

King County Community Health Needs Assessment 2018/2019

LGBTQ Community Spotlight



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Acknowledgements

Public Health-Seattle & King County

Gloria Albetta, Kaylin Bolt, Ronan Cox, Louise Carter, Nadine Chan, Susan Hernandez, Joie Hsu, Eli Kern, Susan Kinne, Amy Laurent, Jay Marshall, Alastair Matheson, Anne McNair, Kristin Moore, Marguerite Ro, Sara Jaye Sanford, Mike Smyser, Lin Song, Celia Thomas, Lee Thornhill, Kim Tippens, Mariko Toyoji, and Eva Wong

EvergreenHealth

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St. Francis Hospital
Highline Medical Center
Regional Hospital

Kaiser Permanente

Kim Wicklund and Victoria Garcia

MultiCare Health System

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Covington Medical Center

Navos

Megan Kelly

Overlake Medical Center

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Seattle Children's

Elizabeth "Tizzy" Bennett and Lara Sim

Swedish Medical Center

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Ballard Campus
Cherry Hill Campus
First Hill Campus
Issaquah Campus

UW Medicine

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UW Medical Center
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Washington State Hospital Association

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 Virginia Mason®

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Hospital Association

Acknowledgements

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We also wish to thank those who provided input to this report:

Navos

Nexus Youth and Families

The NW Network

Seattle Public Schools

Youth Eastside Services

Dr. Shaquita Bell, Seattle Children's Hospital

Debbie Carlsen, LGBTQ Allyship

Julia Crouch, Seattle Children's Hospital Gender Clinic

Edric Figueroa, NW Network

Lara Hayden, Seattle Children's Hospital

Lisa Love, Seattle Public Schools

Jeff Natter, Pacific Hospital Preservation & Development Authority

Catherine Verriere Sumerwell, DNP, ARNP

We thank Aileen Raymond, Nyka Osteen and other King County youth and young adults that helped develop the question guide for listening sessions, and all those who shared their voices to inform this work.

Photo credits:

Pg. 47, Naomi Ishisaka

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Executive Summary

Executive summary

This spotlight on the lesbian, gay, bisexual, transgender, and queer (LGBTQ) population of King County is a special addition to the 2018/2019 King County Community Health Needs Assessment (CHNA) – a King County Hospitals for a Healthier Community collaborative product that fulfills Section 9007 of the Affordable Care Act. In this section of the

report, we examine the health inequities affecting the LGBTQ population, in particular for youth and young adults, as well as provide information about community health needs.

We present findings from a series of eight listening sessions with 72 LGBTQ youth (ages 13-17) and young adults (18-24) living throughout the county, and from seven key informant interviews with advocates who work with LGBTQ youth. To complement these qualitative findings, we present relevant survey data (a) for adults, from the Behavioral Risk Factor Surveillance System (BRFSS), (b) for youth, from the Healthy Youth Survey (HYS), and (c) for homeless youth and adults, from the Count Us In Survey of King County's sheltered and unsheltered homeless population.

The transition from childhood to early adulthood is challenging for everyone. As youth assume more responsibility for decisions about their activities and relationships, interactions with the adults around them can become stressful and sometimes contentious.

Our conversations with key informants and youth participants revealed considerable variability in the ways this delicate negotiation plays out for LGBTQ youth – some that support and some that threaten adolescent health during a key time of identity development. Survey data bolster these conclusions.

WHAT WE HEARD FROM YOUTH & YOUNG ADULT LGBTQ COMMUNITIES

Key informants and youth participants were asked to reflect on access to and experiences with healthcare for LGBTQ youth and young adults in King County. Participants described a set of interpersonal barriers, structural barriers, and societal stressors that make it difficult for youth to get the supportive healthcare they need.

Listening session participants and key informants described the lack of control that LGBTQ youth feel over their own health. Comments were usually set in the contexts of relationships with family, other supportive adults, and healthcare providers.

Control over personal health

Youth want to be involved in decisions about their health and treatment, but generally feel isolated from decision-making processes, largely because of their age. They expressed frustration over doctors and parents discussing their health without soliciting input



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from them. Many stated that doctors – and in some cases their parents – dismissed the health needs they articulated. Youth felt that the inability to speak and be heard by their caregivers and providers created barriers to accessing contraception, puberty blockers, and other types of mental and sexual health services.

Relationships & trust

Support from family & reliable adults

Youth who had stable and nurturing relationships with their families and trusted adults felt safe and supported. Those without these trusting relationships had extreme difficulty getting their health and healthcare needs met. Key informants reported that, for many LGBTQ youth, lack of family support affected mental health, self-esteem, and their ability to effectively navigate the healthcare system.

In many cases, youth do not want to share their concerns in front of their parents, but often do not feel welcome to talk to providers privately. They would like more opportunities to speak privately with their providers, and feel strongly that this needs to be initiated by the provider.

Patient-provider relationships

A strong message from youth was that they needed to feel safe and develop trusting relationships with their providers before they could comfortably talk with them about their physical, mental, and emotional

health needs – all of which extend beyond just sexual health. Negative experiences with providers affect their ability to open up to their providers and can discourage them from seeking healthcare in the future.

Key informants and youth both described limited time during the visit as a barrier to comprehensive care and relationship building. When physicians are rushed, youth perceive those interactions as hurtful and dismissive.

Visibility & acknowledgement

A safe and supportive clinical environment can reduce barriers to care. Two signs of a safe and supportive environment are use of inclusive language and acknowledgement of the possibility that patients/clients may be gender non-conforming, non-binaryⁱ, or transgender. Youth recounted stories of being misgendered, of being told they had to choose a gender, and of having providers who refused to use the appropriate name or pronouns. These youth said they immediately felt disrespected, which affected the quality of subsequent interactions with that provider.

ⁱ Describes a person whose gender identity falls outside of the traditional gender binary structure. This can include people of defined, culturally-specific genders other than male and female (Two-spirit, Fa'afafine, etc.), as well as people of any culture who do not feel an internal sense of alignment with binary genders. Non-binary people may or may not experience gender dysphoria and may or may not seek gender-affirming care (hormone therapy, surgery, etc.).

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Having a queer provider offers many queer youth a sense of ease because they feel accepted just as they are. Some youth imagine that the quality of care from a queer provider would be better because the patient would not carry the burden of educating the provider about who they are and how to deliver care to them.

Youth felt validated when intake forms allowed them to specify their pronouns, distinguish their sex from their gender, or select a gender other than male or female. When an initial encounter did not make them feel “othered” and isolated, youth were more able to engage in open and trusting communication when they entered the treatment room.

Navigating healthcare settings

Youth and key informants described challenges, such as: accessing and navigating health insurance and healthcare settings, lack of provider training to work effectively with LGBTQ patients, and lack of youth education about diverse aspects of human sexuality and healthy interpersonal relationships.

Many LGBTQ youth face barriers when they’re unsure about issues related to insurance coverage and confidentiality. Transgender youth face unique challenges related to knowing how and when to disclose their gender and what their options are for gender-affirming care. Many also encounter barriers when trying to understand and navigate regulations regarding confidentiality, parental permission, and documentation. Patients with health insurance can be

prevented from receiving care if they don’t have up-to-date legal documents that accurately reflect their name and gender.

Standards in medical charting that assume heterosexual, cisgender patients also create barriers to care. Electronic health records often use fixed categories with limited options for gender and only populate a patient’s legal name, so mistakes in addressing transgender patients by the appropriate name and gender are perpetuated throughout the chart and repeated with each interaction. Similarly, sexual health questions assume heterosexual interactions and prevent youth from being able to accurately describe their sexual health and create additional stigma around these relationships.

Provider training

Depending on their area of focus, healthcare providers may have few opportunities to acquire the knowledge and skills needed to work effectively with LGB, transgender, and gender-non-conforming patients. Key informants expressed an across-the-board need for more training of medical and mental health providers—especially in pediatrics, family practice, and primary care.

Youth education

Key informants attributed some of the health concerns and disparities among LGBTQ youth to the paucity of

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accurate and culturally competent health information provided to young people in schools. Youth confirmed that school sex-education courses did not prepare them for the relationships they were actually having.

Youth expressed a desire for information about how to navigate healthcare – including clear communication concerning their rights, confidentiality, and what services they can access without parental consent, especially related to therapy, contraception, and gender-affirming care.

Societal stressors

Key informants emphasized the multiplicative effects of intersecting oppressions on many of the health disparities experienced by LGBTQ youth and young adults. Inequities associated with race, place, income, language, and homelessness are magnified among LGBTQ youth. LGBTQ youth experiencing homelessness were identified as a severely burdened and vulnerable population. Key informants described the unique challenges and inequities experienced by these youth.

WHAT WE LEARNED FROM THE SURVEYS

Findings from surveys of adults (the Behavioral Risk Factor Surveillance System), youth (Healthy Youth Survey), and homeless King County residents (Count

Us In survey) reaffirmed some of our listening session and interview findings.

Note: The Count Us In survey collected data on LGBTQ+ populations whereas BRFSS and HYS surveys did not offer response options beyond straight, lesbian or gay, or bisexual; hence, the use of “LGB” when referencing those data sources.

Safety concerns

Survey data showed that LGB youth were consistently more likely than heterosexual youth to report feeling unsafe at school, feeling unsafe on dates, being bullied, having been physically abused by adults, and lacking emotional support from adults. LGB youth were also more likely than heterosexual youth to have carried a weapon to school. Individuals who identified as LGBTQ+ⁱⁱ were disproportionately represented among King County’s homeless population, and more than half of homeless LGBTQ+ survey respondents reported histories of domestic violence or partner abuse. Among LGBTQ+ respondents to the Count-Us-In survey, 7 out of 10 first experienced homelessness in childhood or before age 25.

The compounding effects of multiple oppressions

For many indicators, the strong relationship between

ⁱⁱ The ‘+’ acknowledges that it is not possible to list every term that people use to describe their sexual orientation or identity.

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LGB identification and exposure to potentially traumatizing experiences persisted across analytic breakdowns – typically racial/ethnic groups. For some indicators, belonging to another subgroup appeared to further magnify risk among those identifying as LGB. For example, LGB youth were significantly more likely than heterosexual youth to report feeling unsafe at school, furthermore, Black LGB youth and LGB youth who identified their race/ethnicity as “other” – had exceptionally high rates of feeling unsafe at school. Additional evidence of compounding of risks were found among:

- Asian, Black, Hispanic, “other” race/ethnicity, and South Region LGB youth for not having an adult to talk to.
- South Region LGB youth for obesity.
- Black and Hispanic LGB youth for binge drinking.
- Black LGB youth for marijuana use.

Substance use & health-related behaviors

Behavioral patterns observed in teens can set the scene for behaviors – and illnesses – later in life. Some of the health-related behaviors reported in this section involve use of potentially addictive substances (tobacco, alcohol, and marijuana), and can be difficult to change in adulthood. Disparities by sexual orientation among youth for cigarette smoking, binge drinking, and marijuana use were mirrored in adult

data on the same behaviors. Similar patterns of youth and adult disparities by sexual orientation showed up on mental health indicators.

Discontinuities between youth and adult data

A few indicators showed significant differences by sexual orientation among youth (higher rates of obesity, inadequate physical activity, and lack of social support for LGB youth), but not for adults. And for some adult indicators (frequent mental distress, binge drinking, and marijuana use), rates peaked in young adulthood. Although some LGB adults experience high rates of substance use, mental illness and disability, or chronic disease, most become healthy and productive adults.

CONCLUSION

Youth participants and key informants identified a complex set of systemic and interpersonal barriers and oppressions that affect the health outcomes of LGBTQ populations and contribute to inequities that impact these communities in King County. The quantitative analyses supported what we heard in listening sessions and interviews, and can be used to raise awareness among the parents, teachers, healthcare providers, and other trusted adults whose support is important to LGB youth as they navigate this vulnerable period of development.

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Introduction

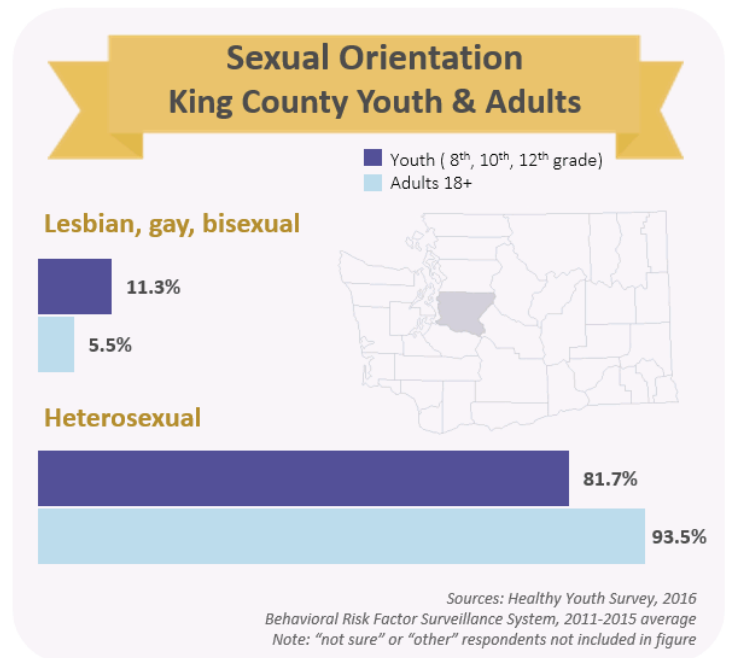
This addendum to the 2018/19 King County Community Health Needs Assessment spotlights the lesbian, gay, bisexual, transgender, and queer (LGBTQ) communities of King County, examining the health needs and disparities impacting this population. Chosen by King County Hospitals for a Healthier Community, this focus reflects King County hospitals' commitment to providing high-quality healthcare and supporting health through initiatives designed to meet the needs of all communities.

Throughout the report we utilize terminology and acronyms that are used in LGBTQ communities, some of which are defined in footnotes. A more comprehensive list of terms and definitions can be found in the [Glossary of LGBT Terms for Health Care Teams](#) (2018) published by the National LGBT Health Education Center (a program of the Fenway Institute).¹

POPULATIONS & POLICIES

Seattle and King County are home to a growing lesbian, gay, bisexual, transgender, and queer (LGBTQ) community. Recent estimates (2011-2015) showed that 5.5% of King County adults and 4% of Washington State adults identified as lesbian, gay, or bisexual (LGB).ⁱ In 2016, an estimated 3% of U.S. adults

ⁱ Washington State Behavioral Risk Factor Surveillance System (BRFSS)



identified as LGB.² Youth estimates from 2016 show that 11.3% of King County public high school students identify as LGB, and 7% are not sure of their sexual orientation.ⁱⁱ

Based on its policies and anti-discrimination laws, Washington is one of the top-ranked states for LGBT equality.^{3,4} Sexual orientation and gender expression or identity are protected classes under state anti-discrimination laws. Washington was an early state to pass marriage equality legislation and prohibits discrimination or harassment based on gender identity and sexual orientation in schools, housing, or employment.^{5,6} The Washington Law Against

ⁱⁱ The 2016 Washington Healthy Youth Survey (HYS) gathered data on lesbian, gay, and bisexual respondents but did not include questions on gender identity.

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Discrimination (WLAD) protects LGBT individuals from violence and bullying in schools, and from discrimination in public accommodations, housing, employment, credit transactions, and insurance transactions.^{7,8} Private health insurers in Washington are legally prohibited from denying coverage to transgender policy holders for services provided to cisgenderⁱⁱⁱ policy holders, and Washington Apple Health covers gender-related care in many circumstances.^{9,10} And in the 2018 session, the Washington Legislature passed a bill banning conversion therapy (clinical practices that attempt to change someone's sexual orientation or gender identity).¹¹

COMMUNITY STRENGTHS & CHALLENGES

The protections afforded by state law are rooted in strong support from King County's many LGBT healthcare, mental health, anti-discrimination, labor, and civil rights organizations. At the municipal level, inclusive laws, city services, policies, and leadership have yielded top ratings for Seattle and Bellevue on The Human Rights Campaign's Municipal Equality Index.¹² For example, since 2016 the City of Seattle passed an ordinance that required that all single-occupancy bathrooms be marked with gender neutral signage, and reaffirmed the right of Seattle residents to use gender-specific facilities appropriate

ⁱⁱⁱ Cisgender: of, relating to, or being a person whose gender identity and gender expression aligns with their assigned sex at birth.

to their gender identity.¹³

Even with increasingly inclusive policies, LGBTQ residents of King County and Washington State experience significant challenges. In Seattle, LGBTQ-related hate crimes have nearly tripled since 2014.¹⁴ Despite increases in health insurance coverage since implementation of the Affordable Care Act (ACA), costs continue to differentially prevent LGBTQ adults in King County from seeking needed medical care. Nearly one third (28%) of Washington state respondents to the U.S. Transgender Survey were living below the poverty line, compared to 13.3% of the Washington population.^{15,16} And although transgender Washingtonians have legal protections in housing and credit decisions, more than 1 in 4 (26%) transgender residents reported experiencing housing discrimination, such as being denied housing or being evicted because of their transgender status.

Transgender individuals face unique barriers to healthcare. Despite improvements in policies for coverage of transgender health needs, 29% of transgender Washingtonians reported problems with their health insurance coverage due to their transgender status in 2015.¹⁶ More than one third (38%) of transgender Washingtonians who saw a healthcare provider in the previous year reported at least one negative experience related to their gender identity, such as being harassed, being refused treatment, being assaulted, or having to teach their provider about transgender people in order to receive

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care. Scarcity of trans-competent providers creates additional challenges. While locally maintained databases of trans-competent providers exist for the Seattle area, many, if not most, practices are full. Many insurers require letters from mental health providers before transition-related medical care can be accessed. If someone does not have coverage for behavioral health services, they cannot access these additional health services.

These kinds of challenges may contribute to the excess of unmet healthcare needs among LGBTQ populations, and to persistent disparities in health outcomes.

The impacts of racism, ageism, poverty, and other forms of discrimination on health have overlapping effects for sexual and gender minorities. Societal bigotry toward any sociodemographic category has compounding negative effects when an individual is subject to multiple interlocking prejudices based on their identity. These challenges, together, create a dense web of barriers where individuals must selectively disclose parts of their identity based on their interaction with healthcare providers.

REPORT APPROACH & METHODS

To better understand the health needs of our local lesbian, gay, bisexual, transgender, and queer communities (LGBTQ), we spoke with local youth

and young adults about their experiences with healthcare and their needs related to its delivery. We also spoke directly to local advocates and providers, gathering their perspectives on the health needs and healthcare experiences of LGBTQ youth and young adults. A review of key community health indicators by sexual orientation was conducted to identify health inequities affecting LGB youth and adults. Data sources used for this section of the 2018/2019 King County Community Health Needs Assessment include:

- Listening sessions with LGBTQ youth and young adults throughout the county (self-identified as gay, lesbian, bisexual, queer, transgender, non-binary and/or gender diverse)
- Key informant interviews with local experts and advocates in the LGBTQ community
- Analysis of the Behavioral Risk Factor Surveillance System (BRFSS) survey data for the LGB adult population; and, analysis of the Healthy Youth Survey (HYS) data for the LGB school-age population. (Note: BRFSS and HYS asks respondents to identify as straight, lesbian or gay, or bisexual; hence, the use of “LGB” when describing these data throughout the report.)
- Review of findings from the “Count Us In” survey of King County’s sheltered and unsheltered homeless population in January, 2018. (Note: The Count Us In survey allowed a broad range of sexual orientation categories (straight, queer, bisexual, pansexual, lesbian or gay, I don’t know/

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questioning, refused, and other), which were ultimately reported as “straight” or “LGBTQ+.”

Additional analyses for these indicators as well as data for other health topics are online at www.kingcounty.gov/chi. Detailed data are reported, when available, by sexual orientation, race/ethnicity, age, income/poverty, gender, and other demographic breakdowns, for neighborhoods, cities, and regions in King County. For a more detailed description of report methods for this addendum, see Appendix A.

What we heard from youth & young adult LGBTQ communities



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What we heard about healthcare experiences

Through a series of youth listening sessions and interviews with local experts, we heard stories about the healthcare experiences of LGBTQ youth and young adults. Many described the foundational importance of trust in facilitating youth's healthcare access and experiences. We heard a candid and heartfelt mix of trust and appreciation as well as distrust and frustration.

As described by one of our key informants,

“ **There is a general distrust of the healthcare system. If you are questioning your orientation/identity and you don't have an adult or community support it creates shame and insecurity, which is also a barrier because you don't have support coming out.** ”

The presence of stable and nurturing relationships is a strong predictor of a child's mental and physical health, and ability to recover from traumatic experiences.¹⁷⁻¹⁹ We heard that trusting relationships with family and with providers are critical health facilitators – through multiple pathways. Youth who had these relationships felt safe and supported. Youth without trusted relationships had difficulty engaging in honest, open conversations regarding their health and healthcare needs.

One youth participant described,

“When I learned I was gay, I felt like... I couldn't tell anyone because they won't like me if they knew. I could only tell people I trusted; I can't trust the doctor because I don't know them at all. So it's harder for me to open myself up to doctors because of that underlying block that has been set long ago. I feel like that's relevant to a lot of queer people as well because of the societal conditioning they've been put through.”

What we heard from youth & young adult LGBTQ communities

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THE HEALTH NEEDS OF LGBTQ YOUTH & YOUNG ADULTS

The predominant message from key informants was that negative health outcomes in LGBTQ populations, "... are not inherent to their sexual orientation or gender identity, but due to the systemic barriers and oppressions that they face because of their identity." When asked about barriers to health and wellness, youth identified similar systemic and interpersonal barriers – not problems stemming from their sexual orientation or gender.

Our conversations with participants revolved around healthcare experiences. Key informants and youth participants emphasized a number of barriers that make it difficult for youth to get the healthcare they need.

Topics commonly raised by both youth and key informants include:

- For youth, lack of control over their own healthcare, often because of age
- Lack of support from family and reliable adults
- Challenges in developing trusting relationships and open/respectful communication with providers
- Challenges navigating health systems
- Lack of sexual health information

In this report, we outline the key topics identified through our community engagement with key informants and LGBTQ youth. We also outline needs of youth who experience multiple forms of oppression. Direct quotes from participants are offered throughout this section of the report.

Control over personal health

Navigating the healthcare system can feel overwhelming for anyone. It can be especially challenging for youth and young adults, and even more difficult for LGBTQ youth who may not have disclosed their sexual orientation to family and friends, or who may be uncertain of their own feelings. Many LGBTQ youth are dealing with internalized stigma, as well as stigma they feel from their provider, and from their family and/or community.

When asked to describe their experiences with healthcare, youth expressed that they wish to be involved in decisions about their health and treatment, but generally feel isolated from decision-making processes. They reported that, when parents were present at appointments, their provider often would not speak directly to them but rather spoke almost exclusively to the parent or guardian in the room. They expressed frustration over doctors and parents engaging in a discussion about their health without their input or involvement.

What we heard from youth & young adult LGBTQ communities

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“I feel a lack of control; this is my body, this is my mental health, this is me; I feel like I’m not in control over any of it.”

Although youth noted that this problem most likely stemmed more from their age rather than their LGBTQ status, the health implications for LGBTQ youth may be more pronounced than for heterosexual and/or cisgender youth. Youth reported not being believed and being denied access to mental health services when they reported depression, anxiety, or self-harm.

Transgender youth reported additional disparities in having control over their health, including being dismissed and/or denied access to gender-affirming care. Some transgender youth reported being unable to access any form of gender-affirming care, including reversible treatments such as puberty blockers, without parental consent.

“ **I’m not medically transitioning yet, which makes things difficult for me, because you’re watching your body grow into things you don’t want, and I can’t help it because my parents are forcing me to be this way. I’ve talked to people at the [school-based health center] about it and they say ‘Oh this is a long-term thing, you need to get your parent’s permission’ but blockers are reversible. People who are born female can go on birth control and have an abortion, but I can’t go on blockers?** ”



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Key informants describe that unmet medical needs (such as hormone therapy or puberty blockers) among transgender youth may result in untreated gender dysphoriaⁱ and mental health concerns, which are associated with increased suicide attempts, sexual violence, and negative school outcomes.

One key informant describes...

“Among the transgender community the number typically reported is that 40% of transgender people attempt suicide at least onceⁱⁱ and I think suicidality is even more of a concern with our transgender youth as compared to cis-gendered who are LGB. ...what makes transgender youth unique is that there are really some medical needs as opposed to just mental health needs that need to be addressed. ...we were seeing such a need in the community for medical services, specifically testosterone and estrogen hormones and access to puberty blockers for those in early puberty. ...we see those as essentially lifesaving interventions when we look at those suicide rates.”

Youth expressed a desire for information about how to navigate healthcare, including clear communication around their rights, confidentiality, and what services they can access without parental consent, especially related to therapy, contraception, and gender-affirming care.

“If someone were to explain how to get care step-by-step instead of saying ‘figure it out or call your parents...’ That’s something a doctor should be able to do. If I ask for a step-by-step, I should be able to get it.”

ⁱ Gender dysphoria involves distress experienced by some individuals whose gender identity does not correspond with their assigned sex at birth.

ⁱⁱ Forty percent (40%) of transgender respondents to the 2015 U.S. Transgender Survey reported having attempted suicide in their lifetime, nearly nine times the rate in the U.S. population (4.6%). <http://www.ustranssurvey.org/>

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How can youth have more control over their personal health?

LGBTQ youth participants reported that they would feel more respected and more in control of their health if they could communicate directly with providers, rather than having to always go through parents or guardians to get care. They also reported that this would be a much easier process if they were aware of what information they disclosed to their provider in private would be kept confidential.

Students with access to one of the 23 King County School Based Health Centers (SBHC) serving middle and high school students greatly valued the availability and privacy provided. SBHC's are specifically designed to serve youth, which may or may not be true of other healthcare settings. The trust in these organizations suggests that having youth-specific providers where kids are is an effective strategy.

“They’re not only treating what’s wrong with you internally – they care about you all the way.”

Youth who were able to directly schedule appointments with their providers without an adult reported high levels of satisfaction with this service, and many youth who did not have access to an SBHC expressed that they wanted such an option.

“The people at the [SBHC] are more reliable; when they say they’re going to do something, they follow through.”

Students described SBHCs as youth-focused spaces where they can access their providers whenever they need them, offering the opportunity to communicate openly with them on an ongoing basis – a structure that, over time, helps students develop trusting relationships with SBHC providers. Having someone check up on them “in the hallways” and provide resources as needed was particularly valued.

“You could pretty much call them your second parents.”

“You could call them your counselor too.”

Support from family & reliable adults

Youth who have supportive parents and other adults in their lives report that they rely on those adults to help them navigate their interpersonal relationships, manage their emotions, and communicate with providers to get the healthcare they need. LGBTQ youth who do not have a trusted adult to assist them often find themselves with few resources for accessing healthcare. In many cases, youth do not want to share their concerns in front of their parents and often do not feel welcome to talk to providers privately.

What we heard from youth & young adult LGBTQ communities

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“My family isn’t the most supportive; they think I should be referred to as my biological sex instead of what I am now; no easy way to say I just want to talk to my doctor and not have my family’s input.”

Others described circumstances in which they just do not have the support to access healthcare in general.

“ ... I’ve never really had [stability] in anything; it’s been forever since I’ve been to the doctor; it’s not because of healthcare - I can’t go to the doctor unless I have a parent/guardian with me; my family won’t go with me, they put it off until the last minute. ”

Key informants describe lack of family support as a huge interpersonal barrier for many LGBTQ youth, affecting mental health, self-esteem, and their ability to effectively navigate the healthcare system. Because of their child’s identity, some parents are unwilling to parent, some are outright abusive, and others are engaged but do not support gender affirming care. The result is often untreated gender dysphoria, which can be associated with increased suicide attempts, negative school outcomes, sexual violence, and homelessness.

Key informants describe the importance of support and acceptance for children and youth in preventing negative health outcomes, such as youth alcoholism, drug addiction, and destructive sexual activity. One key informant emphasized the value of approaches that focus on promoting the safety of young people and involving families in the support and care of their LGBTQ children. Programs such as The Family Acceptance Project provides tools for providers to work with communities and parents who have kids who are questioning or coming out – specifically with parents who aren’t open because of religious or cultural reasons.

“Making that connection that there are tolerant accepting communities, especially adults in their life, ends up being a huge protective factor – promotes stable mental health and wellbeing.”

What we heard from youth & young adult LGBTQ communities

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Patient-provider communication & relationships

Beyond the common feelings of intimidation that can be associated with visiting a healthcare provider, many LGBTQ youth said they feared doctors would tell them that what they were feeling or doing was wrong, or that providers would “out” them to their parents or to their community.

When asked about barriers to receiving the quality of care they need, youth mentioned aspects of their relationships and communication with providers. LGBTQ youth often avoid care because they have had bad experiences in the past. Negative experiences with providers affect LGBTQ youths’ ability to open up to their providers and can discourage them from seeking healthcare.

“They were misgendering me the whole time... so I just left. [I am] trying to find a new doctor now, but it’s hard. Doctors make it that I don’t want to go to them at all.”

For many, the feeling that they were not taken seriously by their healthcare provider inhibited them from clearly stating their needs. Youth are less likely to ask questions or follow up with providers who do not make them feel acknowledged.

“... you can be talking to the doctor but they don’t talk to you, they talk to your parents. People talk about the patient-doctor relationship and trust. It hinders that because I don’t really interact with the doctor that much. That’s something I feel like I’m missing from the experience that normal people would get.”

Youth reported the only time they were able to speak to the doctor alone was during physical exams. They desire more opportunities to speak privately with their providers, and feel strongly that this needs to be initiated by the provider. When youth are responsible for asking their parents to leave the room, it creates suspicion or concern with their parents.

“They should give the choice to the kid, not to the parent. Don’t ask ‘Do you want to step out?’ They should ask the parent to step out. They should give us a time to feel safe to talk; not just during a body checkup or something that makes you feel uncomfortable.”

When seeing providers they didn’t know very well, youth reported difficulties communicating, especially about their most intimate issues and concerns. Many youth felt that providers did not take the time to develop a trusting relationship before asking sensitive questions. And in the absence of trust, youth were less likely to answer truthfully or to continue seeking care.

What we heard from youth & young adult LGBTQ communities

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“If you’re in a room with the doctor, and they ask parents to step out, the first question they ask is, ‘Are you having sex?’ then they bring your parents back in. They don’t let you talk about other things that are personal to you. Sometimes I have other things I want to tell you, but my parents don’t want to acknowledge or agree.”

Key informants and youth both describe limited time during the visit as a barrier to comprehensive care and relationship building. Even when youth do have trust in their providers, they described feeling frustrated, intimidated, and isolated when providers rushed through their visits, talked above their level of comprehension, or failed to explain the treatment process with them as patients.

“It’s not a lack of trust. I do trust them, it’s just I feel like they want me to do things quickly so they can get it over with. It makes me feel like I’m a waste of space. ‘I have other patients to see’ has been said to me every time I’ve walked into a doctor’s office. I don’t feel like I’m included. I feel decisions are being made for me.”

How can providers help?

Ultimately, making the time to support open communication with youth is essential to developing trusting relationships. A strong message from youth was that they needed to feel safe and develop trusting relationships with their providers before they could feel comfortable talking with them about their physical, mental, and emotional health needs – all of which extend beyond just sexual health.

“My pediatrician helped me come out...to my [parent]. She’s really supportive of everything. Before she asks questions, she says ‘do you feel comfortable if I ask this?’ and it’s really nice.”

“One thing my [provider] does to make me feel safe is asking me about telling my mom. He’ll always give me the option, ‘Do you want your mom to come along?’ or if she’s there [he’ll ask] if she should leave. He always leaves it up to me.”

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Visibility & acknowledgement

As described by youth and key informants, LGBTQ youth often enter clinical settings not knowing what to expect. Will they be respected and listened to? Will someone question their identity? Establishing a safe and supportive clinical environment for youth begins before anyone enters the treatment room. Barriers to care develop when staff fail to use inclusive language, use their preferred name or pronouns, or acknowledge the possibility that patients may be gender non-conforming, non-binary, or transgender.

Insensitive and discriminatory interactions create obstacles that are difficult to overcome. Youth described awkward encounters with providers that left them feeling judged and/or unwelcome.

“It makes the relationship uncomfortable if you come out and they start treating you differently; they start treating you worse, saying your parent is irresponsible, disagreeing with you.”

Listening session participants recounted being misgendered (referred to using a word that does not correctly reflect their gender identity), being told they had to choose a gender, and meeting with providers who refused to use an appropriate name or pronouns. Youth who were addressed by the wrong pronouns said they immediately felt disrespected, and the lack of respect affected the quality of subsequent

interactions with that provider. They felt their providers gave the impression of “not listening,” “not



trying,” or failing to respect them. These experiences discourage individuals from seeking care, putting them at risk for serious long-term health problems.

“Every time my doctor uses the wrong name and pronouns... if it’s an accident and it happens once or twice – yeah, that’s fine, but if they’re not respecting what I need, you can’t trust them; you don’t want to tell them anything. You don’t want their help because they’re not helping you the way you need; it can feed into your dysphoria, make you feel really bad about yourself, and it’s very invalidating.”ⁱⁱⁱ

“Then you’re distracted thinking about all that - you’re not thinking about what care you actually need; you’re thinking ‘this person doesn’t care about me, so why should I care about myself if my doctor isn’t wanting to put in the effort?’”

iii A recent study from the University of Washington demonstrates that transgender children who are supported in their identities show positive mental health.

(Olson KR, Durwood L, McLaughlin KA. Mental Health of Transgender Children Who Are Supported in Their Identities. Pediatrics. 2016;137(3):e20153223)

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LGBTQ youth whose identities are less obvious may be relatively protected from being “outed” or harassed in certain settings, but this subtlety can also place them at risk when providers make assumptions based on appearance and fail to ask the right questions. Navigating how and when to disclose their sexual orientation and/or gender identity can be a stressful and intimidating experience for youth.

“ I feel like I’ve been navigating [healthcare] as a straight guy, or not necessarily disclosing that I’m queer ...with the environment I don’t feel safe to talk about it, so I don’t talk about it. That’s sort of a mental strain on me, like I have the choice to say something about it, but I don’t feel ready to. It puts a lot of mental strain on me. ”

What helps youth feel safe & acknowledged?

When youth were asked what they needed from healthcare services, the topic of non-judgmental safe spaces came up in most discussions. Youth identify LGBTQ-friendly resources and services by public displays of allyship, such as Pride flags, safe-space signage, and queer staff. They describe these displays as helping them feel safe, “more at ease,” and like they can, “...get help here if anything happens.”

Many said that as they were filling out intake paperwork they decided immediately if they felt safe, and if they expected to have a comfortable experience. They felt validated when intake forms allowed them to specify their pronouns, distinguish their sex from their gender, or select a gender other than male or female. And this experience made it easier to engage in open and trusting communication once they entered the treatment room, because they did not immediately feel “othered” and isolated.

“...even the simplest things like when you sign up for an appointment and they have a box for ‘sexuality’ and they have an option...bi or pan or queer, that’s like ‘oh!’; that’s a nice little thing that means so much, because it’s visibility... in terms of healthcare and in terms of what you need.”

Youth find Q Cards^{iv} to be an invaluable tool to communicate their name, pronouns, sexual orientation, and gender identity to providers in advance of their visit, and appreciate when providers update the medical record

^{iv} A small card that youth can fill out with their name, pronouns, sexual orientation, and gender identity, and use to communicate with their provider about privacy, confidentiality, and their healthcare needs (www.qcardproject.com).

What we heard from youth & young adult LGBTQ communities

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accordingly for future visits.

LGBTQ youth seek out environments that openly demonstrate their acceptance and commitment to the LGBTQ community. This can include rainbow flags, signs in public areas citing LGBTQ acceptance/non-discrimination policies, visibly out providers (staff bios, rainbow pins on nametags, etc), all-gender signage on restrooms, and LGBTQ-inclusive intake forms, and pamphlets and other materials featuring LGBTQ people in the office.

**“I feel more safe if I know a facility hires queer people and is vocal about it.
... it’s nice to feel like you’re not the odd one out all the time.”**

Having a queer provider offers many queer youth a sense of ease because they feel accepted just as they are. Some youth imagine that the quality of care from a queer provider would be better because the patient would not carry the burden of educating the provider about who they are and how to provide care that meets their needs.

“A positive thing would be a queer-identified provider; not feeling like my identity would make someone uncomfortable. Sometimes I worry about that even with [cis-gender/heterosexual] friends. That happened when I first came out. That feeling of being scared is always on my mind about being open, especially when you’re talking about your sexual health.”

Navigating healthcare settings

Youth and key informants describe aspects of the healthcare system that create barriers even to basic care, especially for youth who are transitioning. Even patients with health insurance can be prevented from receiving care if they don’t have up-to-date legal documents that accurately reflect their name and gender. Mental health is often used as a gatekeeping mechanism to access care. Many insurance companies require extensive documentation for gender-affirming services, even after they have been deemed medically necessary by a primary care provider.



What we heard from youth & young adult LGBTQ communities

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Young people without access to a trans-competent therapist are often blocked from receiving medical care even if their plan lists it as covered. Insurance companies can also deny coverage for routine preventative care (i.e. pap smears) if the procedure is one not typically associated with the gender listed on their insurance.

Outdated categories in medical forms and records can result in unsafe conditions for youth before they even meet with a provider. Electronic health records often use fixed categories for gender that prevent appropriate documentation, so mistakes in name and gender are perpetuated throughout the chart and are repeated with each new interaction. As a result, the prompts guiding practitioners through patient visits will refer to physical exams and screening questions (about sexual partners and contraception) associated with the gender in the chart.

Provider training

One of the biggest barriers to providers delivering quality care is lack of training. Depending on their area of focus, healthcare providers may have few opportunities to acquire knowledge and skills needed to work effectively with LGB, transgender, and gender non-conforming patients. Key informants expressed a need for more training for medical and mental health providers across the board – especially in pediatrics, family practice, and primary care. Until this kind of training is incorporated into medical school curricula,

finding providers who are experienced in working with LGBTQ youth will be an ongoing challenge^v.

Specialized training in LGBTQ healthcare for providers can be hard to find. Even as more webinars and resources become available through continuing education, practitioners who are very busy may find it challenging to find time to watch webinars or familiarize themselves with additional resources.

Regarding medical education, one key informant physician commented,

“In medical school, we do not learn how to either be comfortable with sexuality or how to talk about sex. We’re taught a script or we’re taught risk factors or very scientific things, but we’re not taught to talk to kids about how people make them feel, or being excited by somebody, or being loved or what that feels like, and I think it’s a taboo in our culture. Because of that, people really avoid talking about it.”

^v Training resources for providers are included in the Assets & Resources section of this report (note: this is not intended to be a comprehensive list of all training resources available for providers).

What we heard from youth & young adult LGBTQ communities

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Provider bias and stereotypes also play a role in the quality of care that LGBTQ youth receive. Key informants describe common misconceptions that can contribute to patients feeling stigmatized and having their healthcare needs overlooked.

“...context matters a lot. For sexual assault survivors, for instance, we’ve seen a couple of young people who’ve experienced sexual assault, but because they were queer... the providers, didn’t necessarily track what had happened.”

“...With bi[sexual] folks especially bi[sexual] women... being read as straight and promiscuous because they identify as bi[sexual] has been a barrier they’ve identified in not wanting to go get tested for certain things.”

How can providers respectfully communicate gaps in their knowledge & validate youth concerns?

Youth want to go where they feel understood, and where their provider not only cares about their health and wellbeing but also has knowledge and expertise specific to a patient’s identity. Providers need to have knowledge of LGBTQ health and what it means to provide culturally appropriate care, so they can either treat appropriately or refer the patient to a more suitable resource.

“... if someone’s knowledgeable, it’s a lot easier to talk to them. Some people don’t even know what ‘bisexual’ means, pansexual, gender fluid... Talking about it would make people more comfortable.”

LGBTQ youth do not want to be in the position of having to educate reluctant providers. They also acknowledged that providers should not be expected to know everything about everything, but said they felt validated when a provider respectfully admitted to gaps in their knowledge and showed interest in learning.

“In all of my experiences with doctors after I’ve come out, a lot of them misgender me the first time, but then they will immediately correct themselves, and even if they keep doing it they keep correcting themselves.”

“[My provider] had basic knowledge of that kind of stuff but was also asking me how she can be more helpful as my doctor, asking ‘hey, are there resources I can look into?’ She knew she may have more trans patients in the future, it was really awesome and validating.”

What we heard from youth & young adult LGBTQ communities

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Youth education

Some common concerns mentioned by youth and key informants relate to the quality of sexual education offered to youth and their education about their own legal rights and how to navigate the healthcare system. Key informants also reported that youth often do not have the socioemotional skills to navigate complex interpersonal relationships, something that can be especially challenging when stigma is associated with those relationships. There is a general lack of education about healthy relationships and role models to talk to about how to engage in different types of relationships, how to be open and honest about being queer, and how to discuss the emotional impacts that relationships can have on mental and physical health. One key informant commented,

“We see young people all the time, queer young folks, who are engaging in high risk sexual behavior, but they haven’t been educated by someone they trust enough to say ‘I need access to condoms’, or ‘is there a type of lubricant that’s going to be better for my health’, or getting access to contraceptives.”



LGBTQ youth and young adults have numerous questions about their health and their bodies, and many of these questions go unanswered. Key informants attribute some of the specific health concerns among LGBTQ youth to the paucity of accurate health information provided to young people in schools. Lack of education about LGBTQ sexual health and safe sex practices contributes to disparities in rates of HIV and other sexually transmitted infections, as well as to unintended pregnancies among queer, bisexual, and lesbian young women.

Youth confirmed that sexual education courses in school did not prepare them for the relationships they were actually having.

What we heard from youth & young adult LGBTQ communities

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If trans people were brought up, it wasn't in relation to hormones or what to do if you think you're trans, it was 'you should accept people and use the right pronouns' which is helpful, but doesn't help trans people get the help they need, at all! It's a health class, having some basic resources would be really helpful and it just feels like we're not ever getting those."

"[Sex education in school] is not targeted toward helping LGBT people as much as toward helping people who aren't LGB in term of 'acceptance' and stuff. We had something about relationships where they used two women's names and it was like 'nice job, but can you tell us how to protect ourselves?'"

In the absence of help from their schools, youth learned from their peers and sometimes felt safe seeking answers to their questions and "trying on" new identities through online communities.

Many LGBTQ youth are not "out" to their parents or social networks, and face barriers when they're unsure about issues related to insurance coverage and confidentiality. Transgender youth face unique challenges related to knowing how and when to disclose their gender, what their options are for gender affirming care, and navigating laws, confidentiality, and parental permission.

Overlapping societal stressors

Key informants raised concerns related to intersecting oppressions and key contributors to many of the health inequities experienced by LGBTQ youth and young adults. Many of the described associations are illustrated with population-level data in the next section of the report. Some specific challenges described by key informants include:

- Inequities associated with race, income, and language are exaggerated among LGBTQ youth.
- Queer youth and gender non-conforming youth often move to King County to leave violence and discrimination in rural areas.
- Queer youth are more likely to experience alcoholism, substance abuse, and mental illness – likely in response to stigma and rejection they face in society, and sometimes, in their own families.
- There is a growing population of immigrant and refugee LGBTQ young adults, many of whom are ostracized in their cultures. Some still reside in their cultural communities, but they are unable to access needed services.

What we heard from youth & young adult LGBTQ communities

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LGBTQ youth experiencing homelessness were also identified as a severely burdened and vulnerable population.

“For homeless youth, their first need and ask is housing support; they were kicked out by families, or are in process of trying to come out and know that that will be a consequence; that takes priority for a lot of LGBTQ youth – finding housing or navigating homelessness.”

Key informants described the unique barriers and inequities among these youth:

- LGBTQ youth disproportionately experience homelessness/poverty, and face challenges accessing care or are simply unable to prioritize care when faced with the daily struggles associated with homelessness and housing instability.
- Getting access to safe and affordable hormone therapies is difficult for transgender youth experiencing homelessness. While many can access medication through non-traditional sources (without a prescription or medical supervision), these medications are not always prepared safely, dosed appropriately, or administered correctly.
- Unsheltered youth generally express very low trust in systems, possibly because their experiences with systems are usually tied to incarceration and discipline in schools.

Key informants described a developmental process in which many LGBTQ youth are exposed to traumatic and stigmatizing experiences early in adolescence, and face a new set of interpersonal and societal pressures. Even typical developmental challenges are compounded for LGBTQ youth who have additional conditions or identities that might set them apart as “other” (i.e. race, culture, country of origin, language, poverty, disability, mental illness, drug abuse, etc.). Having to manage these influences without a reliable source of support or information can be devastating, and can have lasting effects on self-esteem and mental health.

Youth who have the tools and supports needed to seek services and navigate the healthcare system are often met with systems that are poorly equipped to meet their needs. Many providers lack the knowledge and skills required to appropriately tailor care for their patients who are LGBTQ. Participants shared examples of solutions to remedy this mismatch of needs and skills. In addition to meaningful integration of physical and mental health services – a big success in School-Based Health Centers – small changes in practice and policy can go a long way to increase trust and, ultimately, improve the quality of life for LGBTQ youth and young adults.



What we learned from surveys



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What we learned from surveys

Listening session participants and key informants told us about the challenges they faced when seeking healthcare, and the scientific literature corroborates their stories.

Sexual and gender minorities often confront barriers in accessing healthcare and experience worse health outcomes when care is inadequate or delayed.²⁰ Several factors – including discrimination, workplace inequality, and stigma – impact the health and quality of healthcare received by individuals who identify as LGBTQ.²¹ Many studies have found that they are more likely than heterosexual individuals to rate their health as poor, and experience higher rates of disabilities and preventable chronic diseases,²⁰ as well as issues with substance use and mental health.²²

Survey data enable us to explore not only the adequacy and timeliness of healthcare, but also other concerns that came up in the listening sessions and interviews. Because the survey measures do not fit into neat categories of “health risk factors” and “health outcomes,” we have loosely grouped the indicators as follows:

- **POTENTIAL STRESSORS:** includes limited access to care, concerns about interpersonal safety, bullying, and lack of adult emotional support.

- **SUBSTANCE USE & HEALTH-RELATED BEHAVIORS:** includes the use of substances such as tobacco, alcohol, and marijuana; obesity, and lack of physical activity.
- **HEALTH OUTCOMES:** includes measures of mental and physical health.

We acknowledge that these groupings are somewhat arbitrary and realize that, depending on the context, any of them could be construed as health risk factors and/or health outcomes.

DATA SOURCES: THREE SURVEYS

To elaborate on the stories we heard from young people who identify as LGBTQ, we examined data from three regional surveys – one administered to students attending public middle and high schools, one administered by phone to adults living in the community, and the third an in-person survey of individuals experiencing homelessness in King County. Although none of these surveys follow the same individuals from their teens to adulthood, patterns in these cross-sectional data can help us identify periods in development when support and/or intervention may be especially important to members of the LGBTQ community.

What we learned from surveys

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We looked at survey data on the following populations:

1. 8th, 10th, and 12th grade public school students who participated in the 2016 **Healthy Youth Survey (HYS)**.²³
2. Adults 18 years and older from the **Washington State Behavioral Risk Factor Surveillance System (BRFSS)**.²⁴ Adult estimates from BRFSS are usually based on 3- to 5-year averages, with the most recent data from 2015.
3. Sheltered and unsheltered homeless individuals – youth and adults – interviewed by peers and service providers in the weeks following the general “[Count Us In](#)” street and sheltered count of King County’s homeless population in January, 2018.²⁵

For the 2016 **HYS**, students answered the question, “Which of the following describes you? a) heterosexual, b) gay or lesbian, c) bisexual, d) not sure.” Students who selected options b and c were combined into a single LGB (lesbian, gay, bisexual) response. Response options on the **BRFSS** for adults were similarly restricted – to a) heterosexual or straight; b) homosexual, gay or lesbian; c) bisexual; or d) other (responses of “don’t know/not sure” and “refused” were also possible). Respondents who selected options b and c were combined into a single LGB (lesbian, gay, bisexual) response. Because additional options were not available to respondents

i The HYS and BRFSS surveys from these years captured data on lesbian, gay, and bisexual respondents but did not capture information on gender beyond male and female.

of either survey, data reported from these surveys are limited to LGB, heterosexual, and occasionally “not sure” groups. The **Count Us In** survey allowed a broader range of sexual orientation categories (straight, queer, bisexual, pansexual, lesbian or gay, I don’t know/questioning, refused, and other), which were ultimately reported as “straight” or “LGBTQ+.”

According to 2016 HYS estimates, more than 1 in 10 (11.3%) King County public school 8th, 10th, and 12th grade students identify as LGB. Another 7% selected ‘not sure’ as their sexual orientation.

The ‘not sure’ group is of interest, not only because adolescents are often still in the process of determining their sexual orientation, but also because, according to our interview and listening-session participants, many young people prefer queer, pansexual, or other terms to the standard categories of sexual orientation. Since the HYS did not offer these alternative terms as options, youth who did not identify as heterosexual, lesbian, gay, or bisexual may have chosen the ‘not sure’ category.

The proportion of students reporting ‘not sure’ decreased as grade level increased – from 10% among 8th graders to 5% of 12th graders. For many of the health-risk and health-outcome indicators that we reviewed, students who were ‘not sure’ of their sexual orientation differed from heterosexual students almost as much as did LGB students.

What we learned from surveys

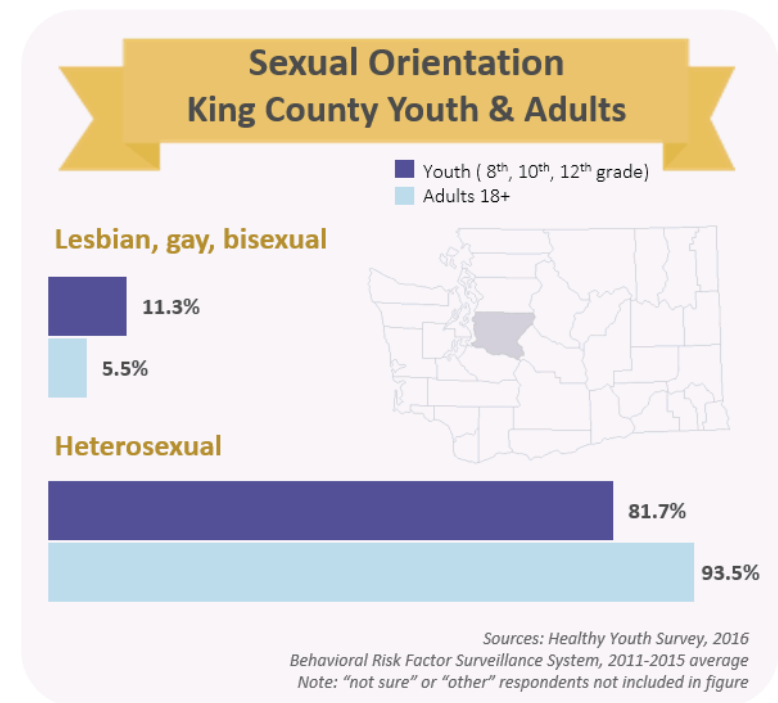
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For adults 18 years and older, estimates averaging BRFSS results from 2011-2015 showed that **5.5% of King County adults and (4% of Washington State adults) identified as LGB.**²⁴ In 2016, an estimated 3% of U.S. adults identified as LGB.²

Of all respondents to **Count Us In's** sexual orientation question, **18% were LGBTQ+**, but among **unaccompanied youth and young adults younger than 25, the percentage rose to 33%, compared to 16% of the other respondents.**

The charts that follow show overall average rates for King County, as well as comparisons between LGB and heterosexual/straight respondents (see Appendix B for technical notes). Comparisons between groups are meant to highlight inequities by sexual orientation where they exist, and not to imply that heterosexuality is the norm or a standard to which others should be compared.

We selected health-risk-factor and health-outcome indicators that would help us understand some of the themes identified during the listening sessions and key-informant interviews. All differences discussed below are statistically significant. Please visit the [Community Health Indicators](#) web page to see additional analyses by sexual orientation.



What we learned from surveys

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POTENTIAL STRESSORS

Limited access to care

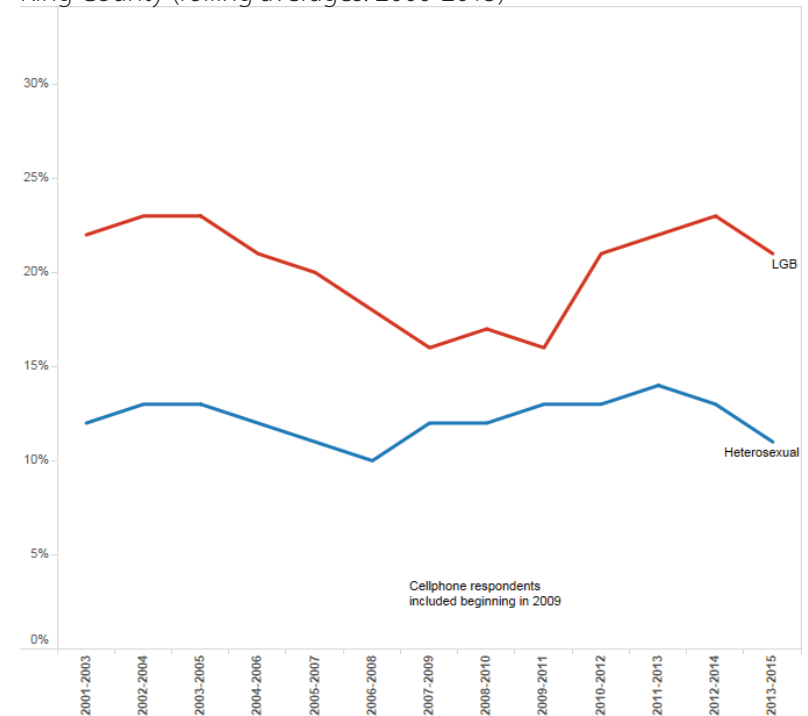
In the previous section, community members described barriers to accessing care that aren't easily captured in a survey – things like outdated intake forms, fear of being judged or “outed” to parents, uncertainty about confidentiality standards, stereotypes and bias, and inadequate provider or staff training.

At the same time that these barriers persist, **implementation of the Affordable Care Act (ACA) has undeniably increased health insurance coverage and improved access to care for LGB individuals.** Lack of health insurance has dropped dramatically among LGB adults nationwide – from 19% uninsured in 2013 to 10% in 2016.²⁶ In addition, a specific provision of the ACA banned insurance companies from discriminating on the basis of gender, including gender identity.

Nevertheless, costs differentially prevented LGB adults in King County from seeking needed medical care during ACA implementation. Although [unmet healthcare needs due to costs](#) were lower in 2015 (the year after implementation of the ACA) than in 2013, data averaged over the transition period showed **21% of LGB adults reporting that they needed to see a doctor in the past 12 months but could not, due to cost – almost 2 times the rate for heterosexual adults (11%)** – a gap that has not diminished since 2011. This finding is supported by data showing that LGB adults were less likely than heterosexual adults to have a usual primary care provider and that, for dental care, LGB adults, LGB youth, and ‘not sure’ youth were less likely than their heterosexual counterparts to have had a dental check-up within the past 12 months (data not shown here; see [Community Health Indicators](#)).

Unmet healthcare needs due to cost by sexual orientation (adults)

King County (rolling averages: 2000-2015)



Source: Behavioral Risk Factor Surveillance Survey

What we learned from surveys

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Concerns about interpersonal safety

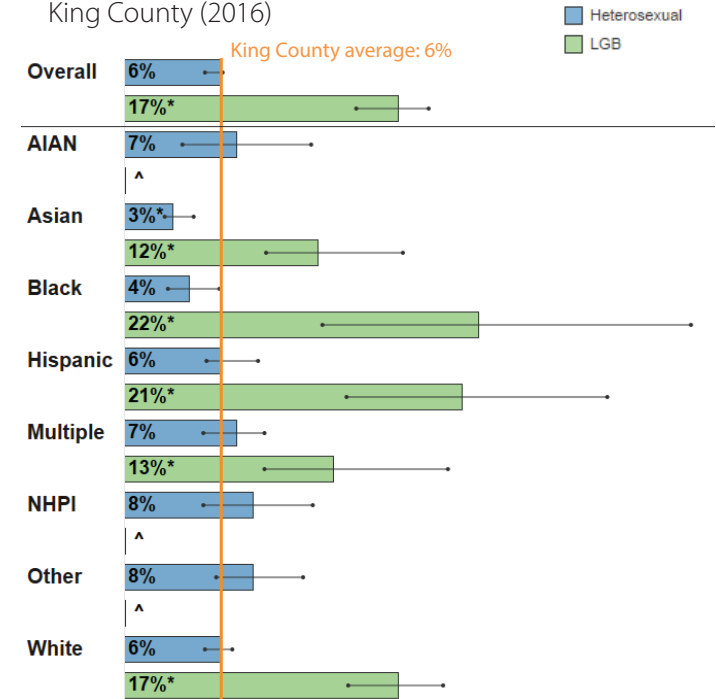
Youth and key informants highlighted the importance of feeling safe – both in the clinical environment and in their relationships with adults. 2016 findings from the Healthy Youth Survey provide more detail about LGB students' safety concerns. (See [Community Health Indicators](#) for data not shown here.)

- More than 1 in 5 (21%) school-age LGB youth reported [feeling unsafe at school](#) – higher than the 12% reported by heterosexual youth.
- 17% of LGB youth also reported [feeling unsafe with or threatened by someone they were dating](#) – nearly 3 times the 6% average for heterosexual youth (in Community Health Indicators, see “intimate partner violence”).ⁱⁱ

ⁱⁱ The survey question asked if, within the past 12 months, the respondents had dated or gone out with someone who had limited their activities, threatened them, or made them feel unsafe in any other way.

Feeling unsafe on dates by sexual orientation & race/ethnicity (8th, 10th, 12th grades)

King County (2016)



Source: Healthy Youth Survey

^ = Data suppressed if too few cases to protect confidentiality and/or report reliable rates

* = Significantly different from King County average

What we learned from surveys

Continued

- When asked if they “ever had an [adult physically hurt them on purpose](#),” LGB youth were twice as likely (37%) as their heterosexual counterparts (18%) to report being physically abused; students who were ‘not sure’ (23%) also differed significantly from heterosexual students.
- Carrying a weapon to school may also reflect a student’s feelings of vulnerability. Compared to their heterosexual counterparts, LGB students were more than twice as likely to have [carried a weapon to school in the past 30 days \(10% vs. 4%\)](#); students who were ‘not sure’ (7%) differed significantly from both groups.

Homeless LGBTQ+ respondents to the 2018 Count-Us-In survey also revealed high vulnerability to personal safety violations: 55% of homeless individuals who identified as LGBTQ+ reported a history of domestic violence or partner abuse, compared to 36% of all respondents. In addition, 71% of LGBTQ+ survey respondents’ first experienced homelessness as children or young adults, compared to 42% of heterosexual respondents.

What we learned from surveys

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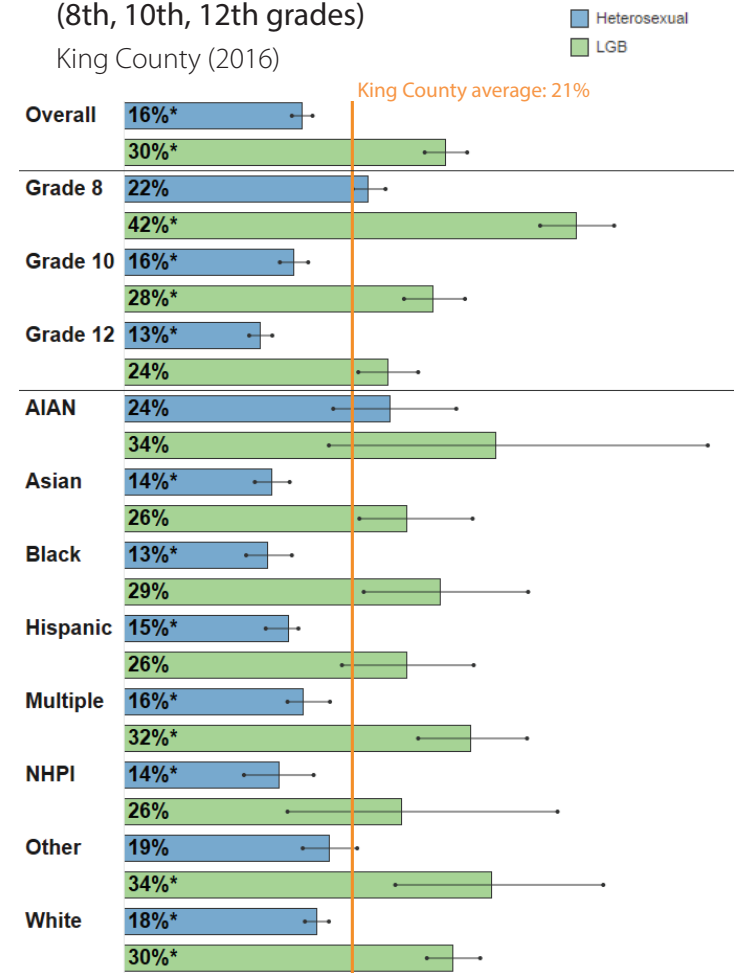
Bullying

LGB youth are especially vulnerable to social and psychological stressors, including those associated with stigma, bullying, and discrimination based on sexual orientation and gender identity. **In 2016, 30% of King County 8th, 10th, and 12th graders who identified as LGB reported that they were bullied at school compared to 16% of those who identified as heterosexual.** Despite reductions in sample size, statistically significant differences in bullying were observed within most race/ethnicity groups. Although the likelihood of bullying was lower in 12th grade than in 8th grade for both groups, differences by sexual orientation persisted at all 3 grade levels.

Bullied at school by sexual orientation, grade, & race/ethnicity

(8th, 10th, 12th grades)

King County (2016)



Source: Healthy Youth Survey

* = Significantly different from King County average

What we learned from surveys

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Lack of adult emotional support

As we learned from interviews with youth, having strong and stable relationships with family and reliable adults was key to their feeling safe and supported. Family, friend, and community support are known contributors to mental health and self-esteem – especially among LGB youth.^{27,28} **Youth survey**

results showed that LGB students were less likely (69%) than heterosexual students (78%) to report that there were adults in their neighborhood or community with whom they could talk about something important; students who were ‘not sure’ (73%) about their sexual orientation were also less likely than heterosexual students to have nearby adults they could talk to.

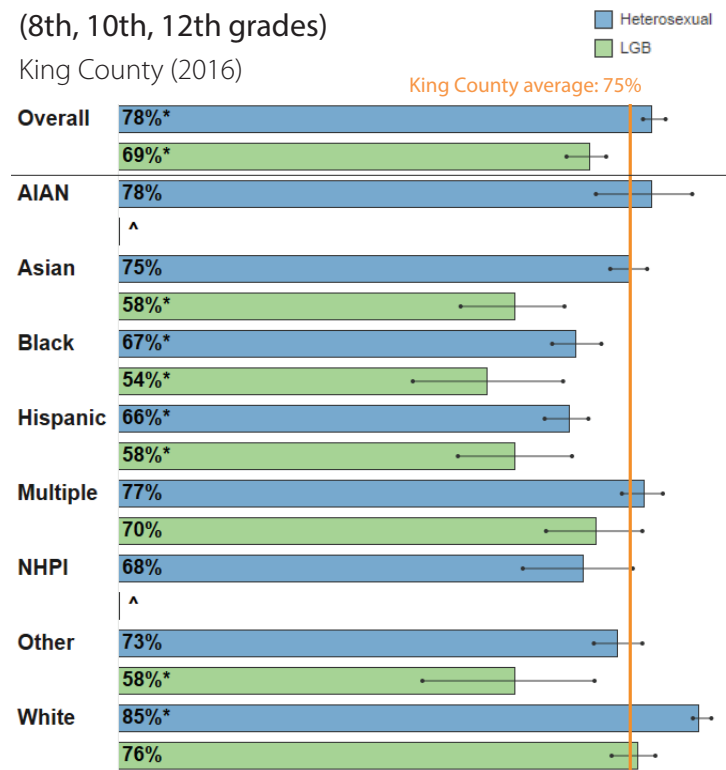
- Among LGB youth, Black (54%), Asian (58%), and Hispanic (58%) students were less likely than white students (76%) to report having an adult connection.
- Regardless of sexual orientation, students living in South Region (69%) were less likely than students of other regions to report an adult connection. Among LGB students in South Region only 60% had an adult in their community they could talk to (data not shown).

Among adults, reported levels of social support did not differ between those who identified as LGB and those who identified as heterosexual.

Adolescents with an adult they can talk with by sexual orientation & race/ethnicity

(8th, 10th, 12th grades)

King County (2016)



Source: Healthy Youth Survey

[^] = Data suppressed if too few cases to protect confidentiality and/or report reliable rates

* = Significantly different from King County average

What we learned from surveys

Continued

SUBSTANCE USE & HEALTH-RELATED BEHAVIORS

In both prospective and longitudinal studies, stress has been associated with initiation and escalation of substance use in adolescents.^{29,30} Experiences of stressors such as harassment, violence, and family rejection can place LGBTQ youth and adults at increased risk for substance use.^{31–33}

Cigarette smoking

National data show that nearly 90% of adult smokers started smoking before they turned 18.³⁴ **In 2016, 13% of King County 8th, 10th, and 12th graders who identified as LGB reported they had [smoked cigarettes in the last month](#), more than 3 times the 4% smoking rate among heterosexual students.**

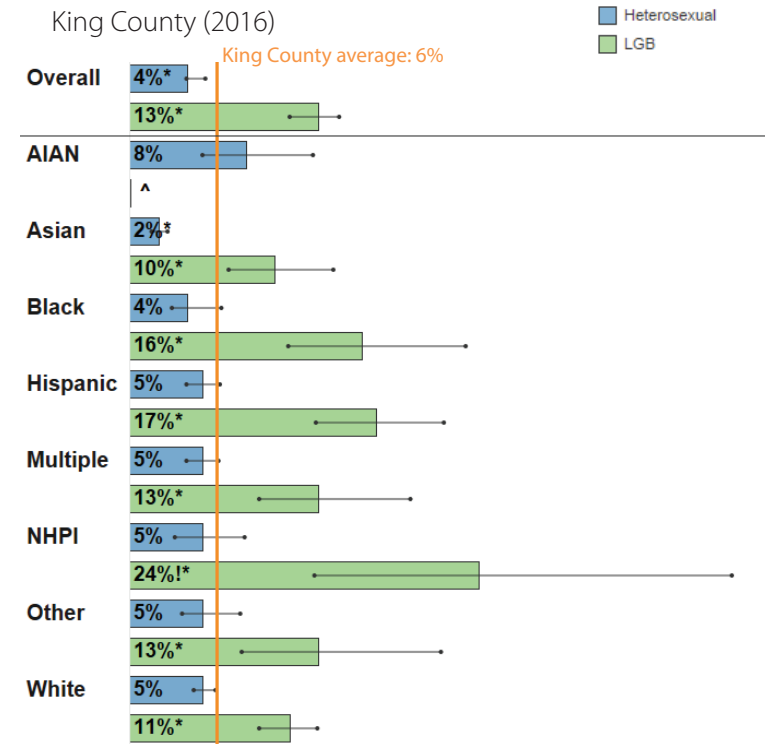
As with bullying, statistically significant differences persisted across almost all race/ethnicity groups.

1 in 4 LGB adults (25%) in King County was a [current cigarette smoker](#), almost double the 13% rate for heterosexual adults. Although high income (>\$75,000 per year) was generally associated with lower smoking rates, high-income LGB adults (14%) were still more than twice as likely as high-income heterosexual adults (6%) to be current smokers. Low income (<\$15,000 per year) showed a strong relationship to smoking for LGB and heterosexual adults, with 47% of LGB adults and 30% of heterosexual adults reporting that they were smokers.

Cigarette smoking by sexual orientation & race/ethnicity

(8th, 10th, 12th grades)

King County (2016)



Source: Healthy Youth Survey

^ = Data suppressed if too few cases to protect confidentiality and/or report reliable rates

* = Significantly different from King County average

What we learned from surveys

Continued

Binge drinking

Among school-age LGB youth, 17% reported [binge drinking](#) (5 or more alcoholic drinks in a row in the past 14 days), compared to 10% of heterosexual students. Binge drinking was especially high among:

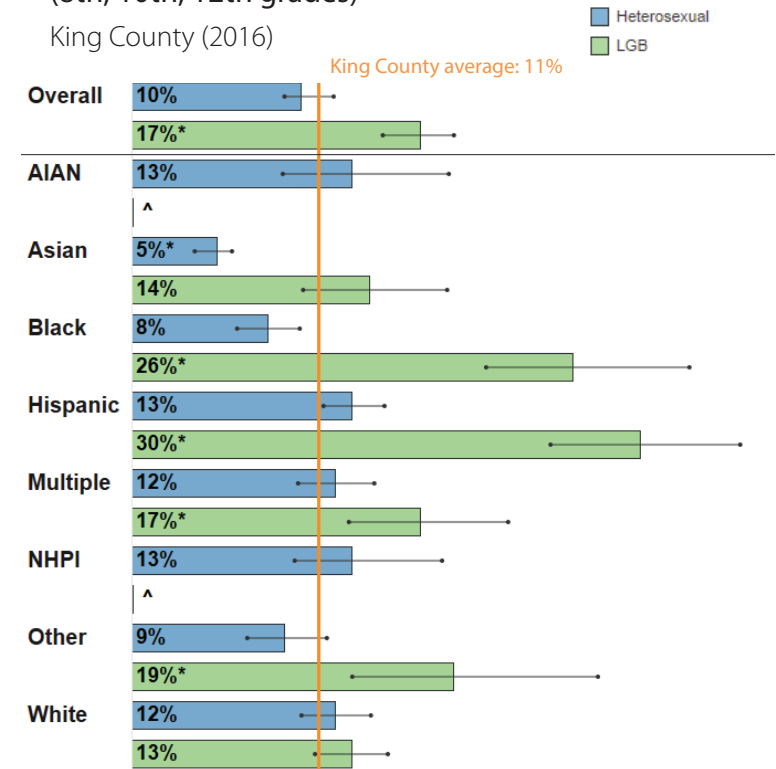
- Male LGB students (22%) vs. 10% among male heterosexual students (data not shown)
- Black LGB students (26%) vs. 8% among Black heterosexual students
- Hispanic LGB students (30%) vs. 13% among Hispanic heterosexual students

Among LGB adults, the rate of [binge drinking](#) (consuming, on one occasion, 5 or more drinks for men or 4 or more drinks for women) was 28%, compared to 19% for heterosexual adults. The rate for LGB adults ages 18-24 was 38%.

Binge drinking by sexual orientation & race/ethnicity

(8th, 10th, 12th grades)

King County (2016)



Source: Healthy Youth Survey

^ = Data suppressed if too few cases to protect confidentiality and/or report reliable rates

* = Significantly different from King County average

What we learned from surveys

Continued

Marijuana use

Among 8th, 10th, and 12th graders who identified as LGB, 25% reported [using marijuana](#) in the past 30 days, compared to 15% who identified as heterosexual. Marijuana use among students who identified as 'not sure' was lower than the county average (11%), possibly because students who expressed uncertainty about their sexual orientation were more likely to be at lower grade levels and were less likely to have used marijuana. LGB youth were more likely than heterosexual youth to use marijuana in most race/ethnicity groups.

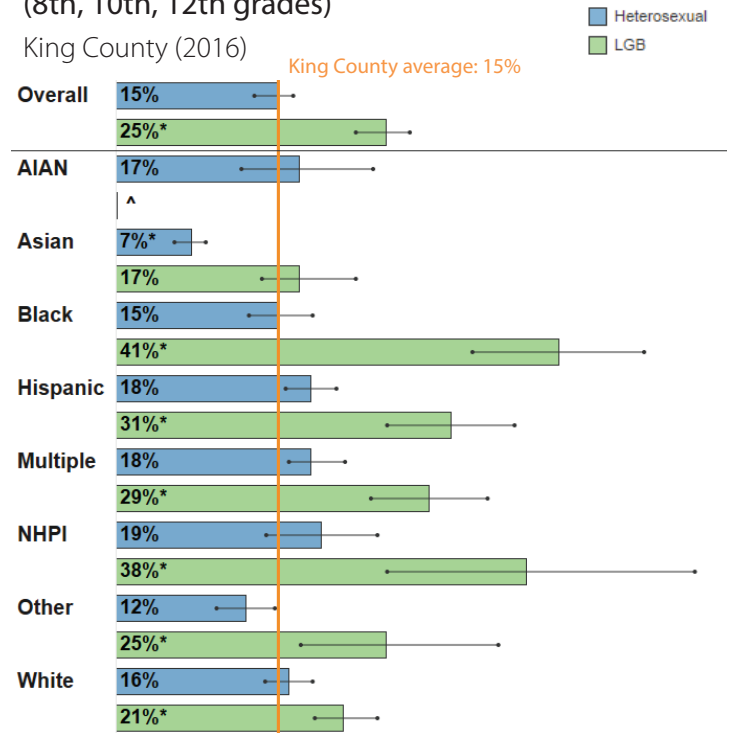
On average, 32% of LGB adults in King County reported [using marijuana](#) in the past 30 days – almost 3 times the 11% rate reported by heterosexual adults.

- This rate was highest (43%) among LGB adults ages 18-24.
- 53% of LGB adults earning less than \$15,000 per year reported using marijuana.

Marijuana use by sexual orientation & race/ethnicity

(8th, 10th, 12th grades)

King County (2016)



Source: Healthy Youth Survey

^ = Data suppressed if too few cases to protect confidentiality and/or report reliable rates

* = Significantly different from King County average

What we learned from surveys

Continued

Obesity & lack of physical activity

Obesity and limited physical activity are risk factors for several chronic diseases; they can also be markers of stress. Just as some people turn to tobacco, alcohol, and other drugs to relieve stress or cope with uncomfortable emotions, others turn to food.^{35,36} Although physical activity generally mitigates the effects of stress, the experience of stress makes it more difficult to be physically active.³⁷

14% of King County 8th, 10th, and 12th graders who identified as LGB in 2016 were obese, compared to 8% of heterosexual students.

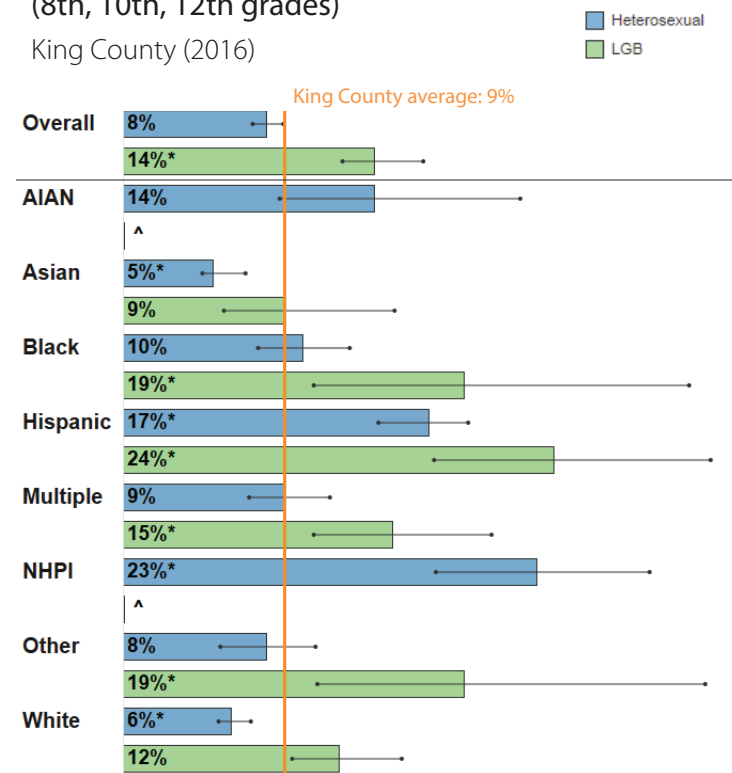
Regional disparities were compounded among LGB students: In South Region, which at 13% had the county's highest rate of youth obesity, 22% of LGB students were obese (data not shown). **The overall pattern is similar for physical activity, where 88% of LGB youth did not meet [physical activity](#) guidelines, compared to 77% of heterosexual respondents** (data not shown).

As with social support, rates of obesity and physical activity did not differ between LGB and heterosexual adults.

Obesity by sexual orientation & race/ethnicity

(8th, 10th, 12th grades)

King County (2016)



Source: Healthy Youth Survey

^ = Data suppressed if too few cases to protect confidentiality and/or report reliable rates

* = Significantly different from King County average

What we learned from surveys

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HEALTH OUTCOMES

Mental health outcomes for youth: depressive feelings

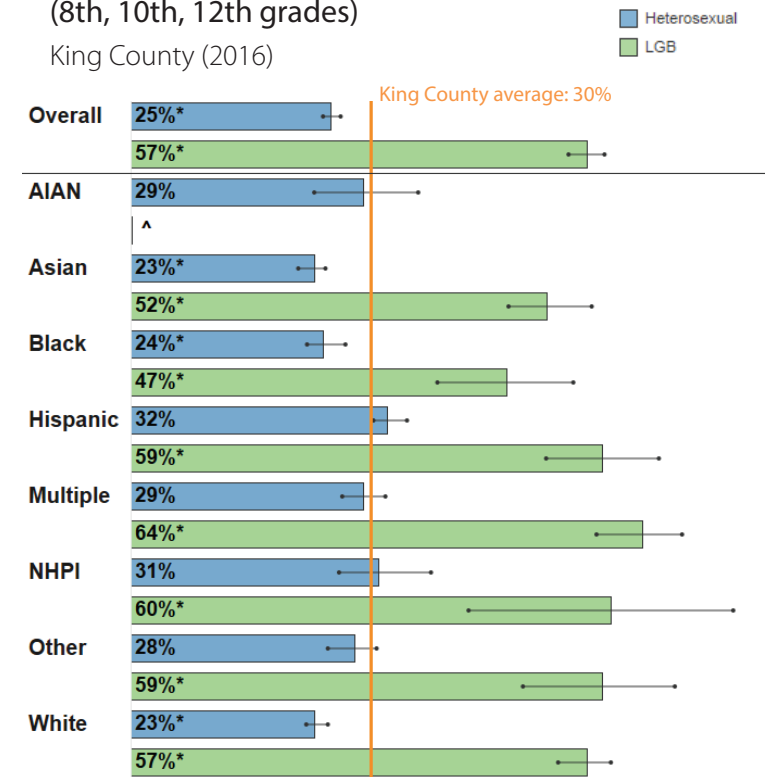
LGB youth are especially vulnerable to social and psychological stressors, including those associated with stigma, bullying, and discrimination based on sexual orientation and gender identity. **In King County, more than half (57%) of LGB students in 8th, 10th, and 12th grade reported depressive feelings,ⁱⁱⁱ compared to 1 in 4 (25%) heterosexual teens** – more than a 2-fold difference; 38% of teens who were ‘not sure’ of their sexual orientation reported feeling depressed. Statistically significant differences between LGB and heterosexual youth were preserved across all race/ethnicity groups for which comparative data were available.

ⁱⁱⁱ “Depressive feelings” is defined as having felt so sad or hopeless that they stopped doing some of their usual activities almost every day for 2 or more consecutive weeks during the past year.

Depression by sexual orientation & race/ethnicity

(8th, 10th, 12th grades)

King County (2016)



Source: Healthy Youth Survey

^ = Data suppressed if too few cases to protect confidentiality and/or report reliable rates

* = Significantly different from King County average

What we learned from surveys

Continued

Mental health outcomes for adults: two kinds of mental distress

In general, LGBTQ adults are almost 3 times more likely than others to experience a mental health condition such as major depression or generalized anxiety disorder.³⁸ 8% of King County adults who identified as LGB reported [serious psychological distress](#).^{iv} Among adults who identified as heterosexual, the rate was 3% – more than a 2.5-fold difference. This difference was amplified among young LGB adults (18-24 years), 12% of whom reported serious psychological distress. While the overall rate of serious psychological distress in King County has been stable for several years, the rate among LGB adults tripled between 2009 and 2015.

Even in the absence of serious psychological distress, many LGB adults experience poor mental health. [Frequent mental distress](#)^v was reported by 19% of LGB adults – nearly twice the average for heterosexual adults (10%). At 27%, the rate was higher among the youngest LGB adults (18-24 years).

On both adult mental health measures, adults at the lowest income level (<\$15,000 per year) did not differ by sexual orientation: LGB and heterosexual rates were equal at 15% for serious psychological distress and

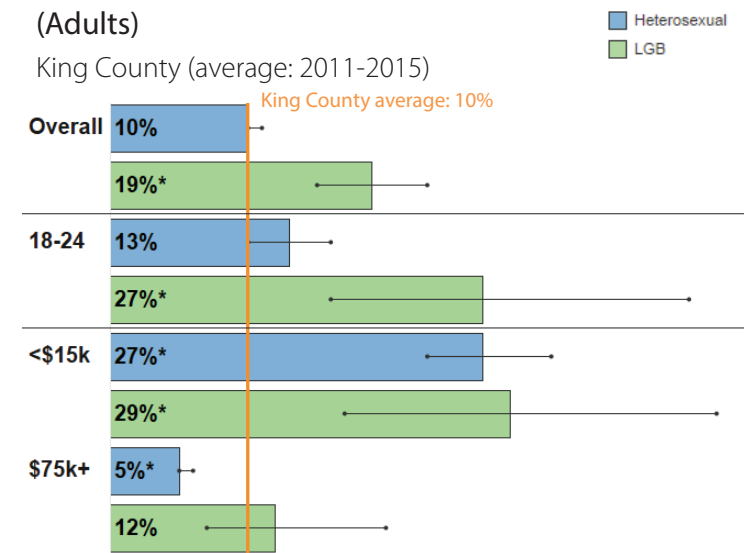
^{iv} Serious psychological distress is defined by the frequency, over the past 30 days, of feeling nervous, hopeless, restless, worthless, that everything was an effort, and so depressed that nothing could cheer them up.
^v Frequent mental distress is defined as having had 14 or more days of poor mental health in the past 30 days.

overlapping at 29% and 27%, respectively, for frequent mental distress. High income (>\$75,000 per year) was associated with lower levels of distress on both measures, but only for heterosexual adults (data for serious psychological distress not shown).

Frequent mental distress by sexual orientation, age, & income

(Adults)

King County (average: 2011-2015)



Source: Behavioral Risk Factor Surveillance Survey

* = Significantly different from King County average

What we learned from surveys

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Other health outcomes

While LGB adults from King County did not differ significantly from heterosexual adults in ratings of their health as “poor or fair,” they did report more days of “poor physical or mental health” in the past month (3 days vs. 2 days) and higher rates of [disability](#)^{vi} (30% vs. 24%) and “[activity limitation](#)” due to physical, mental, or emotional problems (28% vs. 22%). LGB adults in King County were more likely (14%) than heterosexual adults (9%) to report an [asthma diagnosis](#), although self-reported rates of [diabetes](#), [stroke](#), and [heart disease](#) did not differ by sexual orientation.



^{vi} Disability is defined as a limiting physical, mental, or emotional condition.

What we learned from surveys

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CONCLUSION

In both listening sessions and interviews we heard about safety concerns of LGBTQ youth and young adults. Offering more detail about plausible sources of these concerns, survey data showed that LGB youth were consistently more likely than heterosexual youth to report feeling unsafe at school, feeling unsafe on dates, being bullied, having been physically abused by adults, and lacking emotional support from adults. LGB youth were also more likely than heterosexual youth to have carried a weapon to school, which may be associated with the high level of personal safety violations that LGB youth face. We also learned that those who identified as LGBTQ+ were disproportionately represented among the King County homeless population, that more than half of the homeless LGBTQ+ population reported histories of domestic violence or partner abuse, and 7 out of 10 of the homeless LGBTQ+ population first experienced homelessness in childhood or before age 25.

The compounding effects of multiple oppressions

For many indicators, the relationship between LGB identification and exposure to potentially traumatizing experiences persisted across analytic breakdowns – typically racial/ethnic groups. For some indicators, belonging to another subgroup appeared to further magnify the risk of negative outcomes among LGB populations. For example, LGB youth were significantly

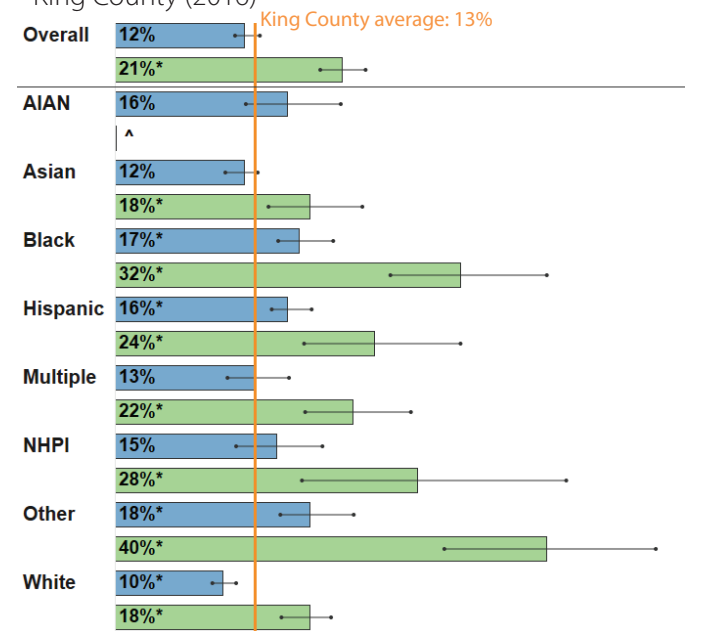
more likely than heterosexual youth to report feeling unsafe at school, but Black LGB youth and LGB youth who identified their race/ethnicity as “other” reported even higher rates of feeling unsafe at school. We saw evidence of similar compounding of risks among:

- Asian, Black, Hispanic, “other” race/ethnicity, and South Region LGB youth for **not having an adult to talk**.
- South Region LGB youth for **obesity**.
- Black and Hispanic LGB youth for **binge drinking**.
- Black LGB youth for **marijuana use**.

Not feeling safe at school by sexual orientation & race/ethnicity

(8th, 10th, 12th grades)

King County (2016)



Source: Healthy Youth Survey

^ = Data suppressed if too few cases to protect confidentiality and/or report reliable rates

* = Significantly different from King County average

What we learned from surveys

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Continuities between youth & adult data

Patterns observed in teens and young adults can impact unhealthy behaviors – and illnesses – later in life. Some of the health-related behaviors more common among LGB youth and young adults are also potentially addictive and can be difficult to change in adulthood.

For example, excessive alcohol consumption increases the risks for unintentional injuries, violence, risky sexual behaviors, and chronic diseases.^{39,40} Among youth, these risks are accompanied by a higher risk of dependence.⁴¹ Like tobacco and alcohol, marijuana can be addictive and can affect brain development – from the prenatal period through early adulthood (about age 25).^{42,43} In our survey analyses, the disparities by sexual orientation reported for youth were mirrored in adult data on the same behaviors. We also saw similar patterns of disparities by sexual orientation for youth and adult mental health indicators. Mental distress and substance use often coexist in an unhealthy symbiosis, however, it's difficult to establish cause and effect.

Discontinuities between youth & adult data

There were some indicators – obesity, inadequate physical activity, and lack of social support – for which we found significant differences between LGB and heterosexual youth, but no corresponding differences among adults. It is unknown whether

some of these observed disparities by sexual orientation narrow in adulthood because King County LGB youth actually achieve better health as they get older, or if heterosexual adults become equally obese, sedentary, and socially isolated. For some adult indicators (both kinds of mental distress, binge drinking, and marijuana use), some of the highest rates were for adults younger than 25 – an age-related risk profile widely used by insurance actuaries. While most LGB youth successfully navigate this transition period to become healthy and productive adults,³² others experience high rates of substance use, mental illness and disability, or chronic disease (although we found little evidence for added chronic disease risk in King County, we do not have sexual orientation data for cancer diagnoses, causes of hospitalization, or causes of death). While, our knowledge is far from complete, we know enough to understand the importance of integrating physical and mental healthcare services, and of raising awareness among the parents, teachers, healthcare providers, and other adults whose support can help ease LGB youths' passage to adulthood.

Assets & resources



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Assets & resources

RESOURCE GUIDES

Extensive, searchable databases of resources available to King County's LGBTQ community have been prepared by the Coalition Ending Gender-Based Violence and Gay City.

[2017 King County Trans Resource & Referral Guide](#)

A comprehensive guide of medical providers, mental health providers, housing resources, community support groups, and other local resources for the Seattle area's transgender and gender diverse communities. Searchable by many areas of focus (Disability Support, POC, LGBTQ, Spanish-Speaking Staff, etc). Available in English and Spanish.

[Gay City: Seattle's LGBTQ Center](#)

Community center with arts programs, youth programs, an STD testing center, and resource navigators for the LGBTQ community. Website offers a comprehensive guide to local resources for LGBTQ people in the Seattle area.

For youth

A more complete list of local organizations for LGBTQ youth can be found through both of the guides above. The organizations listed below were specifically named by LGBTQ youth during listening sessions as

places they found safe and supportive.

[Gender Odyssey](#)

An international conference focused on the needs and interests of transgender and gender diverse children of all ages, their families and supporters, and the professionals who serve them. Offers panels and discussion on topics ranging from social support, emotional health, and medical transition. The conference has multiple tracks including programs for Youth and Young Adults, Families, and Providers.

[Lambert House](#)

A safe community space for LGBTQ youth ages 22 and under. Provides support groups, meals, a computer lab, and activities throughout the year.

[NW Network](#)

Provides LGBTQ-specific advocacy and safety planning support youth and young adults who have experienced or are at risk for any kind of victimization or harm. Teaches classes on healthy relationships for queer and transgender youth and facilitates LGBTQ groups in schools and other settings in the community.

[Planned Parenthood](#)

Provides reproductive health services, general healthcare, and health information to the community regardless of insurance. Bellingham location provides hormone services for transgender patients.

Assets & resources

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[Seattle Children's Hospital Gender Clinic](#)

A multidisciplinary clinic that cares for children, adolescents, and young adults up to age 21 who are transgender or gender non-conforming.

For providers

[2017 King County Trans Resource & Referral Guide](#)

In addition to cataloging resources for members of the transgender and gender diverse community, the guide also includes numerous resources for providers seeking additional training and support on working with these communities.

[Therapists and Physicians Consult Group at Ingersoll Gender Center](#)

A bi-monthly meeting for medical and mental health providers who work with trans, genderqueer, and gender variant clients and their families to network, consult, share resources and learn from one another.

[Gender Diversity](#)

Works with K-12 schools to create gender-inclusive learning environments; offers referrals for additional resources; and provides education about transgender and gender diversity issues to organizations, professionals, and service providers.

[Gender Odyssey](#)

Multi-day conference on transgender and gender-diverse that includes a Professional Track with continuing medical education (CME) credits for

providers who work with these communities.

[National LGBT Health Education Center – Continuing Education](#)

Provider education program run through The Fenway Institute that offers continuing medical education (CME) credits on LGBTQ health topics through many of their online programs.

[Glossary of LGBT Terms for Health Care Teams](#)

The National LGBT Health Education Center, a program of the Fenway Institute, offers a succinct and regularly updated glossary of terms used by lesbian, gay, bisexual, transgender (LGBT) communities (as well as outdated terms to avoid) to assist healthcare teams in providing high quality care to LGBT people. The glossary referenced in this report is from the March 2018 update. Since this glossary is frequently updated, we encourage readers to visit the National LGBT Health Education Center - Continuing Education resource listed above to find the most recent glossary version.

[Stanford Medicine LGBTQ Medical Education Research Group](#)

Collection of resources for providers covering a wide range of LGBTQ health topics.

Additional resources

[Aging with Pride](#)

The Aging with Pride: National Health, Aging, and Sexuality/Gender Study is the first federally-funded

Assets & resources

Continued

longitudinal national project designed to better understand the aging, health, and well-being of LGBTQ midlife and older adults and their families. In 2015, Aging with Pride sponsored Aging the LGBTQ Way Town Hall in Seattle to gather input directly from members of the community, including LGBTQ older adults, family members, caregivers, and service providers. The resulting report, [At-Risk and Underserved: LGBTQ Older Adults in Seattle/King County](#) highlights health disparities and inequities affecting local LGBTQ older adults.

[Family Acceptance Project](#)

Using research-based and culturally grounded approaches, the Family Acceptance project works to prevent health and mental health risks for LGBTQ children and youth in the context of their families, cultures and faith communities.

[Ingersoll Gender Center](#)

Offers trans-led trans competency trainings to community organizations, schools, businesses and government groups. Ingersoll also has a full time Healthcare Access Coordinator that can support transgender and gender nonconforming people in finding trans-competent healthcare providers and in navigating health insurance denials.

End notes



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Appendix A: Methods

Methods

OVERVIEW

We sought to identify the health needs of LGBTQ youth and young adults through a series of key informant interviews and listening sessions with LGBTQ youth and young adults. Interviews and listening sessions were conducted between 2017-2018. The goals of this approach were to:

1. Hear directly from LGBTQ youth and young adults about their healthcare experiences and needs.
2. Identify common challenges LGBTQ youth and young adults are facing when seeking healthcare, and what helps increase their access to high quality care.
3. Inform King County hospitals about the health needs of the LGBTQ youth and young adults they serve.

A range of stakeholders from the King County Hospitals for a Healthier Community and Public Health - Seattle & King County (including regional Public Health Clinics) contributed to the list of potential partners to engage as potential listening session sites or key informants for the LGBTQ Community Spotlight. This list included organizations and individuals known to be trusted entities who serve youth and young adults who identify as LGBTQ. Organizations that

were recommended by multiple stakeholders as well as those that represented geographic diversity in King County were prioritized for outreach and were invited to host a listening session. Recruitment efforts prioritized host sites in each of the hospital regions and achieve diversity in age, race/ethnicity, and gender identity.

Public Health staff – along with input from local youth and young adults as well as content experts - drafted discussion questions and interview guides. The process for community and youth engagement was reviewed by the University of Washington Institutional Review Board and received a 'not-research' determination.

Listening sessions

We collaborated with local organizations that serve LGBTQ youth and young adults (ages 13-24) to host listening sessions. The LGBTQ Spotlight includes results from:

- 8 listening sessions (8 host sites) for a total of 72 youth and young adult participants, who:
 - were between ages 13-24
 - self-identified as gay, lesbian, bisexual, queer, transgender, non-binary and/or gender diverse
 - lived in King County, Washington

Listening sessions were hosted by adults who regularly led support or advocacy groups for LGBTQ youth at each host site. Public Health staff were



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invited to join the regular support or advocacy meetings and co-facilitated the listening session along with the trusted adults. All hosts were responsible for gathering and informing youth of the upcoming listening session, either leading or co-facilitating the listening session with Public Health staff, serving as a mandatory reporter and if needed, following up with youth who requested additional support after the session. A brief training on the project's purpose and objectives, expectations, and facilitation techniques was provided to all listening session hosts prior to the session. Listening session hosts received a \$150 honorarium for their time planning and hosting the session.

Consent for participation

Participants were informed that their participation was completely voluntary, all responses would be collected anonymously, and that conversations would be summarized for a county-wide report using quotes from sessions along with those collected from key informants. Youth were informed that their privacy would be protected and they did not need to share personal stories or answer questions they did not want to answer. Participants were asked to keep listening session discussions confidential and to refrain from sharing the stories of others in the room. Facilitators discussed confidentiality and reviewed Washington state mandatory reporting standards. Youth were told that the listening session host would

be following up with them in cases where reporting was warranted. Participants received a \$25 grocery gift card for their participation.

Discussion topics

Discussion began after all participants acknowledged the objectives, confidentiality procedures, ground rules, and verbally agreed to participate. Public Health staff did not collect or record participants' full names at any point.

Participants were asked to reflect on their experiences with healthcare and comment on barriers and facilitators associated with accessing the care they need. Sessions lasted between 45-90 minutes, depending on the availability of the host organization.

Questions asked during youth listening sessions include:

- Tell us about the people, places, and things that make you healthy, safe, and strong. What makes these people, places, and things important?
- What makes it hard or easy to get the healthcare you need?
- Do you feel it is easy to find information and resources when you have a particular issue or concern?
- What are the supports that help you bounce back and build resilience?
- Think about the last time you went to the doctor, the hospital, or the emergency room. Think about

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your experience, how you were treated, and how it made you feel.

- What went well?
- What did not go well, or what could have made the visit better?
- In general, do you feel comfortable asking your provider questions about your health?
- Do you trust your physicians to tell you everything you need to know about your health?
- Do you feel like your providers involve you in making decisions about your treatment?
- How can providers and other healthcare organizations be involved in addressing the issues you have identified?

Key informant interviews

Seven key informants were identified as experts and advocates for LGBTQ rights, including physicians, case managers, and other service providers who work closely with LGBTQ youth and young adults. Interviews were approximately 45 minutes long, conducted by phone or in-person, and all were facilitated in English. Key informants were asked to provide their perspectives on the health needs and healthcare experiences of LGBTQ youth and young adults.

Key topics covered in interviews included:

- Perspectives on health needs
- Observations of health disparities
- Challenges navigating the healthcare system and getting connected to services

- Perspectives on trust and communication with providers
- Provider experience and accessibility of resources

Health indicators

The health indicators that are included in this report are from the Behavioral Risk Factor Surveillance System (BRFSS) survey to capture results for King County adults ages 18+ as well as from the Healthy Youth Survey (HYS) for King County youth in grades 8, 10, and 12. Specific indicators from these data sources were chosen based on whether the indicator provided additional context and insight to supplement the qualitative findings from listening sessions and key informant interviews, as well as those that aligned with the current priority indicators that the King County Hospitals for a Healthier Community track in the full 2018/2019 Community Health Needs Assessment report. Additional sexual orientation results for BRFSS and HYS data sources are included online on the Community Health Indicators website (www.kingcounty.gov/chi) which features interactive data dashboards and can be used as a tool to supplement the findings in this report. For more information on BRFSS and HYS, see Appendix B.

Methods & analysis

Listening sessions were audio-recorded for notetaking purposes and a note taker was also present during

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each listening session and interview. Audio files were deleted once notes were completed. Notes from interviews and listening sessions were coded and analyzed for themes. In the initial coding stage, moderators reviewed transcripts and developed a code book. Two Public Health staff separately applied these codes to the de-identified notes from each of the interviews and listening sessions. Throughout the early stages of this coding process the codebook was continually refined and consolidated. The purpose of this iterative development of the code book was to ensure that all possible analytic categories were identified, and that the team agreed on the final set of codes. Using the final agreed-upon coding structure, the research team independently re-coded all interviews, and then collectively adjudicated discrepancies in the assignment of codes through consensus. Codes were assigned by each team member to the narrative text using [®]QSR NVivo 11 qualitative data analysis software (QSR International, Australia). This program facilitates organizing and reviewing coded text for the purposes of qualitative analysis.ⁱ

Coding and summaries were reviewed by two staff, who conducted the majority of sessions, and consensus was reached before determining which major themes would be selected for presentation. Key themes were shared with listening session facilitators and key informants during an open comment period.

ⁱ NVivo qualitative data analysis Software; QSR International Pty Ltd. Version 11, 2015.

Appendix B: Report definitions & structure



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Report definitions & structure

DATA SOURCES

Behavioral Risk Factor Surveillance System

Adult LGB (lesbian, gay, and bisexual) health data come from the Washington State Behavioral Risk Factor Surveillance System (BRFSS).

The BRFSS is a random-digit dial telephone survey (including both cell and land-line telephones) of non-institutionalized adults age 18 and over, conducted through collaborations between the Centers for Disease Control (CDC) and all 50 states in the US. In Washington State, the Department of Health (DOH) manages data collection, and the survey is conducted in English and Spanish. The BRFSS collects data on health risk factors, chronic diseases, and other related questions, such as smoking, obesity, diabetes, and physical activity. Beyond the CDC core questions, DOH gives organizations an opportunity to add additional state added questions. Data are weighted by population to provide estimates.

The sexual orientation question is a state added question since 2003. The question is stated as “Do you consider yourself to be: (1) heterosexual, that is straight, (2) homosexual, that is gay or lesbian, (3) bisexual, or (4) Other.”

Healthy Youth Survey

Youth LGB (lesbian, gay, and bisexual) health data come from the Washington State Healthy Youth Survey (HYS). HYS is a collaborative effort between the Office of the Superintendent of Public Instruction, the Washington State Department of Health, the Department of Social and Health Service's Division of Behavioral Health and Recovery, and the Liquor and Cannabis Board. The HYS is administered to students in grades 6, 8, 10, and 12 in school districts across Washington State in October of even-numbered years beginning in 2002. HYS measures health risk behaviors that contribute to morbidity, mortality, and social problems among youth. These behaviors include safety and violence, physical activity, diet, weight, mental health, alcohol, tobacco and other drug use, and related risk and protective factors.

The King County average includes data from 2014 & 2016. HYS data that are analyzed by sexual orientation are from 2016 only, as that was the first year all participating King County schools administered this question.

Students were asked, “Which of the following best describes you? (a) Heterosexual (straight), (b) Gay or lesbian, (c) Bisexual, (d) Not sure.” The survey does not accommodate write-in responses.

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Count Us In

The Seattle/King County Count Us In is conducted to provide a point-in-time estimate of the number of people experiencing homelessness as well as gain additional information about homeless populations through surveys that are conducted both during and after the count. To accomplish this, Count Us In engages a large team to conduct an observation-based count of individuals and families in Seattle/King County who appeared to be experiencing homelessness. The research team combines the results of a general street count (which is a visual enumeration of unsheltered individuals) with the results of the sheltered count (individuals residing in emergency shelter or transitional housing programs) to produce the total number of people experiencing homelessness at one point-in-time in Seattle/King County. The point-in-time count was followed by an in-person survey of sheltered and unsheltered individuals by peer surveyors and service providers in the weeks following the general street count to gather specific information about the conditions and characteristics of the local population experiencing homelessness. The Count Us In team also focused on additional surveys and customized data collection procedures for youth and young adult populations since these individuals are often underrepresented in counts.

A more detailed description of the methodology as well as challenges and limitations for the 2018 Count Us In is provided in their full report.²⁵

Data cautions & caveats

While we consider these data to be robust and a strong picture that represents the King County populations, there are a few potential cautions and caveats that readers may want to keep in mind.

For the BRFSS, the number of individuals who respond to the survey is low, and may be different from those who choose not to respond. In addition, adults without a telephone were not included. It doesn't capture individuals who speak a language other than Spanish or English. Further, some people might be reluctant to respond to certain questions that are considered sensitive; such as the question about sexual orientation.

HYS results are generalizable to the majority of youth in Washington but may underrepresent students attending small and non-urban public schools,³² such as those who attend private schools, nonpublic tribal schools, home school, or who have dropped out of school. Students in juvenile detention facilities are not administered the survey.

Readers should keep in mind that some reported behaviors and risk factors may appear more prevalent in Grade 10 compared to Grade 12 because of increased rate of school dropout after age 16 (i.e., prior to Grade 12). Results for high school seniors are likely to be underestimates because many of the youth most likely to engage in risky behaviors may

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have dropped out of school.³³ The State recommends interpreting results for high school seniors with some caution, particularly when their prevalence rates differ markedly from those of students in earlier grades. While any given year's data on health risk behaviors among Grade 12 students may be an underestimate, the year-to-year comparisons are likely to be less affected by school dropout.³³

Explanation of why numbers in the report may be different from Washington State Department of Health reports

Reports of BRFSS data for King County produced by the Washington State Department of Health are based on sampling weights generated by the CDC/DOH for the purpose of producing valid estimates **at the state level**. In contrast, data produced by Public Health – Seattle & King County are based on in-house-generated survey weights that use county-level population estimates to improve the validity of estimates **at the county** or **sub-county levels**. As a result, the estimated prevalence rates (percentages) might be slightly different from the estimates produced by the state.

Reports of HYS data produced by the Washington State Department of Health are based only on the sample they select for HYS. However, data produced by Public Health – Seattle & King County for the LGB Addendum include data from all King County

participating schools, including the DOH sample and other schools that piggy-backed on the state sample. Because of this, there may be slight differences between the Washington State Department of Health reports and the King County 2018 CHNA Report LGB Addendum.

For additional information about Community Health Indicator definitions and analyses, please refer to Appendix D of the main 2018/19 Community Health Needs Assessment report.

Citation request:

The data published in this Community Health Needs Assessment Report and on the Community Health Indicators website may be reproduced without permission. Please use the following citation when reproducing:

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