARP)

10940 Wilshire Boulevard, Suite 1600, Los Angeles, California 90024
310-966-1500 E-mail: glarp@earthlink.net
www.gaylesbianretiring.org
Dedicated to encouraging gay and lesbian individuals and businesses to give financially and of their time and talent to enhance the aging experience of all retiring gays and lesbians in exchange for tax and other benefits.

Gay and Lesbian National Hotline

1-888-843-4564 212-989-0999 415-355-0999
E-mail: glnh@glnh.organization www.glnh.org
National nonprofit dedicated to meeting the needs of the gay and lesbian community by offering free and totally anonymous information, referrals and peercounseling.

Gay, Lesbian and Straight Education Network (GLSEN)

121 West 27th St. Suite 804, New York, NY 10001
212-727-1035 www.glsen.org
Leading national organization fighting to end anti-gay bias in K-12 schools, working for a future in which every child learns to respect and accept all people, regardless of sexual orientation or gender identity. Web site includes resource guides and workshops for safe schools and staff development, statistic reports, curricula for teachers, and law and policy guides.

Gay Men of African Descent (GMAD)

214 W. 14th Street, New York, NY 10011
212-414-9344 www.gmad.org
Committed to empowering gay men of African descent through education, social support, political advocacy and health and wellness promotion.

Gay Men's Domestic Violence Project

800-832 1901 www.gmdvp.org
Provides community education, resources and direct services to gay, bisexual, and transgendered male victims and survivors of domestic violence.

Gay Men's Health Crisis

Hotline: 1-800-AIDS-NYC (1-800-243-7692) 212-807-6655 212-645-7470 (TTY)
E-mail: hotline@gmhc.org www.gmhc.org
Dedicated to providing AIDS care, education and advocacy worldwide. Web site includes resource guide on HIV/AIDS, living with HIV/AIDS, and information on other STDs. Includes an action center.

Harry Benjamin International Gender Dysphoria Association (HBIGDA)

1300 South Second Street, Suite 180, Minneapolis, MN 55454
612-625-1500 www.hbigda.org
Professional organization devoted to the understanding and treatment of gender identity disorders. HBIGDA

also develops and publishes internationally accepted Standards of Care for the treatment of gender identity disorders.

Human Rights Campaign (HRC)

919 18th Street, NW, Suite 800, Washington, DC 20006
202-628-4160 www.hrc.org
Largest national lesbian and gay political organization, the HRC is committed to an America where lesbian and gay people are ensured of their basic equal rights.

Institute for Gay and Lesbian Strategic Studies

IGLSS, P.O. Box 53036, Washington, D.C. 20009-3036
413-577-0145 www.iglss.org
Supports scholarly inquiry and enhances major public policy debates through research, analysis, and education in order to create an equal and integrated society for people of all sexual orientations and gender identities.

Intersex Society of North America

P.O. Box 3070, Ann Arbor, MI 48106-3070
www.isna.org
A public awareness, education, and advocacy organization which works to create a world free of shame, secrecy, and unwanted surgery for intersex people.

The National Latina/o Lesbian, Gay, Bisexual and Transgender Organization (LLEGÓ)

1612 K Street, NW, Suite 500, Washington, DC 20006
202-466-8240 www.llego.org
National nonprofit organization devoted to organizing Latina/o Lesbian, Gay, Bisexual, and Transgender communities on a local, regional, national and international level, addressing the need to overcome social, health, and political barriers faced due to sexual orientation and ethnic background. Web site in Spanish and English.

National Association of Lesbian and Gay Addiction Professionals (NALGAP)

c/o NAADAC, 901 North Washington Street, Suite 600, Alexandria, VA 22314
703-465-0539 www.nalgap.org
Membership organization dedicated to the prevention and treatment of alcoholism, substance abuse, and other addictions in LGBT communities. Confronts homophobia and heterosexism in the delivery of services to LGBT people and advocates for LGBT-affirming programs and services. Provides information, training, networking and advocacy, and support for addiction professionals, individuals in recovery, and others concerned about LGBT health.

National Association of Lesbian and Gay Community Centers

One Little West 12th Street, New York, NY 10014
212-620-7310 www.gaycenter.org
Provides a home for the birth, nurture and celebration of our organizations, institutions and culture; cares for our individuals and groups in need; educates the public and our community; and empowers our individuals and groups to achieve their fullest potential.

National Center for Lesbian Rights

870 Market St. Suite 570, San Francisco, CA 94102
415-392-6257 www.nclrights.org
Nation's legal center with a primary commitment to advancing the rights and safety of lesbians and their families through a program of litigation, public policy advocacy, free legal advice and counseling, and public education.

National Coalition for Lesbian, Gay, Bisexual, and Transgender Health

c/o Whitman-Walker Clinic, Attn: Cornelius Baker
1407 S St. NW, Washington, DC 20009
E-mail: cbaker@wwc.organization www.lgbthealth.net
Committed to improving the health and well-being of lesbian, gay, bisexual and transgender individuals through federal advocacy that is focused on research, policy, education and training. Web site includes resources and links related to LGBThealth and federal advocacy, as well as the full text of this Healthy People 2010 Companion document.

National Coalition of Anti-Violence Programs

Coordinated by the New York City Gay and Lesbian Anti-Violence Project
240 West 35th Street, Suite 200, New York, NY10001
212-714-1184 www.avp.org
Association of 26 programs that document and advocate for victims of antilesbian, gay, transgender, bisexual and HIV-related violence/harassment, domestic/intimate partner violence, sexual assault, police abuse/misconduct, and other forms of victimization.

Annually publishes the only national report on hate crimes toward the LGBT and HIV-positive community.

National Coalition of Feminist and Lesbian Cancer Projects

Coordinated by the Mautner Project
1707 L St., NW, #1060, Washington, DC 20036
202-332-5536 www.mautnerproject.org
Committed to building and maintaining a communications and support network among local cancer projects dedicated to lesbian and feminist health concerns, providing technical assistance and support for new and existing projects.

National Gay and Lesbian Task Force (NGLTF)

1700 Kalorama Road NW, Washington, DC 20009-2624
202-332-6483 202-332-6219 (TTY) www.ngltf.org
National progressive organization working for the civil rights of gay, lesbian, bisexual and transgendered people. NGLTF also runs a Policy Institute, offers leadership development, and serves as a national resource center.

National Minority AIDS Council

1931 13th St. NW, Washington, DC 20009
202-483-6622 www.nmac.org
National organization dedicated to developing leadership within communities of color to address the challenge of HIV/AIDS.

National Native American AIDS Prevention Center

436 14th Street, Suite 1020, Oakland, CA 94612
510-444-2051 www.nnaapc.org
Committed to stopping the spread of HIV and related diseases among American Indians, Alaska Natives, and Native Hawaiians and to improve the quality of life for members of our communities infected and affected by HIV/AIDS.

National Youth Advocacy Coalition (YAC)

1638 R St. NW, #300, Washington, DC 20009-6451
202-319-7596 www.nyacyouth.org
Advocate for and with young people who are lesbian, gay, bisexual, or transgender in an effort to end discrimination against these youth and to ensure their physical and emotional well being. Web site includes bibliography and resource directory of works appropriate for children, adolescents, educators, and family, and on such topics as religion and HIV/AIDS.

Parents, Families and Friends of Lesbian and Gays (P-FLAG)

1726 M Street, NW, Suite 400, Washington, DC 20036
202-467-8180 www.pflag.org
Promotes the health and well-being of LGBT persons, their families and friends through support, education, and advocacy, to create a society that is healthy and respectful of human diversity.

Senior Action in a Gay Environment (SAGE)

305 Seventh Ave., New York, NY 10001
212-741-2247 E-mail: sageusa@aol.com
www.sageusa.org
Dedicated to meeting the unique needs of senior LGBT persons. Committed to fostering a greater understanding of aging, to promoting positive images of life in the later years, and to supporting and advocating for the rights of senior gay men and lesbians in both the gay and straight communities.

OTHER LGBT RESOURCES

ACLU Lesbian and Gay Rights

125 Broad St., 18th Floor, New York, NY 10004
212-549-2627 www.aclu.org/issues/gay/hmgl.html
Works for fair and equal treatment for LGBT people. This means evenhanded treatment by the government, protection from discrimination in jobs, schools, housing, and public accommodations, and equal rights for gay and lesbian couples and families. The ACLU AIDS Project works to ensure that as society responds to the changing nature of the HIV epidemic, it does not needlessly abrogate fundamental constitutional rights.

Advocates for Youth

www.advocatesforyouth.org
Dedicated to creating programs and promoting policies that help young people make informed and responsible decisions about their sexual health. Provides information, training, and advocacy to youth-serving

organizations, policy makers, and the media in the United States and internationally.

American Medical Students Association Lesbian, Gay and Bisexual People in Medicine

1902 Association Dr., Reston, VA 20191
703-620-6600 www.amsa.org/sc/lgbpm.html
Improving awareness and breaking down the barriers for LGBT health community. A group of LGBT individuals, and our straight allies who support each other and work to educate the medical school community.

American Society on Aging Lesbian and Gay Aging Issues Network

833 Market St, Suite 511, San Francisco, CA94103-1824
415-974-9600 E-mail: lgain@asa.asaging.org
www.asaging.org/lgain.html
Works to raise awareness about the special challenges that LGBT elders face as they age, and about the unique barriers these often invisible populations encounter in gaining access to housing, healthcare, long-term care and social services. Web site includes an extensive annotated directory of Internet resources dealing with LGBT aging.

Asian and Pacific Islander Wellness Center

http://www.apiwellness.org/v20/research/research.html
Educates, supports, empowers and advocates for Asian and Pacific Islander (A&PI) communities - particularly A&PIs living with or at-risk for HIV/AIDS. Provides HIV care services.

Association for Gay, Lesbian, and Bisexual Issues in Counseling

5999 Stevenson Ave., Alexandria, VA 22304
www.aglbic.org
Committed to educating mental health service providers about issues confronting LGBT individuals.

Bi.org

http://bi.org/ This site is continually renovated and is a great resource for the international bisexual community. Bi.org now is a very large site with links all over the globe. Especially strong are the links to bi resources throughout the world outside of North America.

Bi The Way

http://www.bisexual.org/g/bitheway/
This site is a resource and reference for bisexuals, as well as the general LesBiGay community. Quite extensive.

The Center for Health and Sexual Orientation

University of Pittsburgh
3520 Fifth Avenue, Suite 400, Pittsburgh, PA 15213
412-624-5080 E-mail: tonys@stophiv.pitt.edu
With faculty from the University of Pittsburgh, Carnegie Mellon University and The Urban Institute, the Center is dedicated to generating and carrying out health research related to sexual orientation. Current areas of activity include chronic health problems affecting lesbians, HIV, suicide, STDs, nutrition, drug and alcohol use, mental health, aging, health promotion and the Internet, and methodological issues.

Center for LGBT Health at Columbia University

Joseph L. Mailman School of Public Health
Columbia University, 600 West 168th Street, 7th Floor, New York, NY 10032
212-305-3457 E-mail c/o Randy Sell, Ph.D.: rls39@columbia.edu
Coordinates and conducts LGBT health research, education, services, and policy.

Center for Lesbian Health Research

University of California, San Francisco
Laurel Heights Campus, 3333 California St., Suite 340, San Francisco, CA 92118
415-502-5200 www.lesbianhealthinfo.org
Specifically and uniquely concerned with health and wellness issues about lesbians, bisexual women, transgendered individuals, their families, and health care providers. Engages in health research on lesbian, bisexual women, and transgendered individuals. Conducts research, education, training and public service, reflective of a broad vision of health and

wellness and a strong commitment to community collaborations. Ensures that the results of the Center's research will be used in a broad range of settings, from clinical care applications to policy implementation.

Coalition of Lavender Americans on Smoking and Health
Last Drag Smoking Cessation Program

1748 Market St., #201, San Francisco, CA 94102
415-565-7672 ext. 351 E-mail:
info@lastdrag.organization www.lastdrag.org
The Last Drag Program is a free smoking-cessation class for LGBT and HIV-positive smokers held in San Francisco. Confidential and supportive group setting.

FTM International

www.ftm-intl.org
The Internet contact point for the largest, longest-running educational organization serving female-to-male (FTM) transgendered people and transsexual men.

Gay Asian Pacific Alliance

www.gapa.org E-mail: webmaster@gapa.org
An organization dedicated to furthering the interests of gay and bisexual Asian/Pacific Islanders by creating awareness, by developing a positive collective identity and by establishing a supportive community. Formed from the need for an organization to address, through a democratic process, social, cultural, and political issues affecting the gay and bisexual Asian/Pacific Islander Community.

The Gay, Lesbian, Bisexual, and Transgender Health Access Project

Justice Resource Institute Health
100 Boylston St., Suite 815, Boston, MA 02116
617-988-2605 www.glbthealth.org
The mission of the LGBT Health Access Project is to strengthen the Massachusetts Department of Public Health's ability to foster the development of comprehensive, culturally appropriate health care services for LGBT people through a variety of venues including community education, policy development, advocacy, and prevention strategies.

Gay and Lesbian Parent Teacher Student Association of Greater Puget Sound, Washington State

PMB #1425, 1122 E. Pike, Seattle, WA 98122-3934
425-468-9345 E-mail: glptsa@email.com
Addresses the unique challenges and difficulties often faced in schools by students, educators and families who are gay, lesbian, bisexual or transgendered. Everyone is welcome: parents of gay or lesbian students, straight students with gay or lesbian parents, or anyone else who supports the GLPTSA's mission, regardless of sexual orientation.

GayHealth.com

www.gayhealth.com
An online health resource for the gay, lesbian, transgendered, and bisexual communities with information on sex, drugs, general health, violence, nutrition, and exercise. Site includes a health care provider referral service.

Gay Men's Health Summit Listserve

www.egroups.com/group/GayMensHealthSummit
A discussion list discussing emerging issues in the gay men's health movement. Generated from the Gay Men's Health Summit in Boulder, Colorado.

Hetrick-Martin Institute

2 Astor Place, New York, NY 10003
212-674-8650 (TTY) 212-674-8695 www.hmi.org E-mail: info@hmi.org
The world's first and largest not-for-profit, multi-service, education, and advocacy organization dedicated to providing services to lesbian, gay, bisexual, transgender, and questioning youth, and all youth who are coming to terms with issues of sexuality. The Institute has over 20 years of experience providing quality youth services.

Institute on Sexuality, Inequality and Health

San Francisco State University
Human Sexuality Studies Program, Room 336.
1600 Holloway Avenue, San Francisco, CA 94132
415-405-3570 E-mail: hmsxdept@sfsu.edu
http://hmsx.sfsu.edu
A research, policy and training institute of the Human Sexuality Studies Program funded in part by the Ford Foundation that provides high quality academic

research and training in the service of marginalized communities. The Institute is committed to addressing health and social disparities that affect cultural minorities through applied social science research that shapes community-based services and programs and informed public policy. The Institute sponsors an annual Summer Institute on Sexuality, Society and Health for students, researchers and practitioners from the United States and other countries.

Journeys: Midwifery Care

www.homebirthmidwife.com
Includes information on alternative insemination and preconception counseling.

King County Tobacco Council for Sexual Minorities

Seattle, WA 206-296-7613
Addresses the tobacco addiction and targeting of the industry in the LGBT community. For the past four years, this group has been providing the Out and Free Cessation guide to assist in the cessation efforts of the LGBT community. Acts as an advisory group to report to the King County Tobacco Free Council on the disparities with smoking in the gay community.

LavenderCollar.com

www.lavendercollar.com
Resource for LGBT workplace issues. Site includes links to and information about employee groups organized by LavenderCollar; LGBT-friendly employers, including sections on military, government, law enforcement; other relevant organizations; legal links; and transgender resources.

Lavender Youth Recreation and Information Center (LYRIC)

3543 18th Street, #31, San Francisco, CA94110
415-703-6150 415-703-6152
Social interaction and activities for LGBT youth aged 23 and under. Offers Transformations, weekly support group for transgendered youth.

Lesbian Health Foundation of the Gay and Lesbian Medical Association

510-883-0778 E-mail:
info@lesbianhealthfoundation.org
www.lesbianhealthfoundation.org
The Lesbian Health Foundation, a part of the Gay and Lesbian Medical Association, provides a web-based resource for research, information and services on health issues affecting lesbians, bisexual women, and transgendered individuals; education and training for health care professionals; and a national Speakers Bureau for educating and raising awareness of the special health needs of lesbians, bisexual women, and transgendered individuals.

Lesbian Health Listserve

Majordomo@queernet.org
To subscribe, send e-mail to above address with lesbian health in the body of the message.

Lesbian Health Research Institute (LHRI)

212-305-4055 E-mail: Scout@aol.com
www.lesbianhealthresearch.org
Part of the Center for LGBT Health at Columbia University, the Lesbian Health Research Institute is committed to conducting, facilitating, supporting, and publishing high quality community-based research about lesbian health. LHRI publishes a quarterly newsletter and maintains a Web site for lesbian health research issues.

Massachusetts Department of Education Governor's Commission on Gay and Lesbian Youth - Safe Schools Project

www.doe.mass.edu/lss/program/ssch.html
Site includes two papers: A Student Guide to Gay/Straight Alliances and Recommendations on the Support and Safety of Gay and Lesbian Student.

The Mautner Project for Lesbians with Cancer

1707 L St. NW, Suite 500, Washington DC, 20036
202-332-5536 (Voice/TTY) E-mail:
mautner@mautnerproject.org
www.mautnerproject.org
Dedicated to lesbians with cancer, their partners and caregivers. In addition to providing direct services to lesbians with cancer, their partners and caregivers, the Project advocates on behalf of lesbian health and provides information to both health and lesbian communities. Web site includes resource list of sister

sites on cancer, (lesbian-related) health, feminist and lesbian cancer projects, and clinical trials.

National Association of Lesbian and Gay Community Centers

www.gaycenter.org/natctr/index.htm
Site includes a national directory of LGBT Community Centers.

National Clearinghouse for Alcohol and Drug Information

www.health.org:80/features/lgbt/index.htm
Site includes research abstracts on substance abuse in the LGBT population, "how to" on social support and violence prevention, and information on risk factors associated with youth and suicide.

National Consortium of Directors of LGBT Resources in Higher Education

www.lgbtcampus.org
Committed to achieving higher education environments in which LGBT students, faculty, staff, administrators, and alumni have equity in every respect. Supports colleagues and develops curriculum; seeks climate improvement on campuses; advocates for policy change, program development, and establishment of LGBT Office/Centers. Web site includes directory of LGBT resources on college campuses.

The National Women's Health Information Center

1-800-994-9662 TDD: 1-888-220-5446
www.4woman.gov
A service of the Office on Women's Health in the Department of Health and Human Services. Provides a gateway to the vast array of Federal and other women's health information resources.

Network for Battered Lesbians and Bisexual Women

P.O. Box 6011, Boston, MA 02114
619-695-0877 (Voice/TTY) 619-423-SAFE (7233) (Crisis hotline - English and Spanish)
E-mail: nblbw@erols.com www.nblbw.org
Addresses battering in LGBT communities, provides support to battered lesbians and bisexual women, and works toward the elimination of violence against women. Web site includes information on same-sex domestic violence, resources, a newsletter, links and a bibliography on battering in LGBT communities. In Spanish and English.

New Leaf Services for Our Community

1853 Market Street, San Francisco, CA 94103
415-626-5916 (TTY) 415-252-8376
www.NewLeafServices.org
A multi-purpose out-patient counseling center. Community-based and non profit. New Leaf is one of the nation's largest counseling centers for the lesbian, gay, bisexual and transgender communities. Provide substance abuse treatment; individual and group therapy and other general mental health services; HIV/AIDS prevention and counseling; outreach to elders; counseling for children, youth and families; psychiatric assessment and medication services.

Notes on Gender Transition

www.avitale.com/FTM_101.html
An overview of the FTM experience, focusing particularly on health issues.

PREVLINE's LGBT Webpages

www.health.org/features/lgbt
Information on substance abuse, youth suicide, eating disorders, and other health issues compiled by the National Clearinghouse for Alcohol and Drug Information.

Pride Institute

14400 Eden Martin Drive, Eden Prairie, MN 55344
614-934-7554 1-800-54-PRIDE www.pride-institute.com E-mail: support@pride-institute.com
Specialize in providing addiction and mental health treatment to the LGBT community.

Pride Senior Network

356 West 18th Street, New York, NY 10011
212-271-7288 www.pridesenior.org
Promotes services which foster maximum health, well-being, and quality of life for aging LGBT people through community advocacy and education.

Public Health–Seattle and King Counties

www.metrokc.gov/health/glbt
Online resource established by King County (Seattle,

WA) for LGBT health designed to meet the health concerns of the LGBT community and to provide tools to health care providers to ensure that health care environments are welcoming.

Road Map for Male-to-Female Transsexuals

www.tsroadmap.com
Site discusses making informed purchasing decisions and setting realistic, achievable transition goals.

Safe Zone

www.indiana.edu/~out/safezone/links.shtml
List of SAFE programs on college campuses.

Stepping Stone of San Diego

HIV/AIDS and Substance Abuse Services
3425 5th Ave., San Diego, CA 92103
619-295-3995 www.steppingstonesd.org
Dedicated to creating, sustaining, and extending life enhancing alcohol and other drug recovery and prevention services primarily to the LGBT community in San Diego County.

Stonewall Recovery Services

430 Broadway Street, East, Seattle, WA 98102
206-461-3749 www.stonewallrecovery.org
Seattle's only drug and alcohol treatment center for sexual minorities and has been involved in HIV prevention since 1993.

Tenderloin AIDS Resource Center

187 Golden Gate Avenue, San Francisco, CA94102
415-431-7476
Services for transgender clients include substance abuse support groups and individual counseling, HIV/AIDS counseling, case management, street outreach, and weekly transgender support groups and individual counseling.

Transgender Education Network

http://www.jri.org/ten.html
An HIV prevention and health initiative promotion aimed at Greater Boston's transgendered population.

Transsexual Women's Resources

www.annelawrence.com/twr
Medical and other resources for transsexual women (Male-to-Female).

Trikone

www.trikone.org
A registered 501(c)(3) nonprofit organization for lesbian, gay, bisexual, and transgendered people of South Asian descent. Founded in 1986 in the San Francisco Bay area, Trikone is the oldest groups of its kind in the world. Through social and political activities, Trikone offers a supportive, empowering, and nonjudgemental environment where queer South Asians can meet, make connections, and proudly promote awareness and acceptance of their sexuality in society. Trikone actively works against all forms of oppression based on race, gender, class, and other identities.

If you would like your organization to be included in this resource guide online or elsewhere, or if you have changes and updates to the information included here, send information by e-mail to hp2010_lgbt@glma.org.



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Organizations are listed for identification purposes only.
Opinions expressed herein are those of the authors and do not necessarily reflect the official positions or policies of the listed organizations.

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