

LGBT

A Report from the 2015 LGBT Health and Human Services Needs Assessment

Health and

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Human Services

for The LGBT Community Center

Needs

and The New York State LGBT Health & Human Services Network

in New York State

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Executive Summary

The LGBT Health and Human Services Needs Assessment in New York State (the needs assessment) was designed to collect, analyze and communicate about data specific to LGBT people. Data resulting from the needs assessment is intended to:

- Inform programming and policy change.
- Build a knowledge base on LGBT health in order to track progress on improvements in health disparities and identify gaps in LGBT health services.
- Communicate with a wide variety of audiences about the importance of LGBT health.

The needs assessment consisted of more than 20 community focus groups, a variety of expert stakeholder consultations and a quantitative survey with nearly 3,800 respondents statewide. This document reports primarily on the quantitative data collected for this project.

The needs assessment was commissioned by the Empire State Pride Agenda (ESPA) and carried to completion by The LGBT Community Center (The Center) in New York City on behalf of The New York State LGBT Health & Human Services Network (The Network), a group of more than 50 organizations that provide health and human services to LGBT

people in New York State. The goal of The Network is to increase recognition of and available resources for the continuum of health care needs in the LGBT communities across New York State. To accomplish this goal, The Network seeks to:

- Increase public funding for LGBT health and human services in New York State.
- Increase the sustainability of health and human services for LGBT communities in New York State, including the capacity of health and human service providers.
- Strengthen the communication and collaboration between LGBT health and human services in New York State.

When the needs assessment began, The Network was administered by ESPA. The Network is now coordinated by The Center, as of March 1, 2016. Strength in Numbers Consulting Group, a research and evaluation firm that has worked with The Network for eight years, conducted the needs assessment (including community consultations, research design and implementation and data analysis), with support from The Network, ESPA, The Center and the New York State Department of Health AIDS Institute.

Key findings from the quantitative portion of the needs assessment include:

Demographics

- Just over one in four (26.2%) survey respondents identified as people of color.
- Nearly one in four (23.2%) respondents identified as transgender, gender nonconforming or both, a category referred to as TGGNC.
- Almost two in five respondents identified as gay (39.7%), just over one in four as lesbian (26.5%), almost one in five as queer (19.7%) and a similar number as bisexual (18.7%) and just over one in 10 (10.1%) as pansexual.
- Nearly two in five (38.9%) lived in one of the five boroughs of New York City, while the remaining three in five (61.1%) lived upstate.
- More than one in 10 (12.1%) respondents reported having a disability.
- Nearly eighty percent (78.8%) of respondents had been to an event at an LGBT center in the last year.

Health Status and Access to Care

- More than a quarter (26.9%) of survey respondents reported frequent mental distress and more than one in five (20.6%) screened positive for probable depression.
- TGGNC people were much more likely to experience frequent mental distress than their non-TGGNC counterparts (41.9% vs. 22.4%).
- More than one in five (22.6%) respondents had no primary health care provider.
- Although less than ten percent (7.4%) of respondents were uninsured, more than one in five (21.7%) could not see a provider in the last 12 months due to cost.
- Accurate identity documents are critical to accessing health care. Fewer than one in five (17.5%) TGGNC respondents had tried to change their identity documents, while more than one-third (35.7%) had not tried, but wanted to change them.

- Nearly two-thirds (64.9%) of TGGNC respondents had tried to access transition-related health care, including mental health services.
- Nearly half (45.6%) of the TGGNC respondents who had tried to access or were currently accessing transition-related care had experienced disruptions to hormone use.

Barriers to Care

- Nearly one-third (30.7%) of survey respondents reported not enough LGBT-trained health professionals as a barrier to health care.
- Lack of LGBT-trained health professionals was an even more significant problem for TGGNC respondents, where more than half (56.1%) reported this as a significant barrier to health care.
- Almost one in 10 (9.1%) of LGBT respondents reported that they had been refused health care services.
- The most significant structural barriers to health care for LGBT respondents were lack of personal financial resources (36.7%) and inadequate insurance coverage (23.0%).
- All barriers to care measured were higher for LGBT respondents from upstate (outside of the five boroughs of New York City), with the exception of inadequate housing, which was a larger barrier for LGBT respondents from New York City (16.3% vs. 13.4%).
- TGGNC respondents also reported unique structural barriers to care, such as transition-related care not being co-located with primary health care services (43.3%).
- More than sixty percent (61.5%) of TGGNC respondents who had tried to access or were currently accessing transition-related care reported that insurance not covering hormone therapy was a “somewhat” or “major” barrier to care.

Survival Needs (e.g.: food insecurity, housing insecurity) and Access to Public Benefits

- More than one-third (36.1%) of survey respondents had incomes that were under 200% of the federal poverty line, making them eligible for a number of public benefits.
- Two in five (40.0%) respondents reported being food insecure within the past year, while more than a third (35.8%) reported trouble paying for housing or utilities (i.e.: housing insecurity).
- Respondents of color were more likely to be at or below 200% of the poverty line (45.7% vs. 33.1%), housing insecure (47.2% vs. 32.1%) and food insecure (51.8% vs. 36.1%) in the last year.
- Nearly one in five (17.7%) of LGBT respondents had been homeless at some point in their lives.
- People of color (30.2% vs. 13.5%) and TGGNC (28.0% vs. 14.6%) people were much more likely to have been homeless at some point in their lives than white and non-TGGNC respondents.

Pre-Exposure Prophylaxis (PrEP) to Prevent HIV

- Just under ten percent (8.9%) of survey respondents were eligible for PrEP.
- Respondents of color were more likely to say they were eligible for PrEP (12.0% vs. 7.9%).
- Of those who were eligible for PrEP, just over one in five (20.5%) had taken PrEP for two weeks or more.
- The most common barriers to PrEP reported were that PrEP is too expensive (61.8%) followed by concerns about side effects (52.0%) and PrEP not being covered by insurance (46.5%).

Disparities Across the Life Course (i.e.: youth, older adults and families)

Youth

- Almost one in four (24.3%) survey

respondents were age 16–24.

- More than one in five (22.4%) youth ages 16–24 identified as pansexual, about twice as many as in the overall sample.
- One-third (33.0%) of high school respondents reported that their school did not have a policy to protect LGBT students and nearly forty percent (38.4%) were not sure if their school had a policy.
- More than forty percent (41.2%) of high school respondents reported that their school did not have a policy to protect TGGNC students and the same number were not sure if their school had a policy.
- Nearly one in six (15.0%) respondents age 16–24 had been homeless as a result of being LGBT.
- More than a quarter (26.9%) of respondents of color age 16–24 had been homeless as a result of being LGBT.
- Among youth ages 16–24, more than one in five (21.6%) identified aging out of LGBT programs targeting youth as a barrier to care.
- More than half (54.4%) of TGGNC respondents age 16–24 had been punished by family members for their gender identity or expression.

Older Adults

- Nearly one quarter (24.5%) of survey respondents were over age 50.
- Of survey respondents over age 50, more than one in 10 (12.8%) identified as TGGNC.
- Survey respondents over age 50 were more likely to report “fair” or “poor” health (14.7% vs. 11.8%) and frequent poor physical health (more than 14 days per month of poor physical health) (13.8% vs. 11.1%).

Families

- About one in six (13.5%) survey respondents age 25 and over had at least one child in their household.

- Respondents age 25 and over with children in the home were more likely to say they were living in poverty (39.7% vs. 29.5%), had been food insecure (41.7% vs. 35.8%) or housing insecure (43.5% vs. 33.0%) in the last year than LGBT respondents without children in the home.
- Respondents age 25 and over with children in the home were more likely to say that they did not have insurance (6.5% vs. 4.0%) and that they could not get needed care due to cost (27.2% vs. 19.5%) than LGBT respondents without children in the home.
- Respondents age 25 and over with children in the home were more likely to say that their insurance coverage was not adequate (27.9% vs. 22.1%).

Introduction

The landscape for the LGBT community, and in particular LGBT health, has been impacted by a number of changes since Governor Andrew Cuomo was elected in 2010. The passage of marriage equality, the transformation of the health care delivery system by the Affordable Care Act and resulting redesign of Medicaid, and the creation and implementation of the 2015 Blueprint to end the AIDS epidemic by the end of 2020 are all important contextual changes. Conversations about LGBT health are becoming more mainstream, and understanding the complexity of the diverse needs of the entire LGBT community will be critical to improving LGBT population health outcomes.

The New York State LGBT Health & Human Services Network (The Network) is focused on the non-HIV-related health needs of LGBT New Yorkers. The needs assessment is intended to fill gaps in knowledge about these needs, while understanding that health needs are often determined by common or fundamental causes of inequality, such as stigma. In addition, HIV and non-HIV health needs cannot be completely isolated from one another. The needs assessment also contributes data generated by LGBT communities to inform population-specific efforts to improve LGBT health by highlighting community priorities and ensuring key stakeholders from under-represented communities have input into discussions of population health.

The report is organized into findings and recommendations. The findings include sections on

demographics, health status, access to care (including TGGNC people's access to transition-related care), barriers to care, survival needs and pre-exposure prophylaxis (PrEP). The findings section includes population-specific information about youth, older adults and families. Finally, it includes noted differences between respondents from New York City and respondents from the rest of the state.

Background and Methods

The data for the report come from a needs assessment survey conducted between June 5 and August 20, 2015. The survey was distributed throughout New York State in collaboration with more than 70 organizations and programs, 54 of which are members of The New York State LGBT Health & Human Services Network. The report was funded primarily by the New York State AIDS Institute LGBT Health and Human Services Initiative through a grant to The Network, which was administered by the Empire State Pride Agenda (ESPA) at the time of data collection, by ESPA itself and by additional funding from the AIDS Institute's Division of HIV Integrated Planning, which was granted specifically to support additional outreach and survey questions designed for TGGNC respondents. The Network is currently administered by The Lesbian, Gay, Bisexual & Transgender Community Center (The Center).

The needs assessment was an opportunity to update knowledge about LGBT health and human service needs in New York State over five years after the

first New York State needs assessment, which was conducted in 2008 and 2009. The findings of this needs assessment can be found at gaycenter.org/thenetwork#reports.

Prior to designing the survey, there was an extensive stakeholder input process. A group of six representatives from The Network met monthly, beginning in September 2014, to give input and feedback on the process. Twenty-two focus groups with over 150 community members were held from November 2014–April 2015, including seven focus groups with 70 participants focused specifically on transgender respondents and topics. The focus group protocol included the following domains: what health means to transgender people, available services, what works about services accessed and what could be improved, gaps in needed services and causes of stress.

The survey used Qualtrics software. Survey participants had to be age 16 or older and live, work or receive services in New York State to be eligible for the survey. All survey participants were asked about their demographics, health status, health care access, barriers to care and use of social services and benefits. There were also three additional modules for youth, TGGNC people and those who were eligible for pre-exposure prophylaxis (PrEP). In order to view the youth module, respondents must have selected an age category between 16–24 (inclusive).

Respondents could select as many race, gender and sexual orientation identities as applied to them and could also write in responses. The gender identities measured on the survey were taken from focus groups and included “male, man or boy,” “female, woman or girl,” or “male-to-female, MTF, transfeminine, transgender woman or transgirl,” “female-to-male, FTM, transman, transmasculine or transguy,” “genderqueer or gender nonconforming,” “AG, aggressive or stud,” (a masculine spectrum gender identity used most often by African American and Latino/a people)¹, “butch,” “femme,” “intersex” and “two-spirit,” a pan-tribal American Indian/Native gender identity.^{2,3}

In order to view the TGGNC module, respondents must have selected transgender, gender nonconforming or genderqueer, male to female, female to male, or indicated that their current gender identity was male while their birth sex was female or vice versa. If the only way to identify that a respondent should be asked the questions in the TGGNC module was an incongruence between their birth sex and current gender identity, a confirmatory question was asked.

The survey was available online from June–August 2015 in English and Spanish. There were 3,792 valid responses to the survey, including a total of 878 TGGNC responses. This total included 583 transgender and 434 gender nonconforming respondents (including 139 respondents who identified as both). Data were analyzed in Stata. Data are shown rounded to the nearest decimal, except in cases where being compared to a less precisely displayed statistic (as in the “Age” sidebar on page 9).

Terminologyⁱ

Sexual orientation

Sexual orientation is an enduring pattern of emotional, romantic or sexual attraction, behavior or identity that refers to the gender of one's partners in relation to one's own gender identity. While sexual orientation is often discussed in terms of four categories, gay (men who are attracted to other men), lesbian (women who are attracted to other women), bisexual (women and men who are attracted to both women and men) and heterosexual (women who are attracted to men and men who are attracted to women), the LGBT community also includes sexual orientations that do not rely on binary gender identities, such as pansexual, which refers to attraction to a wide range of genders. People do not need to be sexually active in order to have a sexual orientation.

Gender identity

Often distinguished from “sex assigned at birth,” gender identity refers to people's internal sense of their own identity as male, female, transgender or something else.

Transgender

Transgender is a word commonly used to describe people who live in a gender different from the one assigned to them at birth. People often use this word to describe not only people who have changed their gender through surgery or cross-gender hormone therapy, but also people who have non-medical gender transitions or identify as transgender but do not seek to change their gender legally or medically. In the text, we use the term “transgender women” to refer to respondents who identified as “transgender” and “female, woman or girl” or as “male to female or MTF” or who reported “male” as their birth sex and “female, woman or girl” as their current gender identity. Similarly, we used the term “transgender men” to include those who identified as “transgender” and “male, man or boy,” as “female to male or FTM” or who reported female as their birth sex and male as their current gender identity. In the graphs, we refer to transgender women and men using the shorthand “MTF” or “FTM” because

of space concerns. Rather than using the emerging term “cisgender” to refer to those who are not transgender, we refer to respondents who are not transgender as non-transgender.

Gender nonconforming

Gender nonconforming people are people who express their genders differently from society's expectations, reject “male” and “female” as the only gender possibilities and/or blend genders. Gender nonconforming people in the needs assessment survey identified their genders in a variety of ways. In this survey, in addition to “gender nonconforming,” they also identified as “genderqueer,” “non-binary” and “gender fluid.”

Pansexual

Pansexual people are romantically and/or sexually attracted to people based upon features other than gender; people may also choose to describe themselves as pansexual in order to acknowledge attraction to various genders beyond the traditional binary of “male” or “female.”

Lesbian, gay and bisexual (LGB)

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

Pre-exposure prophylaxis

Pre-exposure prophylaxis, or PrEP, is a method of HIV prevention designed for people at high risk of getting the virus. As of 2015, PrEP combines tenofovir and emtricitabine and is intended to be taken daily.

People of color (POC)

This report uses the term “people of color” or POC and similar phrases such as “youth of color” to describe the group of people who selected any racial or ethnic identity other than white. This includes multiracial respondents who also selected “white” when answering the race and ethnicity survey question.

i. Definitions were created in conjunction with a wide variety of stakeholders, including the Needs Assessment Advisory Committee and representatives of the client organizations.

How To Use This Report

This report is written for a wide variety of audiences; thus, some terms may be more familiar to some audiences than others.

We include sidebars comparing the differences between this sample and census or population-based estimates of the distribution of demographics and other findings in this report. These comparisons are included for context only and are not appropriate for making direct comparisons between the two populations because of the differences in sampling techniques between the sources of the comparison statistics and our data sources.

Just as some terms are more familiar to those more experienced in this topic, some ways of expressing statistics may be new to some audiences. The report uses phrases like “more common” when we mean that something was more commonly reported in one subgroup or another who took the survey, regardless of whether the difference referenced is a statistically significant one. We use phrases such as “more likely” to indicate that the *odds* of one thing being reported by one group are statistically significantly more likely. Odds ratios in parenthesis indicate how much more likely.

For example, if we said that “Respondents who had taken PrEP for at least two weeks were only one-third as likely to say that insurance will not cover PrEP compared to those who had not taken it (26.4% vs. 52.3%, OR=0.33)” this means that the odds of people who have taken PrEP saying insurance will not cover it (about 1 to 3) divided by the odds of people who have not taken PrEP saying insurance will not cover it (just over 1 to 1) is 0.33.

Odds are different from percentages, which may be more familiar ways of presenting data, because they compare the frequency of an attribute to the absence of that attribute (out of 100 people, 26.4 say

that insurance will not cover PrEP, meaning 73.6 say that it would) rather than showing the percent who have that attribute (in this case, 26.4%). Odds ratios above one show that something is *more* likely, while those below one show that something is *less* likely. For example, we might say “Respondents who had taken PrEP for at least two weeks were more than *twice as likely* to agree that people will think they are promiscuous if they take PrEP (55.6% vs. 36.3%, OR=2.19).”

The p-value, which accompanies an odds ratio (and some other types of statistical tests), refers to how *certain* we are that the finding is correct. When we report significant statistics, we report those with p-values smaller than .05, which means that we are at least 95% certain that the differences between the groups are actually there. This is a standard level of statistical significance in many texts. In these cases we do not show the exact p-value. We occasionally show odd ratios that are statistically significant at the $p < .10$, and these are marked in the text as such. In addition to odds ratios, we sometimes use t-test, which examines the difference between two means or averages, or chi-squared (χ^2) tests which look at the difference between subgroups when there are more than two categories (for example, race).

We have also indicated when we examine the difference between two groups and find that our data does not show a significant difference when we might expect one to be there if we think that the lack of a difference might be of interest to our readers. For example, when we find that TGGNC respondents of color are no more likely to report poor mental health than are white TGGNC respondents, we report it; when we find that a disparity exists across every age group we measured and analyzed, we report that. This is different from many reports, which only include in the text when they have findings suggesting two groups *differ*.

Findings

Demographics

Age, Race and Gender

As shown in Figure 1, about one in five (20.3%) respondents to this survey were age 18–24 and 27.0% of respondents were age 30–44, with smaller numbers in younger and older age groups. Respondents were asked to select as many racial and ethnic categories as applied to them and could also write in responses. Just over three quarters (78.7%) of survey respondents identified as white. As shown in Figure 2, over one in 10 (11.2%) identified as Latino/a or Hispanic, slightly fewer (9.0%) as black or African American and smaller numbers as American Indian/Native (2.6%), Arab American (1.0%), Asian American (3.3%) and Caribbean (2.1%). Just over seven percent (7.3%) were multiracial.

Age Demographics in Context

The respondents to this survey were much younger than the population of New York State. For example, the U.S. Census estimates that in 2014, 15% of the New York State population was age 65+, while just 5.2% of this sample is in that age group.⁴ Similarly, while about one in five (20.3%) respondents to this survey were age 18–24, just 13% of the census respondents are age 19–25. This is an important difference because health varies along the life course. For example, younger people are more likely to report depression, while older people are more likely to report physical health problems.

FIGURE 1
Age
Among All Respondents

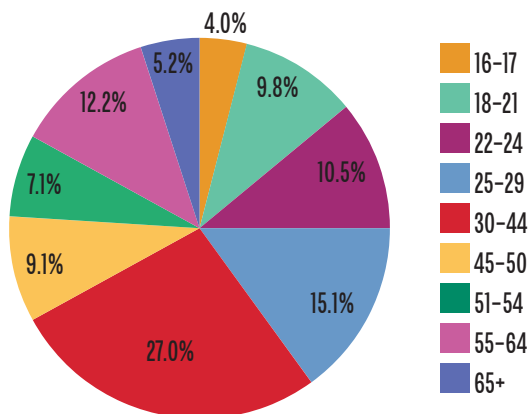


FIGURE 2
Race and Ethnicity of Respondents of Color
Among All Respondents

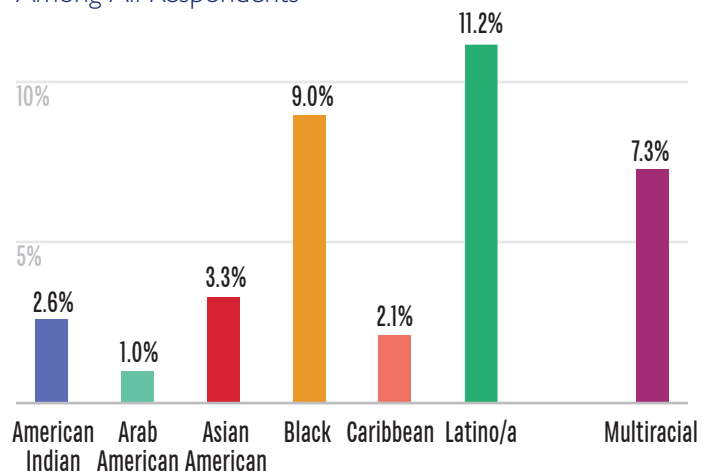


FIGURE 3
Gender Identities
 Among All Respondents

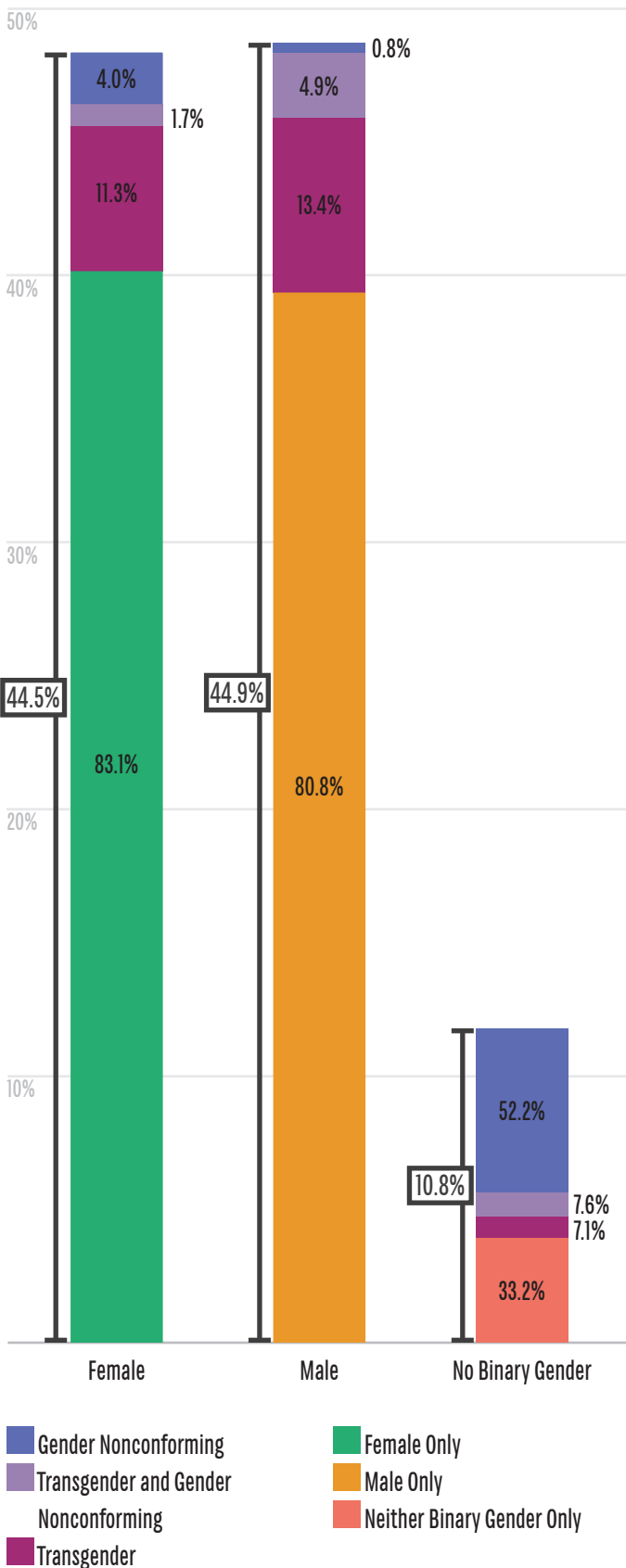


FIGURE 3A
Gender Identity Questions

What was the sex on your original birth certificate?

Please select one answer:

- Male
- Female
- Intersex
- Not Sure

How do you describe your current gender identity?

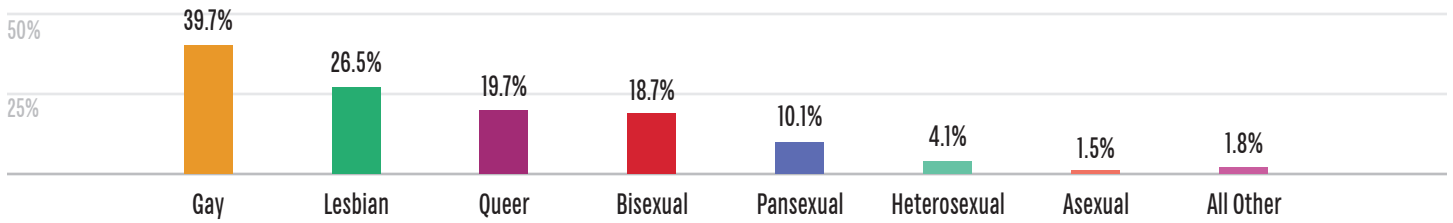
Please select all that apply:

- Male, man or boy
- Female, woman or girl
- Transgender
- Male-to-female, MTF, transwoman, transfeminine or transgirl
- Female-to-male, FTM, transman, transmasculine or transguy
- Genderqueer or gender nonconforming
- AG, Aggressive or stud
- Butch
- Femme
- Intersex
- Two-spirit
- Any other gender identity not listed here

Race and Ethnicity Demographics In Context

This sample over-represents white, American Indian and multiracial respondents compared to the census estimates of New York State's (NYS) population.⁵ For example, the census estimates that just 56.5% of NYS residents are white and no other race, while in this sample, 78.7% identify as white (including multiracial respondents). It under-represents African American respondents, who represent 17.6% of NYS residents but nine percent of survey respondents, Latino/a respondents, who represent 18.6% of NYS residents and 11.2% of survey respondents, and particularly Asian American/Pacific Islander (API) respondents who represent 8.6% of NYS respondents and just 3.3% of survey respondents. While both the distribution of this sample and the measurement of race and ethnicity are different from the census, it is useful to examine these differences.

FIGURE 4
Sexual Orientation
 Among All Respondents



Prior to being asked their current gender identity, respondents were asked about the sex on their original birth certificate, allowing transgender people to be identified by examining whether the sex on a respondent’s original birth certificate was different from their current gender identity.

Respondents were asked to select as many gender identities from a closed-ended list as applied to them and were also able to write in responses. As Figure 3 shows, 44.5% of respondents identified as female, 44.9% identified as male and 10.8% did not identify as male or female. Among those who identified as female, 11.3% also identified as transgender, 4.0% identified as gender nonconforming and 1.7% identified as both. Among those who identified as male, 13.4% identified as transgender, 0.8% identified as gender nonconforming and 4.9% identified as both transgender and gender nonconforming. Among those who did not identify as male or female, 7.1% identified as transgender, 52.2% as gender nonconforming and 7.6% as both transgender and gender nonconforming.

Sexual Orientation and Partner Status

Respondents were asked to select as many sexual orientations as applied to them and could also write in responses. As shown in Figure 4, respondents identified as gay (39.7%), lesbian (26.5%), queer (19.7%) or bisexual (18.7%). Transgender respondents were included if they selected “heterosexual,” as were respondents who also selected other sexual orientations along with heterosexual, for a total of 4.1% heterosexual respondents. Smaller numbers identified as asexual (1.5%) and there were also a

FIGURE 5
Educational Attainment
 Among Respondents Age 25+

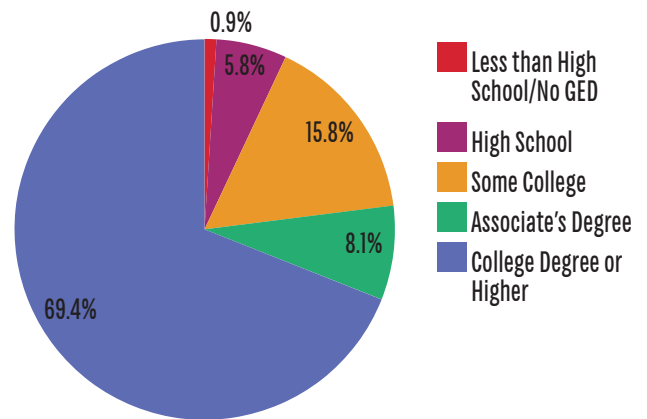
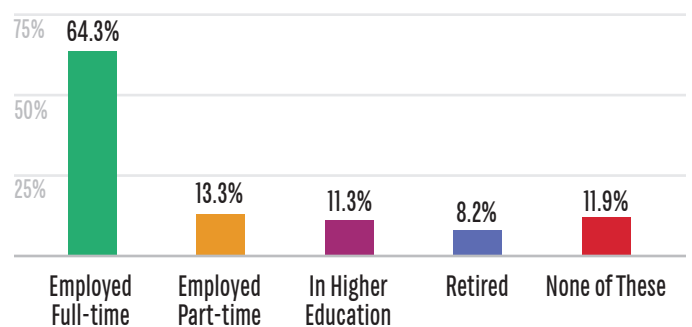


FIGURE 6
Work and School
 Among Respondents Age 25+



Educational Attainment In Context

The respondents to this survey who were age 25 and over were more educated than the population of New York State. Having a college degree was nearly twice as prevalent among those age 25 and over in this survey compared to those in the same age group in New York State population-based estimates (33.7% as of 2014).⁴

variety of other sexual orientations that did not fit into categories such as “sapiosexual” or “demisexual.”

Education and Employment

As shown in Figure 5, the survey respondents age 25 and older were highly educated, with nearly seven in 10 (69.4%) having a college degree or higher.

However, as Figure 6 shows, nearly 12% (11.9%) of survey respondents age 25 and over were not employed, in higher education or retired.

Geography

Nearly two in five (38.9%) survey respondents were from the five boroughs of New York City. Figure 7 shows that in New York City, the largest number of respondents currently lived in Manhattan (35.6%) and Brooklyn (32.5%). Smaller numbers came from Queens (15.8%), The Bronx (8.4%) and Staten Island (7.7%). As Figure 8 shows, of the nearly two-thirds of respondents from outside New York City, 22.3% currently lived in Central NY, 18.3% from Western New York and 17.5% each from the Finger Lakes/Southern Tier and Northeastern New York. Smaller numbers came from the Hudson Valley (15.8%) and Long Island (8.7%).

Geographic Distribution in Context

According to the U.S. Census Bureau, in 2014 about 56% of the New York State population lived outside of New York City (NYC).⁵ Within NYC, the sample over-represents Manhattan and under-represents the Bronx. Outside of NYC, this sample under-represents Hudson Valley and Long Island and over-represents Central New York (and to a lesser extent, over-represents Western New York, Finger Lakes and Northeastern NY). This sample slightly under-represents NYC. For fact sheets on each geographic region, please go to: gaycenter.org/thenetwork.

Other Demographics

As Figure 9 shows, over twelve percent (12.1%) of survey respondents had a disability. Of those, 59.0% had a physical disability, 54.9% had a mental

FIGURE 7
Borough of Residence
Among Respondents from New York City

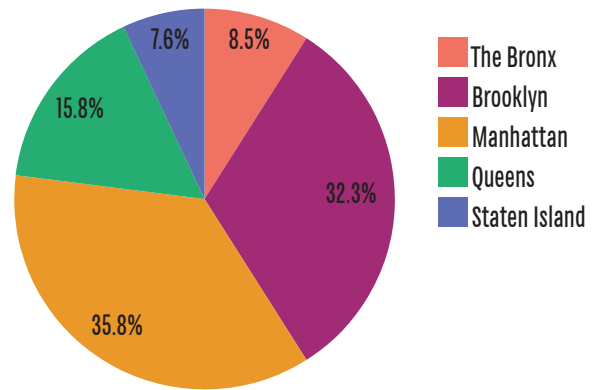


FIGURE 8
Region of Residence
Among Respondents from Outside of New York City

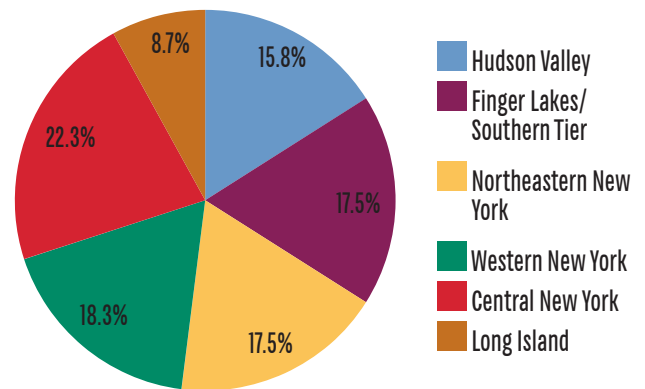
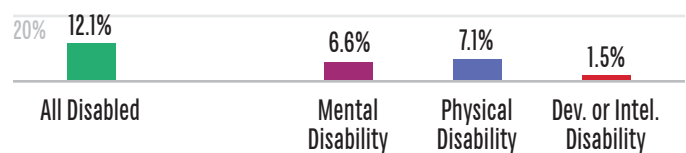


FIGURE 9
Disability Status
Among All Respondents



Disability in Context

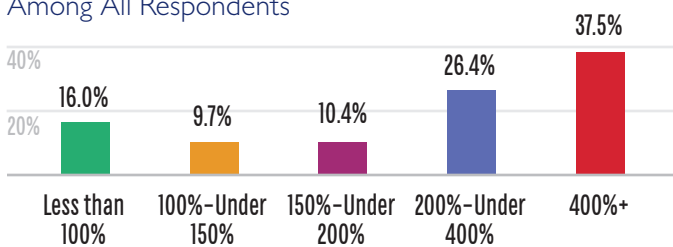
Recent population-based estimates suggest that about one in five people in New York State have a disability.⁶ This sample under-represents people with disabilities, most likely because it over-sampled young people, who are less likely to report disabilities.

health disability and 12.6% had a developmental or intellectual disability.

More than nine in 10 (91.8%) had been born in the United States and four percent (4.0%) had served or were currently serving in the armed forces.

As Figure 10 shows, large numbers of respondents reported living at or below the poverty line in 2014. More than a third (36.1%) lived under 200% of the poverty line. About one in six (15.2%) had at least one child in their household. Nearly one-third (30.2%) lived with roommates.

FIGURE 10
Poverty Status
Among All Respondents



Health Status

More respondents reported problems with mental health than physical health. As Figure 11 shows, one in four (26.9%) respondents reported that their mental health was not good 14 or more days of the past 30 (frequent mental distress) and about one in five (20.6%) reported symptoms of probable depression.ⁱⁱ Just 12.6% reported fair or poor health and even fewer, 11.8%, reported that their physical health was not good 14 or more days of the past 30.ⁱⁱⁱ Racial disparities were found in the prevalence of reporting fair or poor health, with 14.9% of people of color reporting fair or poor health and 11.7% of white respondents doing so (OR=1.32).

ii. The depression screener used in the survey is the Patient Health Questionnaire 2 item measure (PHQ-2). The score ranges from 0 to 6 and the cutoff for “probable depression” is ≥ 3 . The two questions ask respondents how frequently they felt “little interest or pleasure in doing things” or “down, depressed, and hopeless” in the last two weeks.⁸

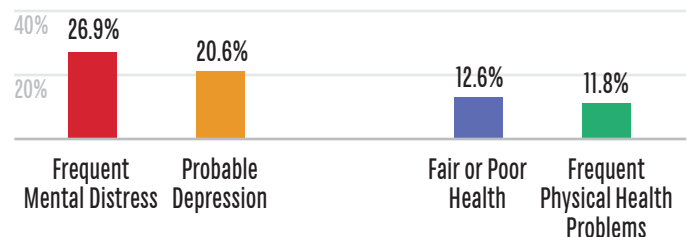
iii. Questions about general health and days of poor mental health and physical health are taken from the Health Related Quality of Life (HRQoL) measures. HRQoL screeners define “frequent mental distress” as experiencing 14 or more days of poor mental health in the past month (30 days). They are included on all Behavioral Risk Factor Surveillance Surveys and many other health questionnaires. The report uses a similar construct of frequent physical health problems, which refers to 14 or more days of poor physical health.⁹

Poverty in Context

The official U.S. Census definition of poverty calculates the cost of food for a given family size and multiplies it times three. That is the official poverty line. For example, in 2014, the poverty line for a family of four was \$23,850 per year. The poverty line does not vary geographically and many people consider it to be very low compared to the actual cost of living, especially in high cost areas such as New York City. In order to reduce the burden on respondents, this survey asked annual income and how many adults and children lived in their household in 2014 and then used a series of skip logic questions to determine the poverty bracket where the individual’s household fell. For more information see census.gov and aspe.hhs.gov.

A recent report using census data suggests that about 16% of New Yorkers are living in poverty.⁷ However, this includes children, who are not sampled in the present survey. In both this sample and the U.S. Census, estimates of New York State find 12.7% of adults age 25+ live in poverty.

FIGURE 11
Health Status
Among All Respondents



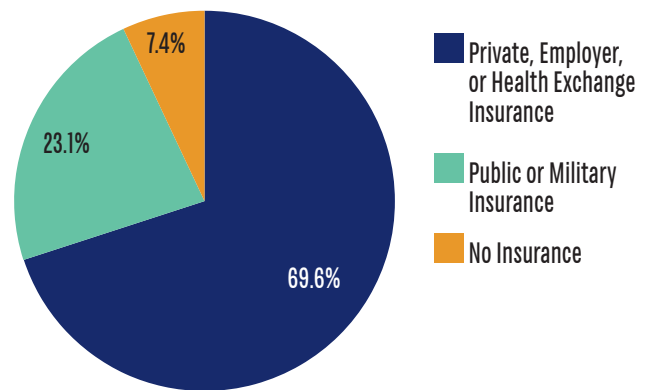
Access

As Figure 11 illustrates, under one in four (22.6%) respondents had no primary care provider. However, more than three quarters did have one (65.1%) or more than one (12.3%) person they thought of as their personal doctor or health care provider. Fully 37.5% had no health home, a place where they regularly go to see the same provider or group of providers when they have health needs. While having no insurance was uncommon among respondents, with only 7.4% reporting being uninsured, being unable to see a provider in the past year due to cost was much more common (21.7%).

Figure 12 shows that 69.6% of respondents had private, employer-based or health exchange insurance, while 23.1% had public insurance such as Medicare, Medicaid or Veterans Administration insurance. Just 5.4% had no usual source of care or used the emergency room as a usual source of care. The most common usual sources of care were a private doctor (63.8%), a community health center, health department clinic or public clinic (16.2%) or a hospital or urgent care clinic (7.8%).

As Figure 13 shows, people of color were significantly more likely to report having no primary care provider (27.6% vs. 20.8%, OR=1.45) and no usual source of care (9.0% vs. 4.2%, OR=2.27). They were also more likely to be uninsured (10.7% vs. 6.1%, OR=1.85) and to be unable to get needed care due to cost (25.9% vs. 20.2%, OR=1.38).

FIGURE 12
Insurance Status
Among All Respondents

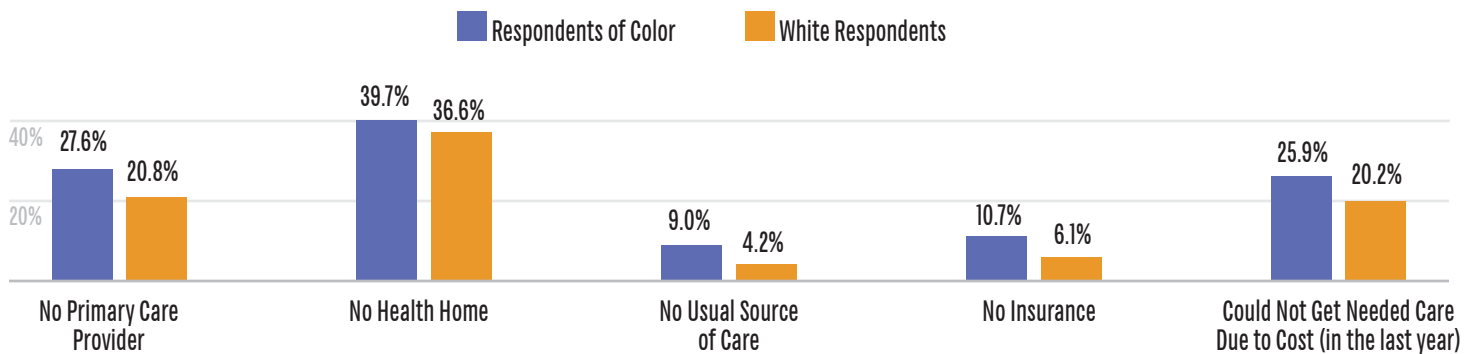


Health Insurance in Context

The recent expansion of health care reform in the United States has benefited LGBT New Yorkers. While about 10% of people age 19-64 were estimated to be without health insurance in New York State, in this sample, 6.4% of those age 18-64 were uninsured.¹⁰ This suggests that outreach to the LGBT community has been successful, especially in light of the fact that this sample is as likely to be in poverty as New York State in general and that poverty and lack of health insurance are related risk factors.

FIGURE 13
Access to Care

Among Respondents of Color and White Respondents



Access to LGBT Health and Human Services

About one in five (21.2%) survey respondents had not attended an event at any LGBT organization in the past year, while almost half (49.9%) had not received health or human services (HHS) that were specifically targeted to LGBT people. Just over one in six (17.2%) attended LGBT center events more than once per month, while just 6.3% used LGBT HHS as frequently. People of color were more likely to visit an LGBT center monthly or more often (32.5% vs. 24.9%, OR=1.46) and to have used LGBT HHS in the past year (55.5% vs. 48.3% OR=1.33) or to use LGBT HHS monthly or more often (14.1% vs. 10.0%, OR=1.48).

Transgender and Gender Nonconforming Respondents' Access to Transition-Related Care

In order to view the module for TGGNC people, respondents must have selected transgender, gender nonconforming or genderqueer, male to female, female to male, or indicated that their current gender identity was male while their birth sex was female or vice versa. If the only way to identify that a respondent should be asked the questions in the TGGNC module was an incongruence between their birth sex and current gender identity, a confirmatory question was asked.

Of TGGNC respondents, 64.9% had tried to access transition-related medical care (including mental health care). Of those who said they had ever accessed hormones, 87.8% had a current, valid prescription and nearly all (92.1%) were accessing hormones from a health care provider, pharmacy or community based organization. As Figure 14 shows, nearly half (46.7%) accessed hormones through a health care provider and nearly one-third (30.6%) through a pharmacy. Just 7.9% accessed hormones through a friend, the internet or another location.

As Figure 15 shows, of those who had experienced a disruption in their hormone use, nearly half (42.9%) said it was related to problems with health care providers and/or pharmacies. These are combined because many people reported problems that related

FIGURE 14
Location Where TGGNC Respondents Accessed Most Recent Dose of Hormones
Among Those Who Had Ever Accessed Gender Affirming Hormone Therapy

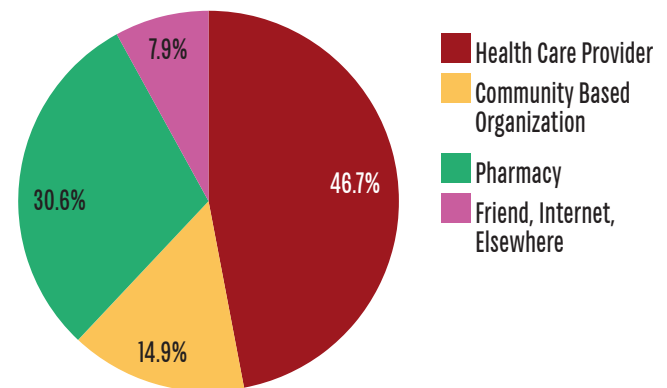
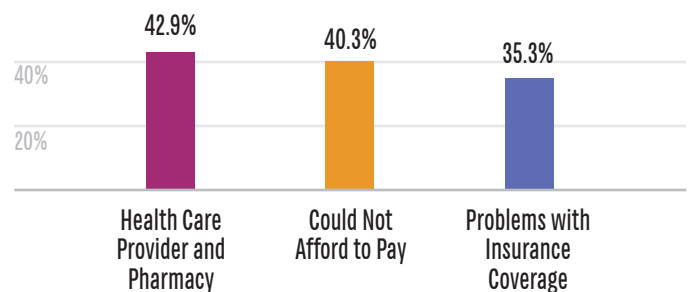


FIGURE 15
Barriers Causing Disruptions in Hormone Access
Among TGGNC Respondents Who Had Ever Accessed Gender Affirming Hormone Therapy



to both, such as poor communication between the provider and pharmacy.

Of those who were using hormone therapy, nearly half (47.6%) had experienced a disruption in their use. Of those, nearly two-thirds (66.7%) said that their longest disruption was more than two weeks.

Of those who experienced disruptions, 40.3% said that they experienced the disruption because they could not afford to pay for hormones and 35.3% said they had problems with insurance coverage.

Barriers to Care Among All Respondents

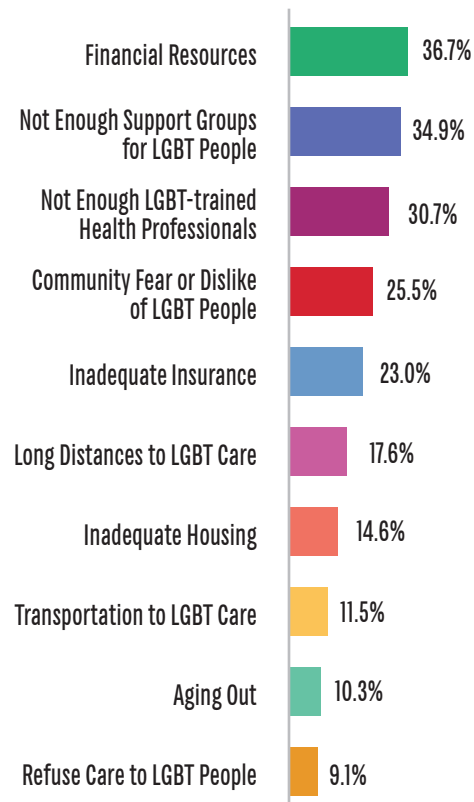
Survey respondents were asked to rate a series of statements about whether various potential barriers to health care were a problem for them. Those who responded that a barrier was “somewhat” or a “major” problem for them were considered to be experiencing a barrier.

As Figure 16 shows, one of the most commonly reported barriers to care was lack of support groups for LGBT people (34.9%). Lack of LGBT-trained health professionals (30.7%) and community fear and dislike (25.5%) were also barriers to care. Fewer than ten percent (9.1%) of respondents reported that doctors who refuse care to LGBT people were a problem or major problem for them.

People of color were more likely to report that community fear or dislike of LGBT people was a problem for them in accessing health care (29.4% vs. 24.2%, OR=1.31). They were also much more likely to report that doctors and other health care workers who refuse care to LGBT people was a problem for them (12.7% vs. 7.8%, OR=1.71). Other stigma-related barriers were similarly elevated among people of color, although differences were not statistically significant.

As Figure 16 shows, the most common structural barrier to care was related to respondents’ personal financial resources (36.7%). Inadequate insurance was also an issue (23.0%), as were long distances to LGBT-friendly providers (17.6%), inadequate housing (14.6%) and inadequate transportation (11.5%). People of color were more likely to report that inadequate housing (21.0% vs. 12.5%, OR=1.87), long distances to care (20.5% vs. 16.7%, OR =1.29) and inadequate transportation (18.9% vs. 9.1%, OR =2.34) were barriers to care.

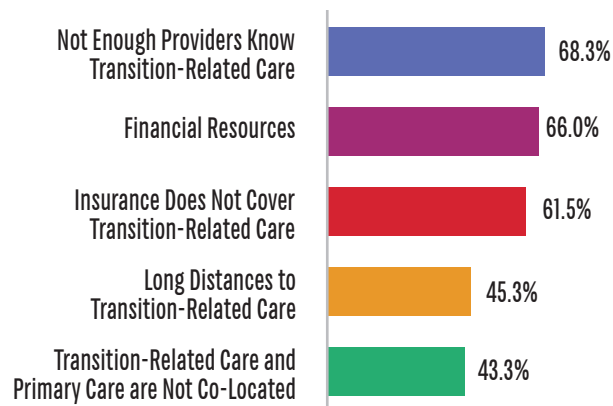
FIGURE 16
Barriers to Care
Among Respondents Age 18+



Barriers to Transition-Related Care Among TGGNC Respondents

TGGNC respondents were asked a series of questions about access to transition-related care. Among the barriers measured, the most commonly reported to be a “somewhat” or “major” problem was not enough health care providers who know how to provide transition-related care (68.3%), followed by barriers related to personal financial resources (66.0%) and insurance does not cover transition-related care (61.5%).

FIGURE 18
Barriers to Transition-Related Care
 Among TGGNC Respondents Who Had Ever Sought or Used Such Care



Barriers to Care Upstate and in New York City

Barriers to care for survey respondents were different in the five boroughs of New York City and upstate.^{iv} With the exception of housing, all measured barriers were higher outside of New York City; all measured barriers were statistically significantly different.

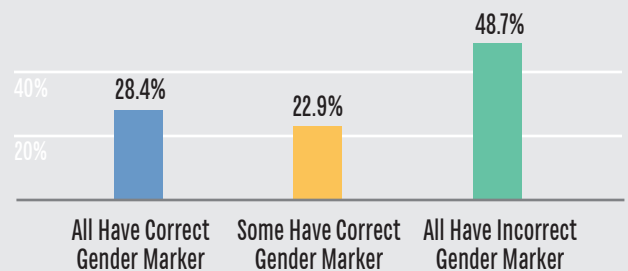
Respondents living outside the five boroughs were about 40% percent more likely to say that it was a problem or major problem that there are not enough support groups for LGBT people (OR=1.41). They were one-third more likely to say that it was a problem or

iv. This report uses the term “upstate” to include all parts of New York State, including Long Island, that are not in the five boroughs of New York City.

Transgender and Gender Nonconforming People’s Access to Identity Documents

About one in six (17.5%) of TGGNC respondents had tried to change the gender marker on their birth certificate. Of those TGGNC respondents who had tried to change the gender marker on their birth certificate, 54.7% had succeeded.

FIGURE 17
Correct and Incorrect Gender Markers on Identity Documents
 Among Transgender Respondents



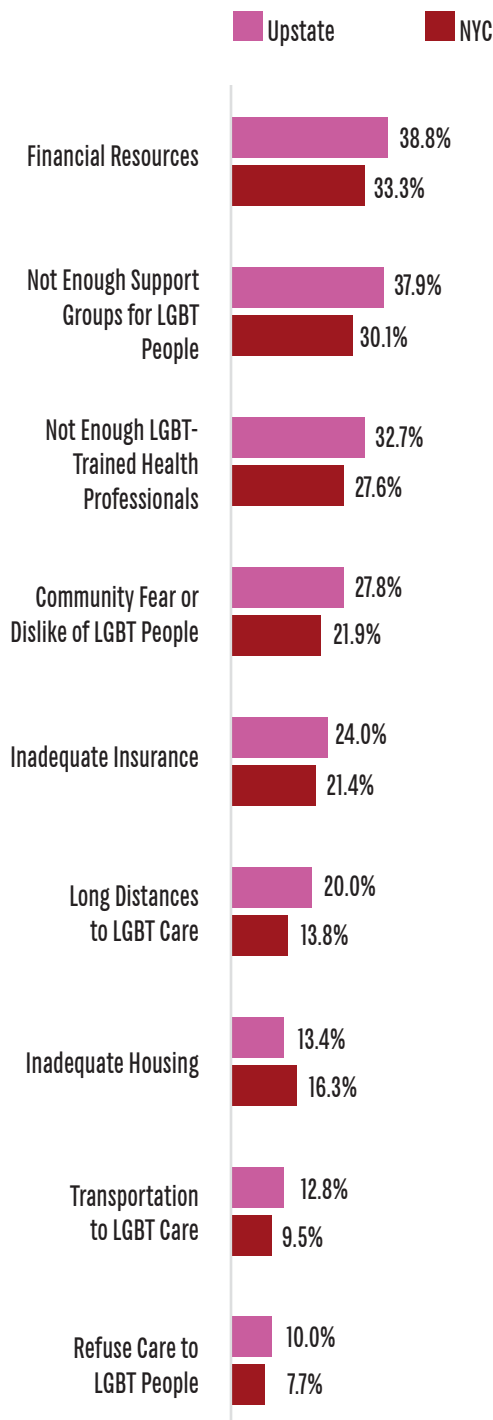
Among transgender women, 34.2% said all of their identity documents had the correct gender marker; among transgender men, the number was just 25.1%.

Transgender respondents who were born in New York State but outside of New York City were slightly more likely to have succeeded in changing the gender marker on their birth certificate (61.3% vs. 50.0%), but were slightly less likely to say that all of their identity documents match their current gender identity (27.4% vs. 32.9%).

major problem for them that they had been refused care for being LGBT (OR=1.33). They were also more likely to say that community fear or dislike (OR=1.37) and absence of trained professionals to work with LGBT people (OR=1.27) were a problem or major problem for them.

FIGURE 19
Barriers to Care

Among Respondents from New York City and Upstate,
Age 18+



Pre-Exposure Prophylaxis

Fewer than one in 10 (8.9%) of respondents to the survey fit clinical guidelines for PrEP, which meant they were both HIV negative *and* fit at least one of the following criteria:

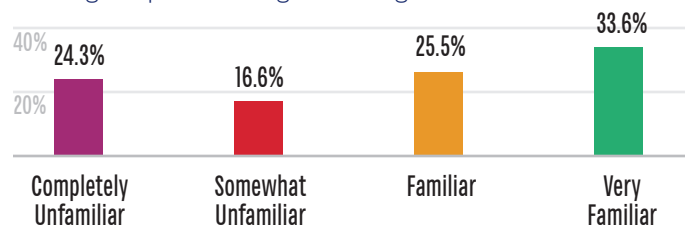
1. Has recently shared needles for injecting medication or intravenous drugs
2. Has recently had a sexually transmitted infection
3. Has recently exchanged sex for money, drugs or a place to stay
4. An ongoing sexual relationship with someone who is HIV positive or meets one of the above criteria

Respondents of color were more likely to say they were eligible for PrEP (12.0% vs. 7.9%, OR=1.61). Of all who were eligible for PrEP, one-third (33.3%) had asked their doctor about PrEP and 26.5% had been offered a prescription for PrEP. Just over one in five (20.5%) had taken PrEP for two weeks or more.

As Figure 20 shows, 24.3% of those who met guidelines for PrEP were completely unfamiliar with PrEP, while 33.6% were very familiar.

FIGURE 20
Familiarity with PrEP

Among Respondents age 18+ Eligible for PrEP



Respondents were asked to rate a series of statements about barriers to PrEP; those who agreed or strongly agreed were considered to have a barrier to taking PrEP that was related to the statement. As Figure 21 shows, the most common barrier was thinking that PrEP was too expensive (61.8%), followed by concern about the side effects of PrEP (52.0%).

People of color were only about half as likely to say PrEP was too expensive (50.0% vs. 68.0%, OR=0.47), but were about 70% more likely to say that it had unwanted side effects (60.8% vs. 47.3%, OR =1.72, p<.10). As Figure 21 shows, barriers to PrEP included concerns that insurance will not cover PrEP (46.5%) and that people will think that the respondent is promiscuous if they take PrEP (41.0%). Respondents who had taken PrEP for at least two weeks were only one-third as likely to say that insurance will not cover PrEP (26.4% vs. 52.3%, OR=0.33) and were more than twice as likely to agree that people will think they are promiscuous if they take PrEP (55.6% vs. 36.3%, OR=2.19). Just over one in five (28.6%) said that PrEP wasn't something they needed; those who had taken PrEP were less likely to agree with this statement (17.0% vs. 31.6%, OR=0.44).

Survival Needs and Access to Benefits

A recent report by the New York City Coalition Against Hunger suggests that about one in six New Yorkers is food insecure. As Figure 22 shows, in the survey, two in five respondents were food insecure (40.0%) and nearly as many were housing insecure (35.8%). Just over one in six had been homeless at some point during their lives (17.7%).

As Figure 22 shows, despite the fact that 36.1% of respondents lived below 200% of the poverty line, only one in five (20.1%) had used any public benefits in the last year. As Figure 23 shows, people of color were significantly more likely to report unmet income, food and housing needs. They were 70% more likely to be living under 200% of the poverty line (45.7% vs. 33.1%, OR=1.70). They were also almost twice as likely to be food insecure (51.8% vs. 36.1%, OR=1.90) and nearly as likely to be housing insecure (47.2% vs. 32.1%, OR=1.89). LGBT people of color were nearly three times as likely to have ever been homeless (30.2% vs. 13.5%, OR =2.78) and nearly five times more likely to have been homeless at the time of the survey (5.1% vs. 0.9%, OR=5.92).

FIGURE 21
Barriers to PrEP

Among Respondents Age 18+ Who Met Criteria for PrEP

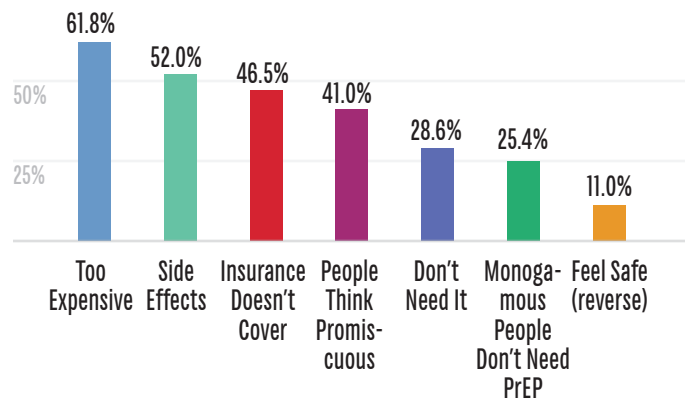


FIGURE 22
Survival Needs

Among All Respondents



Food Insecurity

"Food insecurity" refers to having at least one positive response to the first stage of the U.S. Department of Agriculture (USDA) food insecurity screener, which includes questions about running out of food, lacking money for food and not being able to afford balanced meals. The USDA tools to measure food insecurity can be accessed at ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/survey-tools/#adult.

Housing Insecurity

"Housing insecurity" refers to difficulty paying for housing or utilities in the past 12 months. The wording for the housing insecurity indicator is taken from the National Survey of America's Families and can be accessed at tools.nccor.org/css/system/53/.

FIGURE 23

Survival Needs

Among Respondents of Color and White Respondents

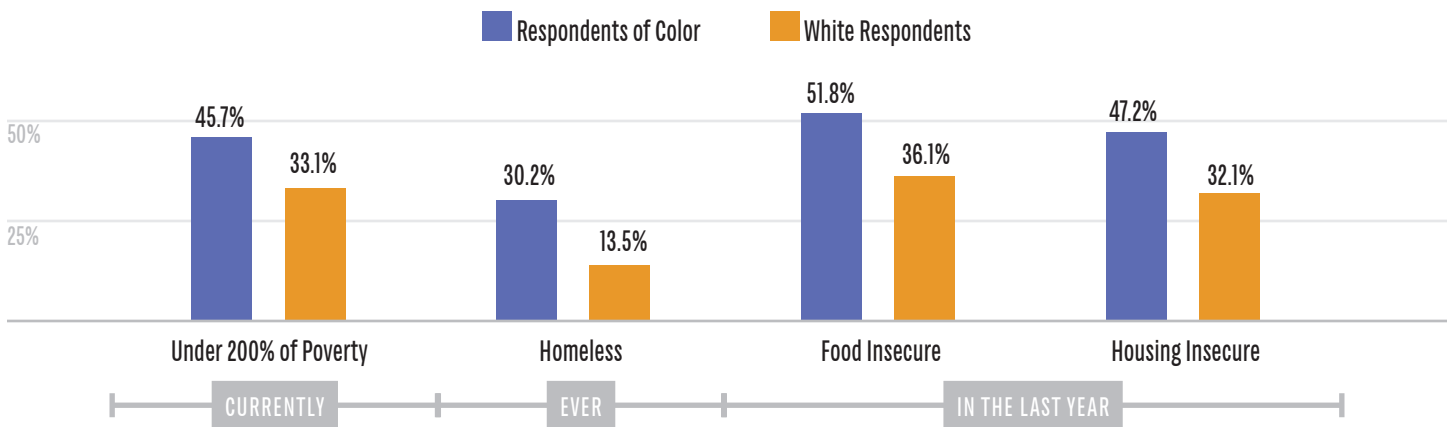
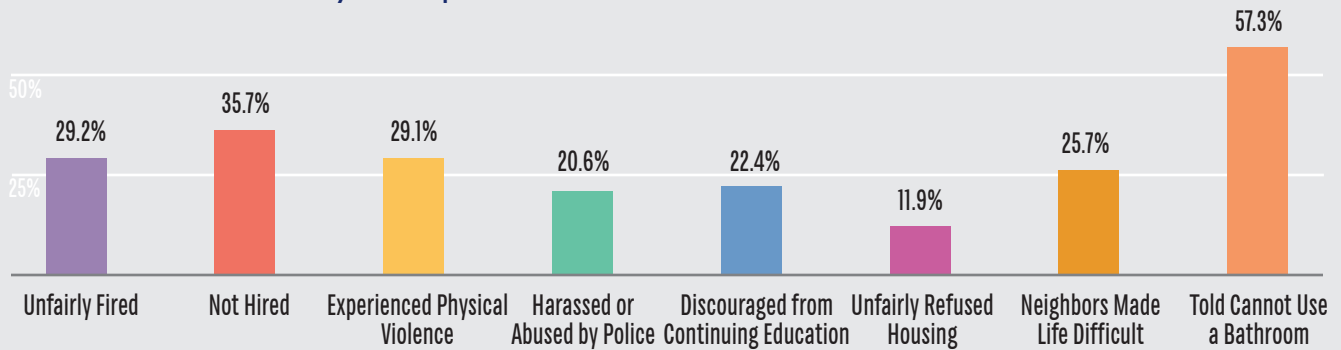


FIGURE 24

TGGNC Respondents' Experiences of Discrimination and Violence Due to Gender Identity or Expression



Transgender and gender nonconforming people face additional health risks related to disproportionate experiences of prejudice and interpersonal violence. Lack of access to employment in the form of discrimination in hiring (35.7%) and being unfairly fired (29.2%) contributes to poverty and lack of access to benefits.^v

v. Items were adapted from a scale designed to measure multiple dimensions of discrimination.¹¹

Disparities Across the Life Course

Youth

LGBT youth age 16–24 face particular challenges and disparities. They are vulnerable to homelessness and family rejection and are over-represented in the foster care system. All youth were asked about housing and homelessness resulting from being LGBT. In this study, 24.3% of survey respondents were between age 16–24. As Figure 25 shows, one in six (15.0%)

reported having ever been homeless as a result of being LGBT and 10.1% had been kicked out for the same reason. Almost five percent (4.9%) had been in foster care.

As Figure 26 illustrates, for each of these experiences, youth of color were three-to-four times as likely to report that this was true for them. They were more likely to say they had ever been homeless because of being LGBT (26.9% vs. 9.1%, OR=3.65) or to have

been kicked out (18.7% vs. 5.9%, OR=3.68). They were nearly four times as likely to have been in foster care (9.4% vs. 2.7%, OR=3.8).

Sexual minority youth (including those who were lesbian, gay, bisexual, pansexual or queer) were asked questions about family rejection relating to their sexual orientation, while TGGNC youth were asked about family rejection relating to their gender expression and identity. Youth who were both a sexual minority and TGGNC had opportunities to answer both sets of questions.

As Figure 27 illustrates, the most common family rejection experiences among sexual minority youth respondents were being told not to tell friends or neighbors about their sexual orientation (31.8%) and being punished for their gender expression (being too masculine or too feminine) (31.1%). Nearly one in four (24.6%) sexual minority youth had been told that their parents were ashamed of them for being gay; this experience was more than twice as common among youth of color as among white youth (37.6% vs. 19.1%, OR=2.55). A slightly smaller number of youth were told that being gay is against the family’s religion (22.3%); this was more than three times more likely among youth of color than among white youth (37.0% vs. 16.1%, OR=3.07).

Just over one in 10 (10.5%) had been taken to a counselor or religious leader who tried to change their sexual orientation (conversion therapy). Sexual minority youth of color were more than three times more likely to have experienced this (18.8% vs. 7.0%, OR=3.08).

As Figure 28 shows, being punished for gender expression was even more common among TGGNC youth than among sexual minority youth, with over half (54.4%) reporting that this was a problem or major problem, as was being told parents were ashamed of them (39.5%). Just over one in five (27.4%) said that being refused transition-related care was a problem and 14.2% had experienced conversion therapy. There were no statistically significant differences between youth who were white and

FIGURE 25
Housing and Homelessness Experiences
Among Respondents Age 16–24

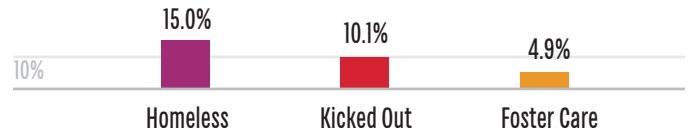


FIGURE 26
Housing and Homelessness Experiences
Among Respondents of Color and White Respondents, Age 16–24

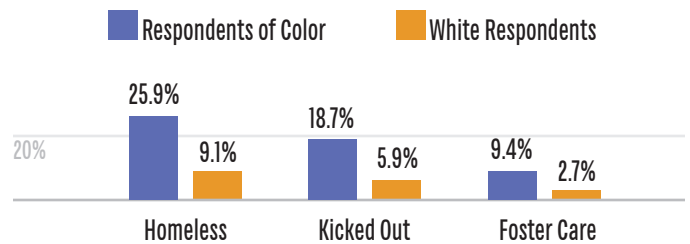


FIGURE 27
Family Rejection Experiences
Among Sexual Minority Youth Respondents, Age 16–24

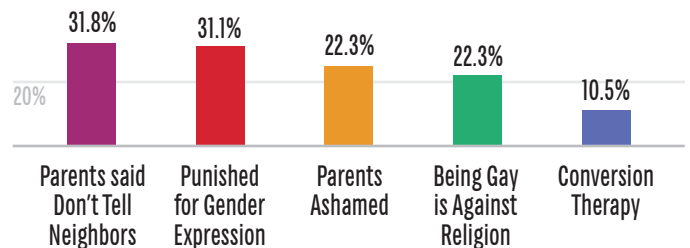
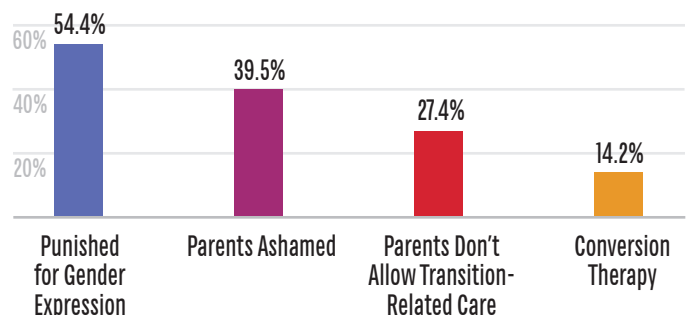


FIGURE 28
Family Rejection Experiences
Among TGGNC Youth Respondents, Age 16–24



those of color; however, this may be due to the small number of respondents in this category.

Sexual minority youth (including those who were lesbian, gay, bisexual, pansexual or queer) were asked questions about school experiences relating to their sexual orientation, while TGGNC youth were asked about school experiences relating to their gender expression and identity. Youth who were both a sexual minority and TGGNC had opportunities to answer both sets of questions. Thus, some youth are included in both sexual minority and TGGNC categories in Figures 29 and 31.

Just over one in 10 (11.2%) of sexual minority youth and just under one in five (18.5%) TGGNC youth said that it was a problem or major problem that they had been taken to an unsupportive health care provider by their parents. Over one in five (21.2%) sexual minority youth and over two in five (41.2%) TGGNC youth said that they were afraid to ask to see a healthcare provider because of being worried about parents or caregivers finding out about them being a sexual minority or TGGNC.

Many youth respondents age 16–21 who were enrolled in high school also reported protective factors in their schools, such as having a GSA (58.7%) or an anti-bullying policy specific to LGBT people (48.8%); these are shown in Figure 30. Some sexual minority youth knew their school had written policies to protect sexual minority young people (28.6%), but more did not (33.0%) or were not sure (38.4%). Even fewer TGGNC young people knew about written policies to protect them in school (17.7%). Two in five (41.2%) said there were no such policies in their school and the same number said that they were not sure whether there was a written policy.

As Figure 31 shows, three quarters (74.1%) of LGB students said that teachers were “very” or “somewhat” supportive of LGB students and over two-thirds (66.7%) of TGGNC students said the same about supportive teachers. Fewer LGB and TGGNC students said that other students were “very” or “somewhat” supportive (61.1% and 39.4%, respectively).

FIGURE 29
Barriers to Care

Among Sexual Minority and TGGNC Youth Respondents, Age 16–24

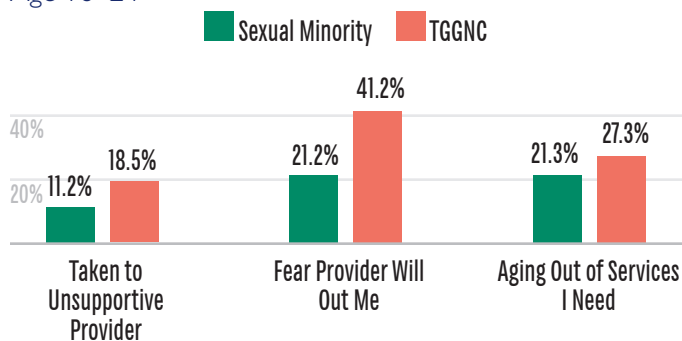


FIGURE 30
Protective School Factors

Among Respondents Age 16–21 Who are Enrolled in School

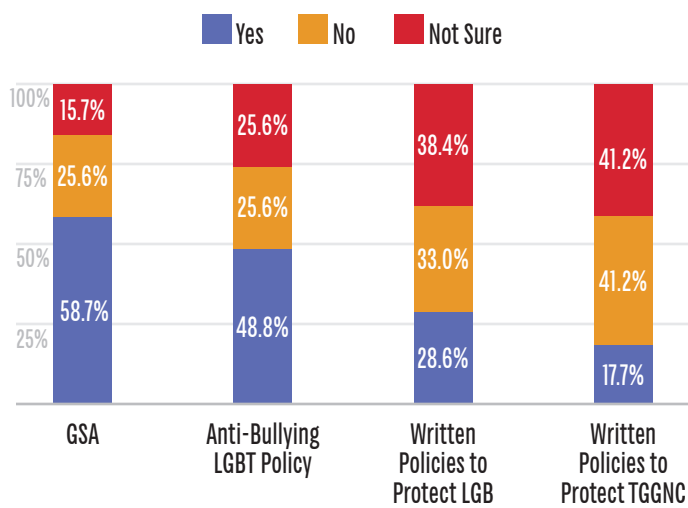
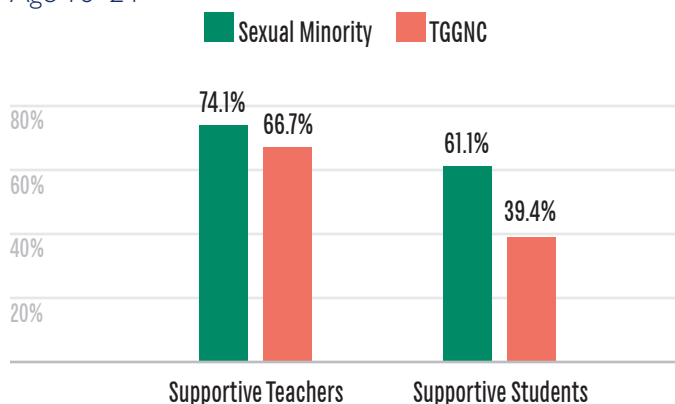


FIGURE 31
Barriers to Care

Among Sexual Minority and TGGNC Youth Respondents, Age 16–24



Older Adults

Nearly one quarter (24.5%) of survey respondents were over age 51. These respondents differed in their demographics from younger respondents in that they were about half as likely to be of color (16.3% vs. 29.4%, OR=0.47), almost fifty percent more likely to be male (52.3% vs. 42.5%, OR=1.48) and less likely to be TGGNC (12.8% vs. 26.5%, OR=0.41).

As Figure 32 shows, they were more likely to identify as gay or lesbian rather than bisexual, queer or pansexual (see below; all differences are statistically significant). They were also more likely to be formally

partnered; over one-third (34.8%) were married compared to less than one in five (17.1%) of those 50 or under (OR=2.58) and 8.2% were in domestic partnerships compared to 5.0% of those who were 50 or under (OR=1.69). Respondents age 51 and older were much less likely to have survival needs and problems accessing care or to experience barriers to care (data not shown). As Figure 33 shows, they were also significantly less likely to have frequent mental distress (17.2% vs. 30.2%, OR=0.48) or depression (13.2% vs. 23.2%, OR=0.51). However, they were more likely to report fair or poor health (14.7% vs. 11.8%, OR=1.29) and frequent physical health problems (13.8% vs. 11.1%, OR=1.29).

FIGURE 32
Sexual Orientation

Among Respondents Age 51+ and Age 50 and Under

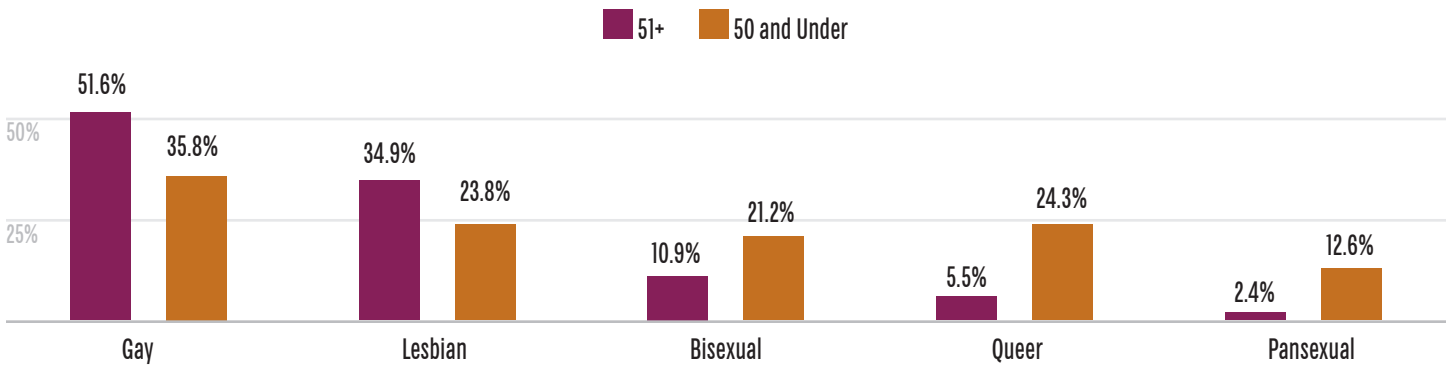
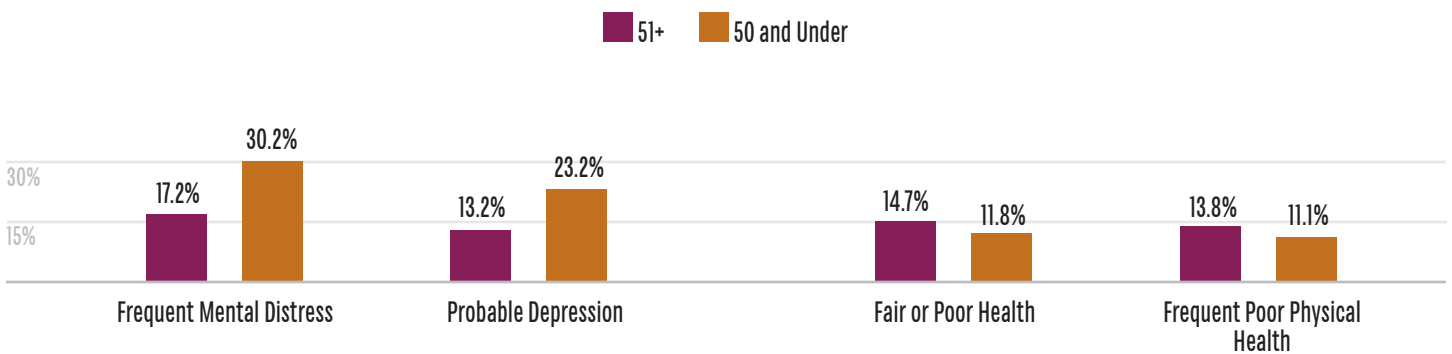


FIGURE 33
Health Status

Among Respondents Age 51+ and Age 50 and Under



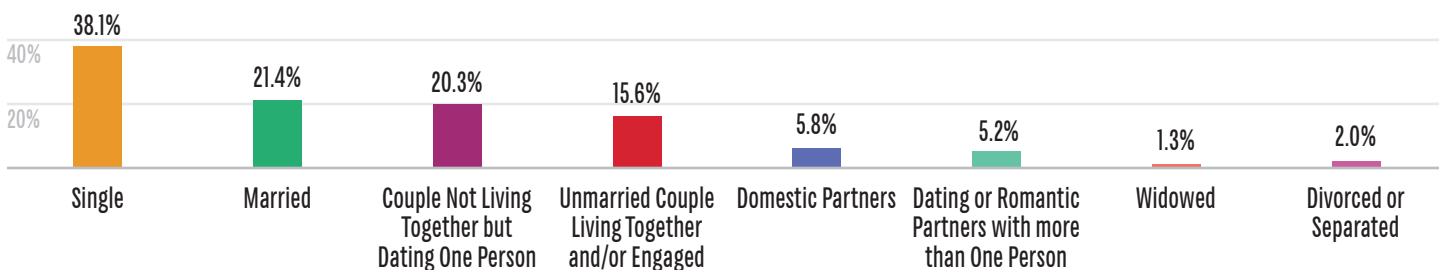
Families

LGBT people make families in a variety of ways; those who choose to have children may foster, adopt, use surrogacy or have biological children that they themselves carry. This section focuses on the variety of family types experienced by respondents to the survey. As Figure 34 shows, respondents were single (38.1%), but many were also married (21.4%), members of a couple not living together but dating exclusively (20.3%) or unmarried couples living together (15.6%). A smaller number were domestic partners (5.8%), dating or romantic partners with more than one person, or polyamorous (5.2%), divorced or separated (2.0%) or widowed (1.3%).

FIGURE 34

Partner Status

Among All Respondents



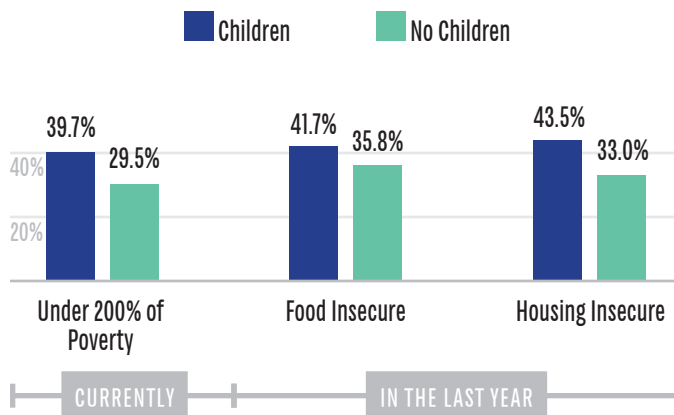
In many ways, respondents with children (13.5%)^{vi}, about one-eighth of the total sample, were similar to other respondents in that they have similar rates of mental and physical health problems and similar access to primary care providers, health homes and a usual source of care. The largest group of respondents with any children was in the 30–44 age group (55.8%). This group more often reported being female (66.4%), married (46.0%) and identifying as lesbian (43.0%). They were more likely than respondents with no children to live outside of the five boroughs of NYC (76.7% vs. 57.1%, OR=2.48), with the most frequently reported regions of residence among respondents with children being Central New York (22.4%) and Northeastern New York (14.2%). Respondents with children were more likely than those with no children to be working full time

vi. This section refers to respondents over the age of 25. Analyses regarding participants age 25 and younger are shown in the “youth” section of this report.

FIGURE 35

Survival Needs of Respondents With and Without Children Present in the Home

Among Respondents Age 25+



(68.4% vs. 63.3%, OR=1.26, $p < 0.10$). Respondents who reported having children in the home had a similar likelihood as respondents who did not have children to be TGGNC or to be people of color. They had similar health statuses.

As Figure 35 shows, respondents with children in the home were more likely to say they were living in poverty (39.7% vs. 29.5%, OR=1.57), had been food insecure (41.7% vs. 35.8%, OR=1.28) or housing insecure (43.5% vs. 33.0%, OR=1.56) in the last year.

These respondents were also more likely to say that they did not have insurance (6.5% vs. 4.0%, OR=1.67) and that they could not get needed care due to cost (27.2% vs. 19.5%, OR=1.54). They were more likely to say that their insurance coverage was not adequate (27.9% vs. 22.1%, OR=1.36). All other measured barriers to care were similar between respondents who did and did not have children in the home.

Conclusions and Recommendations

SEXUAL ORIENTATION AND GENDER IDENTITY AND EXPRESSION AFFECT INDIVIDUAL HEALTH CARE ACCESS

Utilize community-generated data, while improving government data collection

Community based needs assessments are valuable to understand the health and human service needs of LGBT people. Information gained from gathering the perspectives and experiences of community members builds on existing strengths and limitations of government data collection. The New York State LGBT Health and Human Services Needs Assessment reached a significant sample of LGBT New Yorkers, detecting economic and health disparities that impact their health and well-being, including:

- More than one-third (36.1%) of LGBT respondents had incomes that were under 200% of the federal poverty line, making them eligible for a number of public benefits.
- More than a quarter (26.9%) of respondents reported frequent mental distress and more than one in five (20.6%) screened positive for probable depression.
- More than one in five (22.6%) respondents had no primary health care provider.

Such data can be used to inform the allocation of resources and the design and implementation of

programs to meet LGBT health and human service needs and address disparities that most impact LGBT communities.

New York State has progressed in including data collection on LGBT people in administrative and survey demographic questions, particularly in the area of health. However, more can be done to routinely include questions about sexual orientation and gender identity on every form where other demographics, such as age and race, are asked. For example, the Department of Labor does not include sexual orientation and gender expression in all the places where they collect data. Recently, New York City's Human Resources Administration has started to collect data on sexual orientation and gender identity in a way that could detect how LGBT people are accessing public benefits. Such data can be instrumental to improve the accessibility of public services for LGBT people in New York State.

Increase clinical education and cultural competency efforts for non-LGBT health care providers

Sensitive and inclusive clinical education and cultural competency training for health care providers is crucial to ensuring the provision of quality health services to LGBT communities. Respondents to the LGBT Health and Human Services Needs Assessment reported a number of stigma-related barriers to care that impacted their ability to seek and receive health care:

- Nearly one-third (30.7%) of survey respondents reported not enough LGBT-trained health professionals as a barrier to health care.
- Lack of LGBT-trained health professionals was an even more significant problem for TGGNC respondents, where more than half (56.1%) reported this as a significant barrier to health care.
- Almost one in 10 (9.1%) LGBT respondents reported that they had been refused health care services.

Resourcing, implementing and evaluating provider education for LGBT and particularly transgender clinical competency at all levels is important to address stigma-related barriers to care. Training can be integrated into medical education curriculum for doctors, physician assistants, nurse practitioners and nurses, both during their initial training and through continuing education efforts. Clinical and cultural competency training led by health care providers (i.e.: clinician to clinician) have been most effective. Such training will also increase access to qualified health care providers, including those competent in the specific needs and concerns of TGGNC people (e.g.: hormone initiation and maintenance), but can also address these needs in a holistic, primary care context.

NEW YORK'S HEALTH CARE AND EDUCATION INFRASTRUCTURE IMPACTS THE LGBT COMMUNITY

Ensure public and private insurance are responsive to the health needs of LGBT people, particularly transgender people

In 2014, New York State's Department of Financial Services sent guidance to private insurance companies stating that they may not deny medically necessary treatment for gender dysphoria. This guidance sought to ensure access to commercial health insurance coverage for transgender New Yorkers. For individuals denied care, an appeals process has been instituted.

In the same year, the New York State Department of Health announced that Medicaid would also cover transition-related care.

However, transgender people continue to report challenges in accessing transition-related care through Medicaid and private insurance. Respondents to the LGBT Health and Human Services Needs Assessment reported a number of insurance and cost-related barriers to accessing transition-related care:

- More than sixty percent (61.5%) of TGGNC respondents who had tried to access or were currently accessing transition-related care reported that insurance not covering hormones was a "somewhat" or "major" barrier to care.
- Nearly half (47.6%) of respondents who had tried to access or were currently accessing transition-related care had experienced disruptions to hormone use.
- Although less than ten percent (7.4%) of respondents were uninsured, more than one in five (21.7%) could not see a provider in the last year due to cost.

To ensure that transgender New Yorkers get needed health care, enforce transgender care parity among private insurers and pass and enforce parity among public insurers.

Enforce LGBT protections for young people in New York State

Robust LGBT and transgender specific protections for young people in schools exist in the form of legislation and implementation guidelines in New York State. The Dignity for All Students Act (DASA) was passed in 2010 to ensure a safe and supportive environment free from discrimination, intimidation, bullying, taunting or harassment on school property in public elementary and secondary schools. In 2015, the New York State Education Department (NYSED) released guidelines to foster safe and discrimination-free environments for TGGNC students.

Yet, LGBT young people responding to the LGBT Health and Human Services Needs Assessment continue to report a lack of protective factors and adverse experiences at home and in school as a result of their LGBT identity:

- One quarter (25.6%) of high school respondents reported that their school did not have a policy to protect LGBT students from bullying and the same number were not sure if their school had a policy.
- More than forty percent (41.2%) of TGGNC high school respondents reported that their school did not have a policy to protect TGGNC students and the same number were not sure if their school had a policy.
- More than one in seven (15.0%) respondents age 16–24 had been homeless as a result of being LGBT.
- More than a quarter (26.9%) of respondents of color age 16–24 had been homeless as a result of being LGBT.
- More than half (54.4%) of TGGNC respondents age 16–24 had been punished by family members for their gender identity or expression.

While policies and guidance in this area are robust, implementation is often lacking. To implement policies, resources are needed for training and to build redress mechanisms to ensure incidents are resolved and build the capacity of school systems to enforce DASA and NYSED guidelines to protect all TGGNC young people.

STRUCTURAL RACISM, ECONOMIC INEQUALITY AND GENDER DISCRIMINATION COMPOUND HEALTH DISPARITIES FOR LGBT PEOPLE

Support programs for LGBT people that address the social determinants of health, including housing, economic and employment opportunities, access to nutritious food and mental health care

LGBT people of color and TGGNC people experience multiple intersecting types of oppression that impact their health status and access to care. Respondents to the LGBT Health and Human Services Needs Assessment from these groups reported poorer health and more significant barriers to care including:

- Respondents of color were more likely to be at or below 200% of the poverty line (45.7% vs. 33.1%), housing insecure (47.2% vs. 32.1%) and food insecure (51.8% vs. 36.1%) in the last year.
- TGGNC people were much more likely to experience frequent mental distress than their non-TGGNC counterparts (41.9% vs. 22.4%).
- People of color and TGGNC people were much more likely to have been homeless at some point in their lives than white and non-TGGNC respondents (30.2%; 28.0% vs. 10.4%).

Improve access to job training and entitlements for LGBT people and particularly for TGGNC people, who experience some of the most profound barriers to employment and for whom lack of employment leads to lack of access to health and human services

TGGNC people in this study were more educated but less likely to be employed than either other LGBT people in the study or the general population.

They also experience high rates of unfair discrimination in hiring and firing practices, suggesting that their human capital is underutilized due to discrimination based on gender identity and expression.

Pass, enforce and evaluate the effectiveness of policies that prevent administrators of benefit entitlements such as food stamps, cash assistance and social security from denying TGGNC people access to those benefits

TGGNC people face additional barriers to accessing public benefits due to having identity documents with names and gender markers that may not match their gender identity or expression. TGGNC people can struggle for years to ensure that their correct names and gender markers are reflected in all their identity documents. In our focus groups, we also learned that changing your name or gender marker for Medicaid or public benefits can be especially challenging. Discrepancies in name and gender marker can make it difficult for individuals to compile the necessary paperwork to qualify for public benefits or to adhere to the rigorous requirements for recertification. These bureaucratic challenges further compromise the economic well-being of TGGNC people in New York State and the ability of public services to meet existing needs.

NEW YORK STATE'S RESPONSE TO LGBT POPULATION HEALTH NEEDS INCREASED INVESTMENT

Increase funding for organizations providing LGBT health and social services and ensure LGBT people are represented in local and statewide bodies that impact the delivery of health and human services to New Yorkers

There is an ongoing need for funding for LGBT health and human services particularly for the

most marginalized LGBT people. LGBT health and human service providers make available targeted and customized services to meet community needs. They also offer training and supported referrals for other aspects of social services to ensure they meet the needs of the LGBT community. Among respondents to the LGBT Health and Human Services Needs Assessment:

- About half (50.1%) of respondents had been to an event at an LGBT health and human service providing organization in the last year.
- Among youth ages 16–24, more than one in five (21.6%) identified aging out of LGBT programs targeting youth as a barrier to care.
- LGBT New Yorkers in upstate New York have higher barriers to care, that may be intensified in rural areas.

In focus groups, we also heard how LGBT health and human service providers were the entry point for other health and social services, including health insurance, primary health care, mental health counseling, public benefits and food pantries, among others. LGBT health and human service providers also offer support groups, where marginalized communities can connect with others facing similar challenges, which was a significant gap identified by survey respondents. They can also identify and meet needs that are specific to particular aspects of the LGBT community, such as offering training in crisis response that are vital for communities of color who are criminalized and highly policed. In many places in New York State, the LGBT health and human service providing organization is the first point of contact for LGBT people about their health and human service needs.

Limitations

This sample is a convenience sample, meaning that it does not necessarily represent the underlying population distribution of LGBT New Yorkers. The sample is younger than New York State and underrepresents less educated adults, people of color, and middle-age and older adults. As with all surveys of the LGBT community, it relies on respondents to self-identify. All data are self-reported.

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Contributing Partners

The following organizations assisted the authors with distributing the survey to community members and identifying individuals to participate in the focus groups.

New York City

The Bronx

Adolescent AIDS Program, Montefiore Medical Center
BOOM!Health
Bronx Works
Destination Tomorrow
Hispanic AIDS Forum

Brooklyn

Brooklyn Community Pride Center
Family Permanency Program, MercyFirst
Gay Men of African Descent (GMAD)
GRIOT Circle, Inc.
Make the Road New York
Rainbow Heights Club
HEAT Program, Research Foundation of SUNY/
SUNY Downstate Medical Center

Manhattan

Ali Forney Center
New York City Anti-Violence Project (AVP)
Asian & Pacific Islander Coalition on HIV/AIDS
(APICHA), APICHA Community Health Center
Audre Lorde Project
Callen-Lorde Community Health Center
Gay Men's Health Crisis, Inc. (GMHC)
Grand Street Settlement
Harm Reduction Coalition
Hetrick Martin Institute (HMI)

Institute for Human Identity (IHI)
Latino Commission on AIDS
Lawyers For Children, Inc.
Metropolitan Community Church of New York
(MCCNY)
National Alliance on Mental Illness (NAMI)
LGBT Cancer Network
LGBT Law Project, New York Legal Assistance Group
Peter Cicchino Youth Project, Urban Justice Center
Project Reach
Safe Horizon Streetwork Project
SAGE (Services and Advocacy for GLBT Elders)
Sylvia Rivera Law Project
The Lesbian, Gay, Bisexual & Transgender Community
Center
The Trevor Project
Transgender Legal Defense and Education Fund
(TLDEF)
Trinity Community Connection, Inc.
Trinity Place Shelter
Unity Fellowship Breaking Ground

Staten Island

Pride Center of Staten Island

Queens

AIDS Center of Queens County, Inc.
Queens Center for Gay Seniors - Queens Community
House
Queens Pride House

Western New York

Gay & Lesbian Youth Services (GLYS) of Western
New York, Inc.
The MOCHA Center, Inc.
Pride Center of Western New York

Long Island

Family Residences & Essential Enterprises
North Shore Hospital
Pride for Youth
Long Island Gay and Lesbian Youth (LIGALY), LGBT
Network
SAGE-LI

Hudson Valley

Youth Pride Initiative, Community Awareness
Network for a Drug-free Life and Environment,
Inc. (CANDLE)
Center Lane, Westchester Jewish Community Services
The LOFT: LGBT Community Services Center
Hudson Valley LGBTQ Community Center
Mid-Hudson Family Practice Residency Program, The
Institute for Family Health
Lesbian & Gay Family Building Project/Pride and Joy
Families
Greater Hudson Valley Family Health Center
Hudson River Health Care

Central New York

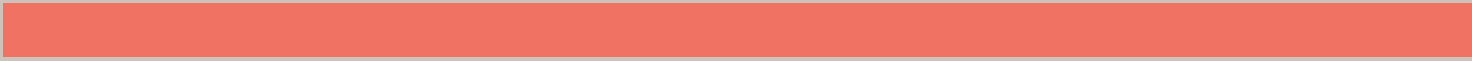
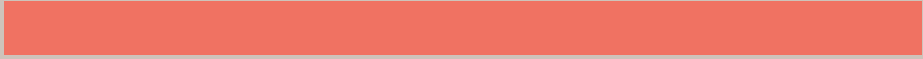
SAGE Upstate
The Q Center AIDS Community Resources
Cortland LGBT Resource Center, Cortland Prevention
Resources, Family Counseling Services of Cortland
County, Inc.

Finger Lakes/Southern Tier

Immune Health Services, SUNY Upstate Medical
University
Gay Alliance of the Genessee Valley (GAGV)
Trillium Health
United Health Services, Binghamton General Hospital
Out For Health - Planned Parenthood of the Southern
Finger Lakes
Identity Youth Center, Southern Tier AIDS Program

Northeastern New York

LGBTQ Education and Outreach Project, Planned
Parenthood Mohawk Hudson
Alliance for Positive Health
In Our Own Voices, Inc.
Pride Center of the Capital Region
Rainbow Access Initiative, Inc.



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