

Health Equity Series: **Responding to LGBT Health Disparities**

August 2012



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Issue Statement

Lesbian, gay, bisexual, and transgender (LGBT) individuals experience poorer health outcomes than their heterosexual peers.^{1, 2, 3, 4} These poor outcomes are a result of differences in access to health coverage; limited availability of culturally competent health care services; absence of medical settings that are affirming and free of discrimination; scarcity of medical staff trained in LGBT health issues; health behaviors that do not foster good health; and social and economic systems that have not supported and protected minorities.¹

This paper draws on research from multiple sources, therefore a variety of terms are used to describe sexual and gender minorities (SGM). The background section of this paper presents definitions of the terms used, as well as an explanation of why one overarching term was not selected. Following the background, this issue brief explores common experiences among LGBT individuals that impact their ability to lead healthy lives. This paper concludes with a review of current policies in Missouri, and offers policy recommendations that will lead to greater health equity and improved health outcomes for all Missourians. Below is a list of the disparities highlighted in this paper:

- LGBT Missourians are more than twice as likely to not receive needed medical care or surgery compared to the general population.⁵
- Sexual and gender minorities in Missouri are 1.5 times more likely to be uninsured than the general population.⁵
- Fewer than 15 of 5,704 primary care physicians in the state have registered as LGBT-affirming in the Gay and Lesbian Medical Association's online provider network.^{6, 7}
- LGBT Missourians who belong to racial and ethnic minority groups experience higher rates of negative health outcomes.^{3, 5}
- Missouri's Medicaid coverage explicitly excludes transgender transition care, but surgery is required for a transgender person to change the gender marker on state identification documents.^{8, 9}
- More than one third of gay and lesbian young people have not disclosed their sexual orientation to their doctors.^{4, 10}
- More than two thirds of health care organizations do not require that physicians attend cultural competency training that includes LGBT health issues.¹¹
- The average medical student spends fewer than 5 hours learning about LGBT health issues, and the majority of that time is dedicated to HIV/AIDS.¹²
- LGBT families in the U.S. are more likely to be poor, underemployed, and multiracial than non-LGBT families.^{4, 13, 14, 15}
- One in seven LGBT Missourians reports experiencing discrimination in the workplace.¹

Background

Health Equity

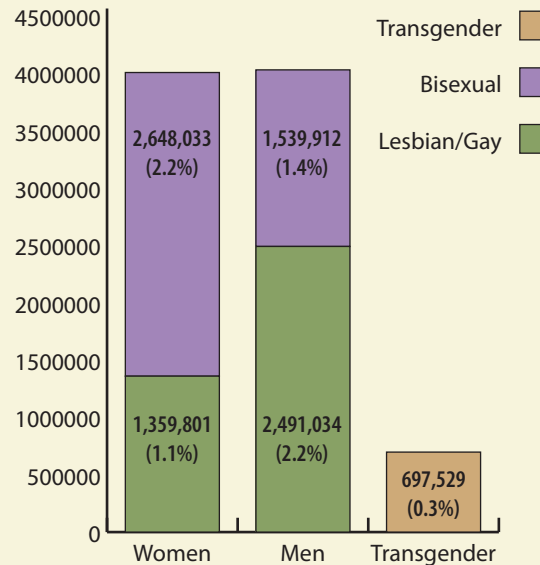
For the purpose of this paper, health equity refers to the presence of practices, policies, and systems promoting health and equal access to health care.

The term “health disparities” has been assigned multiple definitions in the past 20 years.¹⁷ Generally, the term “disparity” is used to refer to an observed difference between groups. Drawing from this definition, the National Institutes of Health has defined a health disparity as “the difference in the incidence, prevalence, morbidity, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups.”¹⁸ Over the last decade, this term has been expanded by some. It now refers to inequalities in health outcomes and inequities in access to health care that are experienced by minority groups, including racial and ethnic minorities, people living with disabilities, lower income individuals and families, sexual minorities, rural and urban populations, and immigrant communities.^{19, 20} In some cases, definitions of “health disparities” have been extended to include determinants that impact individual and community health.²⁰ Some of these determinants include income and social status, social support networks, education, employment, social and built environments, genetic and biological variation, personal health practices and coping skills, and healthy child development.²⁰

Various public and private entities have outlined their determinations of the factors that contribute to differences in health. Some agencies separate determinants of health into categories such as “avoidable” and “unavoidable;” others categorize them as “fair” versus “unjust” in origin.²⁰ As these poor health outcomes have been

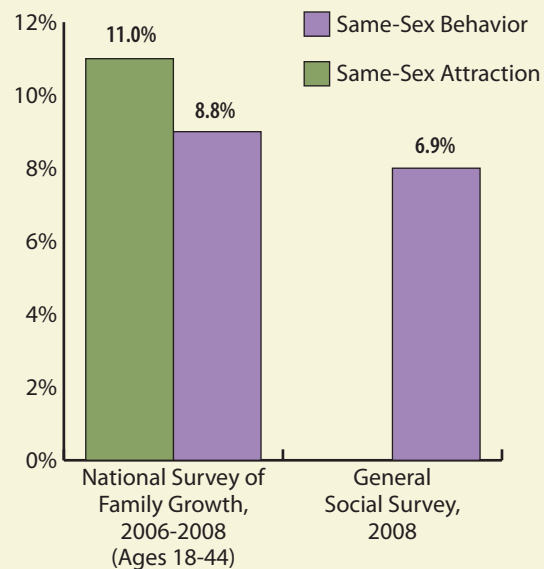
How Many People are Lesbian, Gay, Bisexual or Transgender (LGBT) in the United States?

Percent and Number of U.S. Adults who Identify as LGBT



GJ Gates, “How Many People are Lesbian, Gay, Bisexual and Transgender,” The Williams Institute, April 2011.

Percent of Adults Who Report Any Same-Sex Attraction and Behavior



GJ Gates, “How Many People are Lesbian, Gay, Bisexual and Transgender,” The Williams Institute, April 2011.

examined more closely, health professionals, community leaders, and policymakers have found that health disparities often are associated with policies and practices in the health care system and other sectors that impact health.

LGBT individuals experience poorer health outcomes than their heterosexual peers.^{1, 2, 3, 4} These outcomes are due in part to differential access to health insurance coverage; limited availability of health care services that are culturally competent and compassionate; and the impact of stigma, harassment and systemic discrimination.²¹ Individuals belonging to multiple minority groups, such as a Latino gay man or an African-American transwoman, experience exponentially worse health care and health outcomes compared to their white, heterosexual neighbors.²¹ The Centers for Disease Control and Prevention has recognized these disparities, and acknowledged LGBT communities as medically underserved populations in Healthy People 2020.²² Additional recognition of these disparities came in 2011 when the Institute of Medicine (IOM) released *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*, which presented existing knowledge on the health issues of sexual and gender minority groups and suggested research gaps to be explored for a better understanding of the health of LGBT communities.³

In Missouri, sexual and gender minorities are more than twice as likely to not receive needed medical care or surgery, compared to the general population.⁵

The term LGBT is used in scientific literature and popular media to collectively refer to multiple populations including lesbians, gay men, bisexual men and women, transgender persons and individuals who do not conform to gender identity norms. Just as each racial and ethnic group in the U.S. is unique in its experiences and history, each population in LGBT communities presents its own unique health concerns and distinct expressions of resiliency. Sexual minority groups and gender nonconforming persons, like other minority groups, are often referred to as one community (LGBT) because of common experiences of prejudice and inequity, as well as shared historical victimization, social stigmatization, and discrimination.³ In the face of systemic discrimination, these communities have come together to advocate for equitable treatment for LGBT individuals and their families.

Sexual Orientation

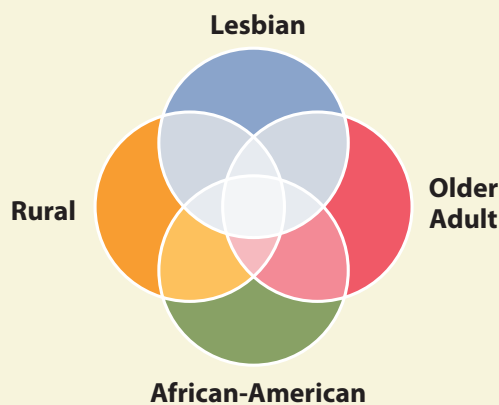
The IOM has defined sexual orientation as “an enduring pattern of or disposition to experience sexual or romantic desires for, and relationships with, people of one’s same sex, the other sex, or both sexes.”³ According to this definition, the terms lesbian, gay, and bisexual (LGB) refer to sexual orientation, whereas the term transgender refers to gender identity. Much of the original research on sexual minorities focused on individuals whose sexual orientation was not exclusively heterosexual; therefore, health research has largely excluded transgender persons and focused on lesbians, gay men, and bisexual men and women. Research also has focused on individuals who have sexual relationships with people of the same sex but may not identify as lesbian, gay, or bisexual.³ In some studies presented in this issue brief, these individuals are referred to as MSM (men who have sex with men) and WSW

The Intersection of Multiple Identities

Types of identity:

- Sex, gender
- Age
- Socioeconomic, class
- Sexual orientation
- Race/ethnicity
- Disability
- Cultural
- Religious
- Linguistic
- Territorial, geographical
- Indigenous, newcomer

Below is a depiction of the intersecting identities for an African-American lesbian who is an older adult and living in a rural area.



J Rummens, "Conceptualizing Identity and Diversity: Overlaps, Intersections, and Processes," *Canadian Ethnic Studies*, 35, 3, (2003): 10-25.

(women who have sex with women). These two terms have come under scrutiny in recent years, as some hold that they limit individuals and can be stigmatizing.

Gender Identity and Gender Expression

While the term LGB reflects sexual orientation, the terms "transgender" and "trans" are used collectively to refer to individuals whose gender identity (innate sense of being male, female, or another gender) or gender expression (representation of personality, appearance, and behavior) may not correspond with cultural expectations or stereotypes of the sex assigned to them at birth.^{3, 8, 23} These umbrella terms include transsexuals, cross-dressers, transgenderists, bigender, gender queer, and two-spirit individuals.³ In this issue brief, some data are presented for LGBT communities, while other data are reported solely for sexual minorities, (i.e., lesbians, gay men, and bisexual men and women, denoted as LGB) or gender minorities, (i.e., transgender and gender nonconforming individuals, referred to as transgender or trans).

Intersectionality of Minority Status

As research about the health of sexual and gender minorities has become more widely promoted, additional health disparities have been identified in subpopulations of LGBT communities. These disparities in health outcomes have been particularly serious among community members who are also members of racial and ethnic minority groups, live in rural communities or lack legal documentation of citizenship. The intersections of race/ethnicity, sexual orientation or gender identity, geography, socioeconomic status, age, health literacy, and immigration status have been found to have multiplicative effects on health outcomes.³

In Missouri, sexual and gender minorities are 1.5 times more likely to be uninsured than the general population.⁵

Documenting Health Factors and Outcomes

While numerous disparities have been documented, national and state level data for sexual and gender minority communities are limited. Few health surveys have included questions on sexual orientation or gender identity in their demographic data.¹ Federally funded health

research has not historically required that data be collected on sexual orientation and gender identity, and to date no federal health survey has offered members of the LGBT population a means to fully identify themselves by race/ethnicity, sexual orientation, and gender identity.¹ Several states have conducted statewide health surveys that included questions on sexual orientation and gender identity.¹ And several local and regional health surveys in Missouri have included sexual orientation and gender identity. But there has been no comprehensive health survey that includes such demographic information for Missouri as a whole. For the purpose of this paper, local Missouri data will be provided where available. Supportive data from other U.S. regional surveys will be used in areas where statewide Missouri data have not yet been collected or published.

Health Factors

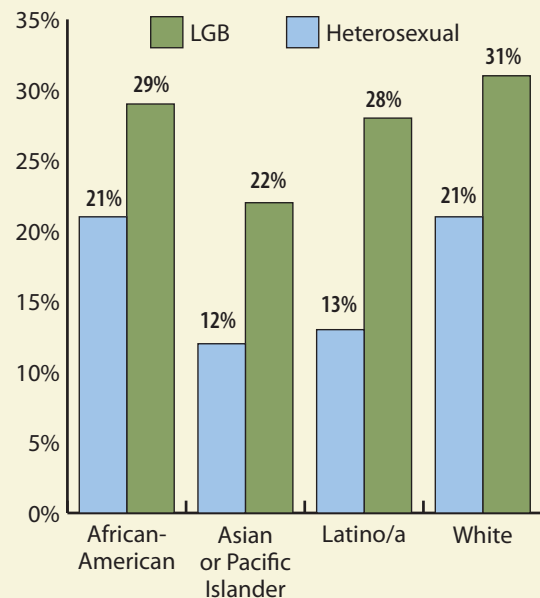
Health factors are the conditions in an individual's life that foster or discourage good health outcomes. This paper explores health factors and health outcomes. Factors essential to good health include:

- access to health insurance and the care included in coverage;
- quality and regularity of a person's clinical care;
- cultural competency in health care services;
- access to preventive care;
- the social and economic environment in which an individual lives, works, and plays; and
- an individual's health behaviors.

Access to Care

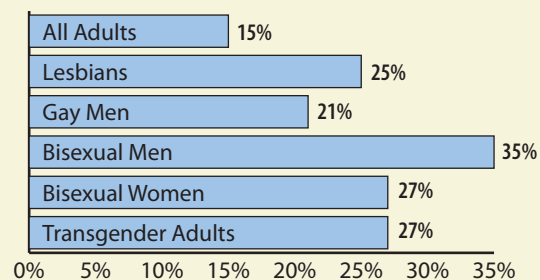
LGBT communities in Missouri and throughout the nation face inequalities in the regularity and quality of their health care, and in access to health coverage and culturally competent health services.^{2, 3, 15} Throughout the U.S., heterosexual adults are more likely to be covered by health insurance (82% coverage) than sexual and gender minorities (77% coverage for LGB

Percent of Adults Delaying or Not Seeking Health Care



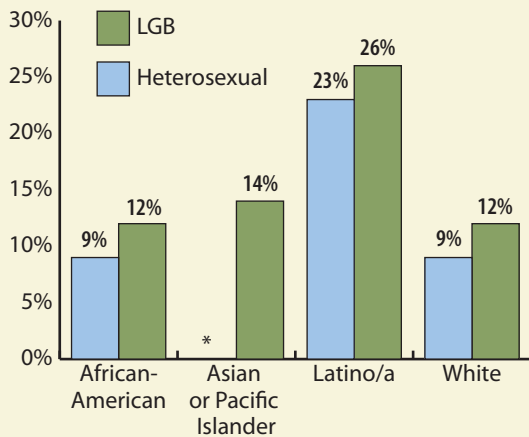
J Krehely, "How to Close the LGBT Health Disparities Gap: Disparities by Race and Ethnicity," Center for American Progress, 2009.

Percent of Missouri Adults Without Health Coverage



J McElroy & K Everett, "Out, Proud and Healthy Project: SGM Health Behaviors and Access to Care," (PowerPoint presentation), April 27, 2012.

Percent of Adults Without Regular Health Care Source



J Krehely, "How to Close the LGBT Health Disparities Gap: Disparities by Race and Ethnicity," Center for American Progress, 2009. * Asian or Pacific Islander sample data too small for reliable result.

adults, 57% coverage for trans adults).¹

The same trends exist among sexual and gender minorities (SGM) in Missouri, as SGM individuals are on average 1.5 times more likely to be uninsured than their heterosexual peers.⁵

The lack of advertisement of LGBT-affirming providers also presents barriers to care. In 2009, there were 5,704 primary care physicians offering services in Missouri's 114 counties and St. Louis City.⁶ Fewer than 15 of these have registered with the Gay and Lesbian Medical Association's LGBT-affirming online provider network. Six behavioral health providers and two alternative medicine providers also have registered as welcoming environments for sexual minorities in the state.⁷ All of these practices are located within 20 miles of urban areas (St. Louis, Kansas

City, Columbia, and Springfield). In other words, rural Missourians who seek LGBT-affirming medical care and behavioral health services cannot rely on publicly available information to identify a welcoming and trustworthy provider.

Transgender individuals face additional disparities in health coverage as the majority of health insurance plans do not cover trans-specific care and gender-specific care. Trans-specific care may include hormone treatments, sex or gender reassignment surgery, and transition-related care. Gender-specific routine care may include gynecological exams for a trans man or prostate exams for a trans woman. Despite the American Medical Association's support for the effectiveness of sex reassignment surgery for physical transition, many insurance companies continue to refer to this procedure as "experimental."^{8, 15, 23}

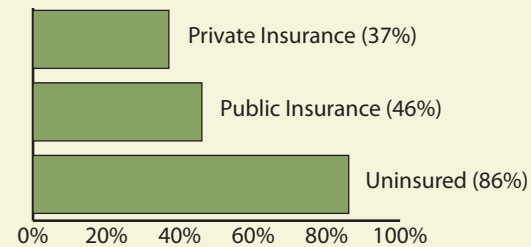
Barriers to insurance coverage for transgender people exist in Medicare, Medicaid, private insurance, and veterans' health care. Throughout the U.S., private insurance companies have been found to:

- deny coverage on gender-specific routine care;
- not offer plans that provide coverage for transgender individuals regardless of cost; and
- illegally reject claims for transgender individuals.

In some cases employers, labor unions, and pension funds have successfully advocated for inclusive private insurance policies. Medicare and veterans' plans do not cover most transition-related care. Medicaid coverage is determined by each state, and currently 22 states explicitly exclude transition-related care, including Missouri.^{8, 9} Twenty-eight states do not have specific exclusions, but have refused coverage of transition-related care, deeming it "experimental" regardless of health providers' determination that it is not optional.⁸

Because insurance companies do not offer certain types of coverage, transgender individuals often seek health care services through unconventional means, such as through self-administered hormone treatments and silicone injections.²³ When hormones are taken without medical supervision, individuals risk taking too much or too little. This can lead to health risks and unintended effects. Self-administered estrogen and testosterone can cause serious health consequences for transgender individuals, including increased risk of blood clotting, hypertension, increased blood sugar levels, water retention, and liver damage. Other hormone treatments such as anti-androgens can cause dehydration, low blood pressure, and electrolyte disturbances. These hormone-related health risks, when combined with other issues such as tobacco use, hypertension, and obesity, may contribute to an increased risk for heart attack or stroke.¹⁵

Percent of Transgender Adults Delaying or Not Seeking Care Due to Cost



JM Grant et al., "Injustice at Every Turn: A Report of the National Transgender Discrimination Survey," National Center for Transgender Equality & National Gay and Lesbian Task Force, 2011.

Different cultures accept or discriminate against transgender individuals in different ways. Culture impacts the way we conceptualize gender and gender conformity. In some nations, including the U.S., gender nonconformity is pathologized. The American Psychological Association's most recent edition of the Diagnostic and Statistical Manual of Mental Disorders IV Text Revision maintains the diagnosis of Gender Identity Disorder (GID). According to the definition of GID, individuals born with intersex or hermaphroditic conditions are not considered to have GID. The two criteria for GID are:

- persistent and strong cross-gender identification; and
- disidentification and discomfort with the assigned or birth gender.²⁴

Advocates differ in their activism surrounding GID. Some argue that it is inappropriate and harmful, and should not be seen as an illness, others are concerned that if GID is not viewed as a medical condition, transgender persons with inclusive insurance coverage will no longer qualify for hormone and transition care. Most insurers do not cover transition care regardless of a GID diagnosis.

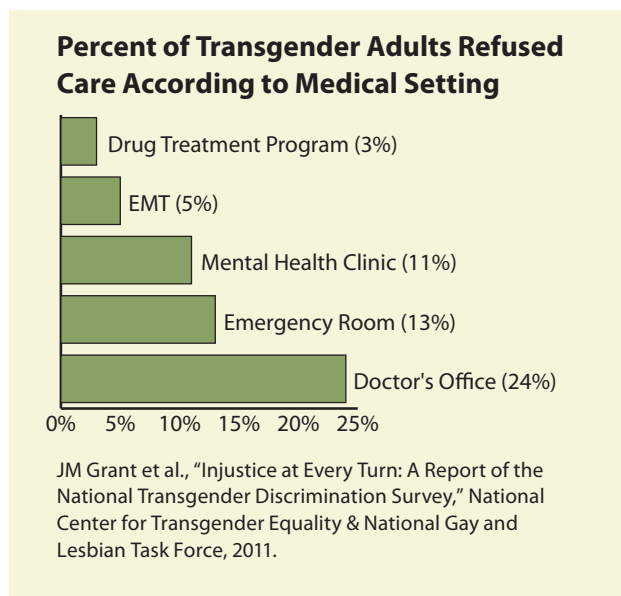
Clinical Care

Nationally, sexual and gender minorities experience differences in their access to clinical, dental, and preventive care compared to their heterosexual and gender conforming counterparts.²

³When seeking care, sexual and gender minorities report discrimination and harassment from providers. These are experiences that impact an individual's willingness to seek future medical care.²⁵ Lesbians, gay men, and bisexual individuals are more likely than heterosexual individuals to delay or avoid seeking health care and more likely to delay filling prescription medicines.²¹ As LGBT individuals are less likely than heterosexual persons to have a regular source for basic health care, they are also more likely to receive health care services in emergency rooms (24% compared to 18%).¹

In Missouri, sexual and gender minorities are more than twice as likely to do without medical care or surgery when it is needed.⁵ These differences in access to care are exaggerated when race and ethnicity are also examined. The likelihood for LGBT individuals to have a regular source of health care is on average three percent less than their heterosexual counterparts in each racial and ethnic subgroup, with LGBT Latino adults being least likely of all groups examined to have a regular source of care (26% have no regular source).²¹ This disparity in clinical care persists among older LGBT adults age 65 years and above, despite their qualification for Medicare.⁵

According to the National Transgender Discrimination Survey,²⁶ the largest representative survey of transgender and gender non-conforming individuals in the U.S., transgender individuals report delaying or avoiding needed and preventive medical care due to both cost and discrimination. In fact, nearly half of transgender individuals surveyed (48%) report delaying care due to cost when they are sick or injured. The percent of transgender individuals delaying preventive care due to cost is even higher (50%). Transgender individuals without insurance coverage are much more likely to delay needed care due to cost (86%) than those with public insurance (46%) or private insurance (37%).²⁶



Discrimination in medical settings also plays a significant role in transgender individuals' decision to delay or avoid health care.²⁶ More than one in four (28%) transgender patients report experiencing verbal harassment in doctor's offices, emergency departments, and medical settings. Similarly, more than one quarter of transgender individuals (28%) delay needed care due to discrimination. Preventive care is delayed at an even greater rate, with one in three transgender individuals (33%) delaying or not seeking preventive care due to discrimination. Two percent of transgender individuals report being physically assaulted or attacked in a doctor's office or hospital. Certain groups of transgender individuals report higher rates

of being physically attacked in a doctor's office, including African-Americans (6%); individuals who have lost their jobs (6%); those involved in sex work, drug sales, or the underground economy (6%); young adults who transitioned prior to age 18 (5%); and undocumented non-citizens (4%). It is not uncommon for transgender individuals to be denied care by medical providers, as nearly one in five (19%) report being refused care. These rates differ according to the type of service provider, with 24 percent of transgender persons reporting refusal of care from a doctor. Transgender individuals also report being denied care by emergency rooms, mental health clinics, emergency medical technicians and drug treatment programs.²⁶ While deliberate discrimination of sexual minorities is less common in medical settings than in school or work settings, the direct consequences of being denied appropriate medical care can be serious. The 2006 Pulse survey in Kansas City found that 2.7 percent of respondents who had same-sex relationships had experienced discrimination in health care settings.¹⁶ Among

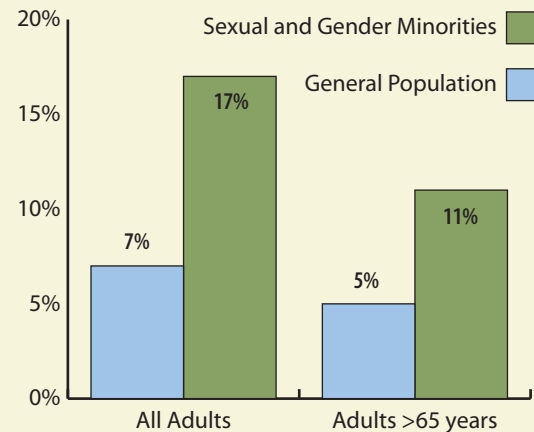
transgender patients, one in four of those surveyed had been harassed in a doctor's office or hospital.²⁶

Culturally Competent Care

The absence of culturally competent and compassionate care keeps some individuals from accessing health services. Creating a welcoming and culturally competent practice allows patients to feel safe to discuss their sexuality. This can improve treatment and enhance providers' ability to care for the whole person and better understand the populations they are serving. Studies have determined that hesitancy to disclose one's sexual orientation is related to provider bias toward lesbian and gay populations.⁴ This bias ranges from a provider's lack of comfort or training in providing appropriate and culturally competent care, to hostility and refusal to treat gay and lesbian patients. In 2000, more than 1 in 3 (36%) gay and lesbian young adults did not disclose their sexual orientation to their doctors.^{4, 10} A patient's decision to not disclose this information can result in delayed treatment, lack of preventive care, and less care for chronic conditions.⁴

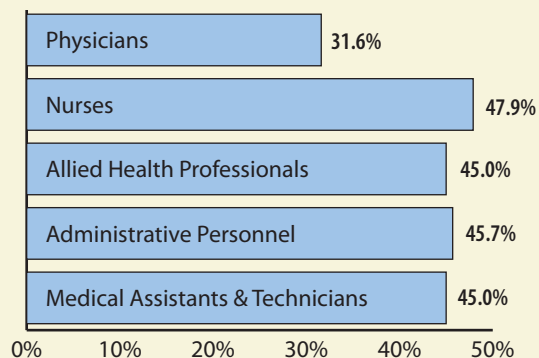
Training in cultural competency allows health care providers to examine their own biases and better control any biases that may impact the care they provide. These can be unconsciously communicated, creating an unintentionally hostile or confusing environment for patients. Unintended negative actions and communication stemming from provider bias are known as microaggressions.²⁷ Over a period of time, these acts result in an environment that is hostile and confusing for the individual who is targeted. Bias, prejudice, and stereotypes in health care settings foster unwelcoming and unsafe environments that can keep individuals from returning for future care. Microaggression in a mental health care setting can include overemphasis of an individual's sexual orientation and gender identity.²⁸ When a practitioner cites an individual's sexual orientation as the root cause of all symptoms, this is an example of microaggression. In contrast, when a practitioner refuses to acknowledge

Percent of Missouri Adults Not Receiving Needed Medical Care



J McElroy & K Everett, "Out, Proud and Healthy Project: SGM Health Behaviors and Access to Care," (PowerPoint presentation), April 27, 2012.

Percent of Health Professionals Required to Complete Training Within Organizations Offering LGBT-Inclusive Cultural Competency Trainings



A DelPercio, (Edited by E Kahn & T Sullivan), "Healthcare Equality Index Survey 2011: Creating a National Standard for Equal Treatment of Lesbian, Gay, Bisexual and Transgender Patients and Their Families," Human Rights Campaign Family Foundation Project, 2011.

the role sexual orientation may play in a person's life, this lack of recognition is also a result of bias.²⁸ Well-meaning medical practitioners may unintentionally promote a hostile environment by assuming heterosexuality of all patients, presenting materials and brochures that only depict heteronormative families, failing to include sexual orientation and gender identity on intake forms, and making stereotypical assumptions about patients who choose to "come out" to their providers.

Nearly all medical associations in the U.S. support ethical standards that prohibit discrimination against LGBT people in the practice of medicine. In an effort to support patients' health, many of these associations, together with the IOM, Joint Commission, and Department of Health and Human Services (DHHS), are recognizing the importance of cultural competency among providers in improving patients' health outcomes. The Joint Commission, an accrediting organization that certifies the quality performance of more than 19,000 health care organizations throughout

the U.S., urges hospitals and health providers to avoid discrimination and take the lead in creating communicative, welcoming environments for all patients. The Joint Commission

Most physicians are not required to complete cultural competency training that includes LGBT health issues. In fact, more than two thirds of health care organizations offering cultural competency trainings on LGBT issues do not require physicians to attend.¹¹

recognizes that the leaders of health organizations must direct these initiatives and ensure that the needs of sexual minority patients and families are considered in the planning, delivery, and evaluation of all health care services.²⁹ In addition to encouraging greater cultural competency through leadership, the Joint Commission also provides guidelines for cultural competency in the provision of care, treatment and services; workforce development; data collection and use; and patient, family, and community engagement. Providing checklists to ensure effective communication and cultural competency, the Joint Commission has offered hospitals and health care organizations a useful tool to ensure compliance and foster a more culturally competent, patient-centered medical environment.²⁹

The Healthcare Equality Index (HEI) Survey,¹¹ conducted by the Human Rights Commission, is another tool used by health care organizations to evaluate the inclusiveness of their policies for patients and staff, and the breadth of their cultural competency trainings. Hospitals and health care providers can participate in this survey to record their progress as they strive to make their facilities more culturally competent and patient-centered. Across the nation, 87 health care organizations participated in the survey, representing 375 facilities. Nationally, the HEI Survey identified that fewer than half of the agencies providing LGBT-inclusive cultural competency trainings to staff members actually require participation. And fewer than one third (31%) of the organizations require their physicians to complete them.¹¹ In Missouri, two organizations, representing 19 facilities, participated in the survey. Greater participation is needed from Missouri's health care organizations in order to better understand how the state compares to national trends in LGBT-inclusive policies and procedures.

Examining changes in health impact and patient satisfaction rates related to cultural competency trainings can be challenging when trainings are optional. Individuals served in health care organizations with optional cultural competency trainings may have different

experiences and outcomes when staff members are trained differently within the same organization. These differences may mask cultural competency trainings' impact on patient satisfaction reports and health outcomes.

Fewer than 10 percent of public health programs offer courses covering LGBT health topics beyond HIV/AIDS.³¹

Many medical schools and public health training programs do not require the inclusion of information on sexual minority populations. Data limitations often are cited as the reason for medical schools' limited coverage of LGBT health issues and cultural competency. More than half of medical school curricula do not contain any information on gay and lesbian populations.¹⁴

When sexual minority health issues are discussed, medical school curricula often limit their teaching to HIV/AIDS in the LGBT community. A 1999 survey found that medical schools spent an average of 2.5 hours over a 4-year period teaching on LGBT health topics.³⁰ By 2010, medical schools reported spending an average of 5 hours on these issues.¹² An emphasis on HIV/AIDS remains in medical education, but is due in part to research focusing on disease rather than on LGBT population health experiences, positive health outcomes, and resiliency.¹⁴ Lack of cultural competency and sensitivity in working with trans patients remains a concern, and these issues usually are not addressed in U.S. medical schools.

Similarly, the majority of U.S. public health schools do not include coursework about LGBT health disparities, and those that do focus primarily on HIV/AIDS. Among 34 public health programs surveyed, fewer than 10 percent had offered a course covering LGBT health topics beyond HIV/AIDS.³¹ Of those same schools, 10.8 percent planned to offer such a course in the next three years. And while the majority (71%) of these schools offered nondiscriminatory health insurance coverage for sexual orientation in employment and education, most did not offer health insurance for domestic partners of faculty or staff (51.4%), or domestic partners of students (88.6%).³¹

During 4 years of education, the average medical student spends about 5 hours learning about LGBT health issues, the majority of which is focused on HIV/AIDS.¹²

Prevention

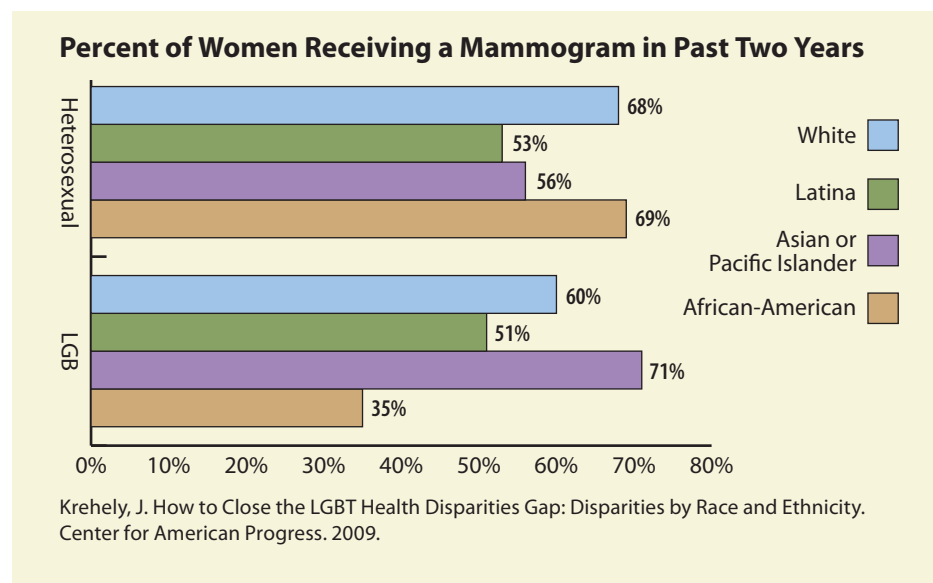
Members of the LGBT community are less likely to receive preventive care such as cancer screenings.¹ When coupled with other limitations in access and behavior, this has resulted in lesbians having the highest risk factors for breast cancer of all women worldwide.³² Data from the 2007 California Health Interview Survey revealed that while sexual minority women and heterosexual women had differing mammogram rates over the previous two years, these differences grew dramatically when subpopulations were examined based on race and ethnicity.

Lesbians are also at increased risk for some gynecological cancers,³² and are significantly less likely to report receiving Pap smears in the previous 12 months (38.3% of lesbians compared with 66.2% of heterosexual and 66.7% of bisexual women).³³ Data from Kansas City, Missouri, indicate that 54 percent of local WSW over age 20 had at least one Pap smear each year.¹⁶ According to the Pulse, 76 percent of WSW reported having the recommended age-appropriate screenings for breast and cervical cancers. The same survey found that only 32 percent of WSW had received recommended, age-appropriate screenings for colorectal cancer. These data provide a look into rates of cancer screenings according to age, but they do not provide screening rates according to race and ethnicity.

In the U.S., disparities in preventive care and cancer screenings also exist for gay men. As gay men have higher rates of anal cancers and anal papilloma than heterosexual men, it is important that gay men receive HPV screenings beginning at age 20, and cancer screenings.³⁴ The Pulse found that 12 percent of gay men over age 20 had been screened for anal cancer using the Pap smear. Among Kansas City MSM age 50 or older, 70 percent had received appropriate prostate cancer screening, but more than half (51%) had not received colorectal cancer screening.¹⁶ Higher rates of HIV/AIDS among gay men have motivated many individuals in the LGBT community

to be regularly tested for HIV. Regular HIV testing among gay men demonstrates the impact that public health campaigns can have, and shows the resilience of LGBT communities.

While state level data on preventive care among sexual minorities do not yet exist in Missouri, several



local surveys provide valuable information from sample populations across the state. The Pulse found that more than half (53%) of MSM completing the survey had been tested for HIV in the past year. The Pulse also found that MSM were less likely to report regular physical exams and receive dental exams than WSW, with 16.5 percent and 14 percent reporting that they had never received dental care, respectively.¹⁶

Transgender individuals experience lower rates of cancer screenings and therefore experience poorer outcomes and delayed diagnoses.²³ This is particularly true for cancer in reproductive organs.²³ Some providers refuse to treat cancers in transgender individuals whose reproductive organs differ from their gender identity.¹⁵ Trans men remain at risk for uterine, ovarian, and breast cancer, while trans women remain at risk for prostate cancer.²³

Social and Economic Factors

Health professionals are increasingly recognizing the critical role that one's social and economic environments play in one's health. According to the 2012 County Health Rankings, a person's social and economic environments combine to impact an individual's health more than access to health insurance or the quality and regularity of clinical care.³⁵ Less access to employer-sponsored health coverage has been identified as a contributor to poorer health outcomes and fewer health care visits among sexual and gender minorities.²¹ Disparities in domestic partner insurance coverage impact LGBT couples' and families' ability to access health care.¹⁴ Sexual minorities receiving partner benefits from employer-sponsored health coverage are taxed on these benefits as though they are income.⁴ This additional tax on income can prove particularly burdensome, because it compounds the financial inequalities experienced by sexual and gender minorities. LGBT individuals face higher rates of unemployment and underemployment, and lower incomes, than their heterosexual peers.^{4, 15} Transgender individuals experience twice the rates of unemployment and poverty than the general population.²⁶ Among transgender individuals of color, poverty rates are significantly higher. Poverty rates are 7 percent for the general population; 15 percent for all transgender individuals; 23 percent for multi-racial transgender persons; 28 percent for Latino transgender persons; and 35 percent for black transgender individuals.²⁶

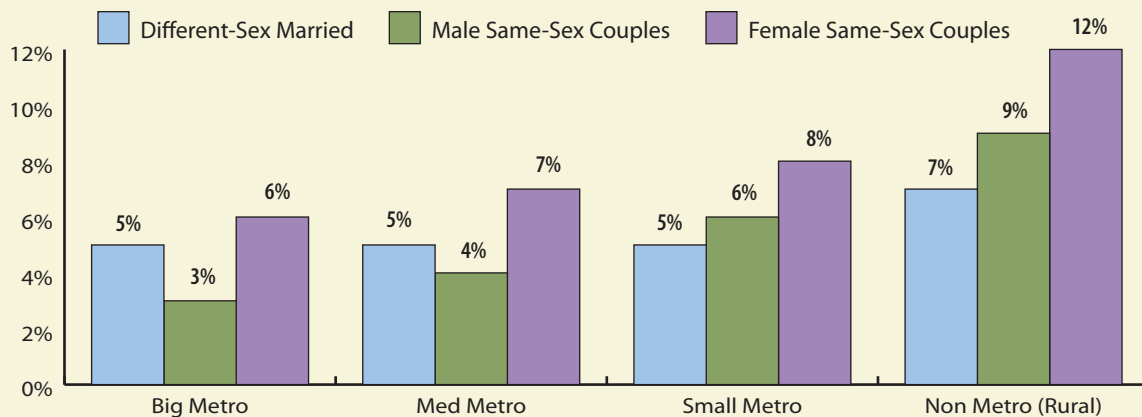
Table 1. Percent of U.S. Poor Children in Coupled Families by Household Type, by Race, Ethnicity, and Age of Child

	Married Different-Sex	Male Couples	Female Couples
All			
Householder & Partner	9.4	20.9*	19.7*
Race			
White	6.8	15.9*	13.8*
Black	13.1	27.9*	31.6*
Native American/Alaskan	21.5	41.1*	29.4
Asian/Pacific Islander	14.1	23.2	16.3
Other Race	21.4	23	24.7
Ethnicity			
Hispanic	23.8	26.9	31.9*
Non-Hispanic	6.6	17.8*	16.6*
Age			
0-5	10.5	22.9*	21.1*
6-13	9.2	19.5*	19.4*
14-18	8	19.7*	17.2*

Abelda, R., Lee Badgett, M. V., Schneebaum, A., and Gates, G. J. Poverty in the Lesbian, Gay, and Bisexual Community. The Williams Institute. 2009. Tabulations from 5% Public Use Microdata Sample (PUMS) Files, U.S. Decennial Census, 2000. *Difference from married different-sex is statistically significant at the 5% level.

Contrary to stereotypes promoting that sexual minorities only reside in urban areas and are more affluent than their heterosexual peers, LGB families with children live in 96 percent of U.S. counties and are more likely to be living in the South.^{13, 14} In Missouri, 94.8 percent of counties have same-sex couples describing themselves as spouses or “unmarried partners.”³⁶ Multiple studies have determined that same-sex couples are as likely or more likely to be living in poverty than different-sex couples.^{13, 14} Closer examination of these studies reveals wider economic disparities for same-sex couples when they are grouped according to their geographical location, metropolitan status, and racial and ethnic background.¹³ According to the National Survey of Family Growth, LGB men and women were more likely to be poor, (living in a family with an income below the federal poverty level,) than heterosexual men and women. In particular, lesbian and bisexual women are significantly more likely to be poor than heterosexual women (24.1% and 9.3%, respectively).¹³ Lesbian and bisexual women are twice as likely to receive food stamps when compared to heterosexual women (20.7% and 10.6%, respectively). Economic disparities increase further among families with children living in the home, as children of LGB families are twice as likely to be poor than children in heterosexual families.¹³ Poverty rates are particularly high among young children with same-sex parents who are Black, Native American/Alaskan, or Hispanic. As LGB families are more likely to be multiracial than heterosexual families, same-sex parents and their children may encounter discrimination and prejudice because of their racial and ethnic backgrounds and their sexual orientation and gender identities.¹⁴

Percent of Poor Householders and Partners in Coupled Families by Metropolitan Status¹³



R Abelda et al., “Poverty in the Lesbian, Gay, and Bisexual Community,” The Williams Institute, 2009.

Workplace discrimination

Discrimination on the basis of one’s sexual orientation or gender identity can occur in a variety of ways, including:³⁷

- being fired;
- being denied employment or promotion;
- being overlooked for added responsibilities;

- verbal and physical harassment;
- verbal, physical, or sexual abuse;
- vandalized workspace; and
- unequal pay or benefits.

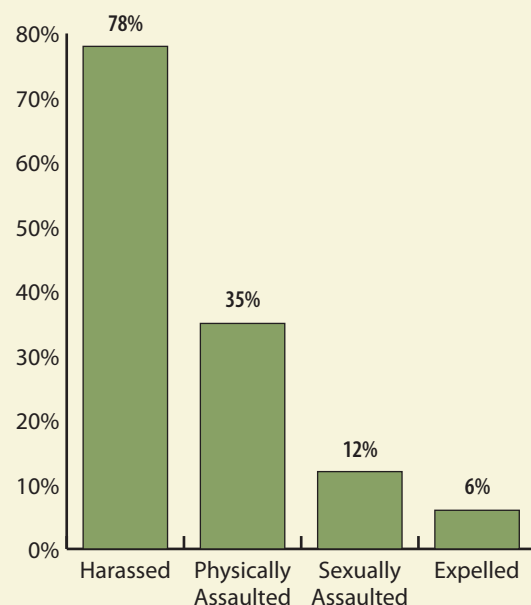
Discrimination and stigmatization in the workplace and health care settings negatively impact the health of sexual and gender minorities.^{3, 38} While a 2007 Gallup poll reported that 89 percent of Americans believe LGB individuals should have equal job opportunities,³⁹ workplace discrimination against sexual and gender minorities persists. Studies examining workplace discrimination have found that between 15 and 43 percent of LGB men and women report having been discriminated against because of their sexual orientation.³⁷

The Pulse found that 14.1 percent of sexual minorities reported discrimination in the workplace.¹⁶

In this survey, rates of workplace discrimination were highest (18-20%) among MSM who were over 50 years old, and WSW ages 20 to 29 years (23%).¹⁶ Rates of employment discrimination are also high among gender minorities; transgender individuals, for example, experience double the unemployment rate of the general population. Nationally, nearly half (47%) of transgender people expressed being fired, not hired, or denied a promotion because of nonconformance to gender norms.²⁶ Additionally, 90 percent of transgender individuals reported being harassed or mistreated while on the job, or having to hide their gender identity to avoid harassment.²⁶ More than one in four transgender individuals report being fired due to gender identity, and half of gender-nonconforming individuals report being harassed.²

When individuals are fired for gender identity, their unemployment places them at increased risk of negative health outcomes and factors. These include becoming homeless, contracting HIV, and misusing substances to cope with mistreatment. According to the National Transgender Discrimination study, survey participants who had lost their jobs because of bias experienced “four times the rate of homelessness, 70 percent more current drinking or misuse of drugs to cope with mistreatment, 85 percent more incarceration, more than double the rate working in the underground economy, and more than double the HIV infection rate, compared to those who did not lose a job due to bias.”²⁶

Harassment, Assault, and Discrimination of Trans Students in K-12 Settings



JM Grant et al., “Injustice at Every Turn: A Report of the National Transgender Discrimination Survey,” National Center for Transgender Equality & National Gay and Lesbian Task Force, 2011.

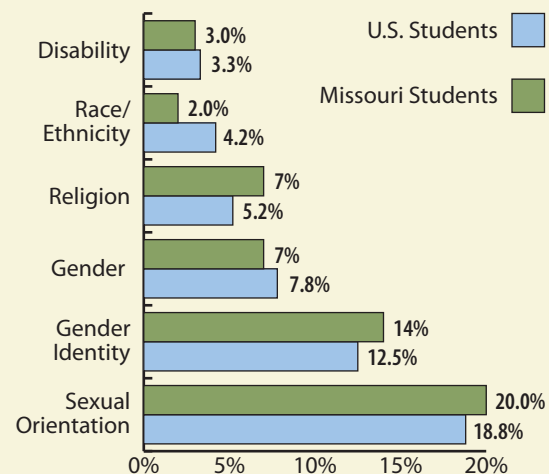
School Settings

Social stigma, discrimination, and isolation from family and peers also contribute to negative health outcomes among sexual and gender minorities, including increased risk for cancer, higher rates of mental and physical illnesses, and higher risk for psychological distress.^{1, 26} Among the general population, 23 percent of students report being bullied on their school campuses; four percent of students ages 12 – 18 report being victimized* in the previous six months; and less than two percent of students ages 12 – 18 report experiencing violent victimization** or serious violent victimization,** which include physical and sexual assault.⁴⁰ In 2009, the National School Climate Survey found that nearly nine in ten (84.6%) LGBT students reported being harassed at school for their sexual orientation.⁴¹

Missouri students experience higher rates of physical assault in school because of actual or perceived sexual orientation and gender identity, compared to national averages.^{41, 42} A high level of victimization and harassment experienced by LGBT youth in schools is associated with higher levels of depression, anxiety, and low self-esteem.⁴¹ Transgender individuals who expressed their gender identity during their youth report experiencing higher rates of harassment (78%), physical assault (35%), and sexual violence (12%) in K-12 school settings when compared with the general population.²⁶ The National Transgender Discrimination Survey found that students who had been bullied, harassed, or assaulted while at school experienced higher rates of suicide attempts, drug and alcohol use, homelessness, and HIV than transgender students who had not been victimized at school. Notably, students who had been harassed or assaulted by teachers at school experienced the highest rates of attempted suicide. Attempts were noted among 59 percent of trans students who had been harassed by teachers; 69 percent of trans students who had been sexually assaulted by teachers; and 76 percent of trans students who had been physically assaulted by teachers.²⁶ Transgender students who dropped out of school because of the intensity of harassment and assault also had higher levels of suicide attempts (68%).²⁶

Nationally, LGBT secondary students were four times more likely to have missed at least one day of school in the previous month because of feeling unsafe or uncomfortable (30% of LGBT students compared to 6.7% of the general student population).⁴¹ School bullying, harassment, and assault impact students' learning, and have been associated with poorer mental and

Comparison of Missouri and U.S. Reports of Physical Assault of Students at School
(Based on Actual or Perceived Identity)



JG Kosciw et al., "The 2009 National School Climate Survey: The Experiences of Lesbian, Gay, Bisexual and Transgender Youth in our Nation's Schools," GLSEN, 2010.

GLSEN, "School Climate in Missouri," GLSEN, 2011.

* Where victimization is categorized as: theft, violent victimization, and serious violent victimization.

** Where violent victimization includes: serious violent crimes and simple assault

*** Where serious violent victimization includes: rape, sexual assault, robbery, and aggravated assault

Youth Descriptions of the Most Important Problems They are Currently Facing

Most Important Problems Identified by LGBT Youth ⁵⁰		Most Important Problems Identified by Non-LGBT Youth ⁵⁰
Non-accepting families (26%)	1	Class/exams/grades (25%)
School/bullying problems (21%)	2	College/career (14%)
Fear of being out or open (18%)	3	Financial pressures related to college or job (11%)

Human Rights Campaign, "Growing Up LGBT in America: HRC Youth Survey Report Key Findings," HRC, June 2012.

physical health outcomes, including increased rates of self-injury, feelings of guilt and shame, depression and anxiety, Post-Traumatic Stress Disorder (PTSD), high-risk behaviors, and social isolation.^{43, 44, 45, 46} There are significant differences between the health risks of students who experience low levels of teenage victimization and those experiencing high levels. Students experiencing high levels of teenage victimization are 2.6 times more likely to be depressed; 5.62 times more likely to attempt suicide; 1.54 times more likely to have substance abuse problems; 2.53 times more likely to be diagnosed with a sexually transmitted infection (STI); and 2.28 times more likely to report HIV risk as a young adult.⁴⁷

LGBT Youth

Today, the average age of individuals "coming out" or verbalizing their sexual orientation and gender identity to their family and friends is 13 years.⁴⁸ This is nearly a decade younger than the average age that individuals chose to "come out" 20 years ago. This age difference brings a unique challenge, as many of these youth are still dependent on their parents or caregivers. Acceptance from family and peers has been found to have protective health effects, while stigma, isolation, and negative reactions about one's sexual orientation from parents, family, and peers are associated with negative health outcomes.¹ Familial and social support also are associated with greater resiliency and coping skills in discriminatory public settings.⁴⁹ A 2012 survey of more than 10,000 teens found that fewer than half (49%) of LGBT teens reported having at least one adult family member to turn to for help, while 79 percent of non-LGBT teens reported the same.⁵⁰

LGBT youth who have experienced high levels of family rejection are 8 times more likely to attempt suicide than LGBT peers not experiencing family rejection.⁴⁸

LGBT youth are disproportionately represented among homeless populations. In 2010, it was estimated that between 1.6 million and 1.7 million youth ages 12-17 years were homeless in the U.S.⁴⁸ While 5 to 10 percent of all youth identify as LGBT, estimates suggest that 10 to

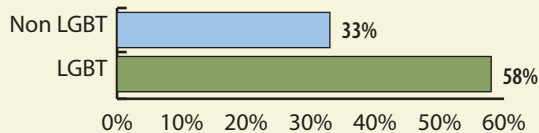
20 percent of homeless youth identify as LGBT. Among studies that included homeless youth from Missouri, 15-22 percent of the homeless youth surveyed identified as LGBT.⁴⁸ Family rejection and isolation are associated with the increased risk of homelessness among LGBT youth. They are also disproportionately youth of color. Nationally, 44 percent of homeless LGBT youth are Black, and 26 percent are Hispanic. This disparity is even greater among transgender homeless youth (62% Black, 20% Hispanic).⁴⁸

Individuals with families who accept them are less likely to engage in negative health behaviors, and less likely to experience negative health outcomes.²⁶

Homeless LGBT youth are more likely to attempt suicide; become victims of sexual violence; be solicited for sex in exchange for food, clothing, or shelter; and have PTSD than their

heterosexual homeless peers.⁴⁸ Often, social safety nets intended to provide care to homeless youth, including foster care, juvenile justice facilities, and homeless shelters, are not culturally competent in providing care for LGBT homeless youth. Sexual and gender minority youth, often experiencing violence and discrimination in these care facilities, are more likely to leave safety net agencies and return to homelessness. Family rejection and homelessness make LGBT teens more

Homeless Youths Who Have Been Sexually Assaulted



NS Quintana, J Rosenthal, & J Krehely, "On the Streets: The Federal Response to Gay and Transgender Homeless Youth," Center for American Progress, June 2010.

vulnerable to social and economic factors that contribute to negative health behaviors and outcomes. These factors include challenges in accessing public education during housing instability, and difficulty accessing health care services.

LGBT Elders

Having aged in a society where it was illegal to be anything but heterosexual, older LGBT adults age 50 years and above report high rates of lifetime victimization. In a national survey of more than 2,500 older LGBT adults ages 50-95, 82 percent reported having been victimized at least once in their lives, with 64 percent having been victimized at least three times. The survey, which included respondents from Missouri, found the following lifetime levels of victimization and discrimination reported by LGBT elders:⁵¹

- physical assault (19%);
- property damage (20%);
- denial of job promotions (21%);
- threat of being outed (23%);
- harassment by police (27%);

- threat of physical violence (43%); and
- verbal assault (68%).

While the majority of LGBT elders are out to family and community members, they are also more likely to be socially isolated than heterosexual older adults. LGBT elders are also less likely to have a partner or be married than non-LGBT elders. Nearly one in three LGBT elders (29%) report that they do not have someone in their lives to love them and make them feel wanted.⁵¹ The company of a partner or spouse affords seniors social support, and provides financial security and assistance with housing costs. Lacking social support is associated with decreased mental and physical health, premature chronic diseases, and premature death. Despite discrimination and isolation, studies have found that LGBT elders maintain positivity and resiliency, as 9 in 10 LGBT elders report feeling good about belonging to their communities.⁵¹

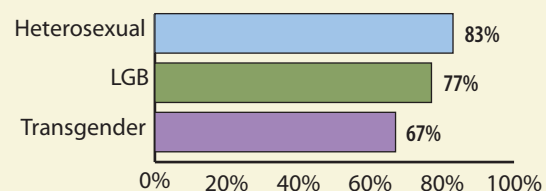
Health Behaviors

Individuals' actions and behaviors also impact their health. Health behaviors, both positive and negative, can be used to cope with stress. The Gay and Lesbian Medical Association (GLMA) has warned that the experience of stress and anxiety caused by discrimination can lead to increased risk for heart disease for sexual minorities in the U.S.³² Higher rates of smoking and obesity increase the risk of heart disease among sexual minorities.³² Smoking and alcohol consumption are associated with increased risk for emphysema, cancers, osteoporosis, and heart disease in lesbian and bisexual women;³² and lung cancer, lung disease, hypertension, and heart disease in gay and bisexual men.^{15, 34}

In Missouri, SGM have significantly higher rates of smoking than their non-LGBT peers (36% SGM compared to 22% non-LGBT).⁵² While 23.7 percent of heterosexual women report smoking at least one cigarette per day on average in the past year, 44.8 percent of lesbian women and 55.9 percent of bisexual women report the same.³³ Sexual and gender minorities also report higher rates of binge drinking and substance use than the general population. A statewide health survey in Massachusetts found that sexual minorities were more likely to report 30-day tension or worry, drug use, and current smoking than heterosexuals.² A statewide survey conducted by the Colorado Department of Public Health and Environment found that some lesbian, gay, and bisexual individuals were using smoking and substance abuse to deal with workplace and societal discrimination, family and social rejection, and minority stress. The study found trends similar to those in national surveys, which showed that binge drinking was more common among lesbian and gay respondents (25%) and bisexual respondents (28%) than heterosexual individuals (16%). This same study found that lesbian and gay individuals reported twice the rate of unemployment for more than one year (8%, compared to 4% of the general population).⁵³

Some individuals cope with discrimination and trauma by engaging in high-risk behaviors. Others cope through wellness activities, social events, and physical fitness. While each person experiences unique stressors and practices individual

Percent of Adults Reporting Excellent or Very Good Health



J Krehely, "How to Close the LGBT Health Disparities Gap," Center for American Progress, 2009.

stress-relieving activities, identifying trends among subgroups of the population can be helpful in identifying effective strategies to promote healthy coping skills and improve health outcomes. The majority of LGBT elders (91%) report engaging in wellness activities, with 82 percent of LGBT elders participating in physical activity. Despite high rates of physical activity, LGBT older adults also have higher rates of smoking cigarettes and drinking alcohol.

Statewide and local surveys confirm these trends. In a Massachusetts statewide survey, gay men were 3 times more likely to use illicit drugs than their heterosexual counterparts.² Gay

Nearly one in three transgender individuals currently smoke, but this number increases exponentially for those who have been victims of physical and sexual assault due to bias.²⁶

men were equally likely to engage in binge drinking. Lesbians were twice as likely to use illicit drugs, and bisexual women were nine times more likely to use illicit drugs than heterosexual women. Nearly one third of lesbians (31.8%) and one fifth of bisexual women (21.2%) report having five or more

drinks within a couple hours, at least once a month on average, compared with 12.7 percent of heterosexual women.³³ Results from the National Transgender Discrimination Survey found that while nearly one in three (30%) transgender individuals reported smoking daily, these percentages increased among trans individuals who had been victims of physical assault (40%) and sexual assault (45%) due to bias.²⁶

Gay and bisexual men report higher rates of sexual risk taking than their heterosexual peers. One survey in Missouri found that 30 percent of men having sex with men reported never using a condom, while 76 – 79 percent of MSM reported never using a condom for oral sex. MSM also report more frequent HIV testing, but HIV testing was found not to correlate to the number of sexual partners a man had in the previous year. Additionally, 88 percent of MSM reported never having had an anal cancer screening or HPV screening.¹⁶ Research has found that the more comorbid mental health problems experienced by an individual, the greater the odds of sexual risk behaviors (e.g., unprotected sex, number of partners, lack of STI testing). High levels of neighborhood homophobia and discrimination also have been found to influence sexual risk behaviors, as have negative cultural and societal messages about homosexuality. In contrast, social support, resiliency, and positive intimate relationships have been found to decrease sexual risk behaviors and substance use.

Health Outcomes

When researchers measure health outcomes, they are measuring individuals' physical health and mental health, and how well they feel. These are known as morbidity measures. Individual and population health outcomes also are measured by how long people live, and whether deaths are premature or preventable. These are known as mortality measures.³⁵

The IOM report on LGBT health drew attention to the disparities in morbidity and mortality experienced by sexual and gender minorities, as well as the lack of comprehensive data on the health experiences of LGBT communities.³

LGBT adults are less likely to experience good health, as 77 percent of LGB adults and 67 percent of transgender adults report having excellent or good health, compared to 83 percent of heterosexual adults.¹ A population-based survey in Massachusetts found that LGB individuals were more likely to have poorer outcomes for 16 of 22 health characteristics and risk factors, including:²

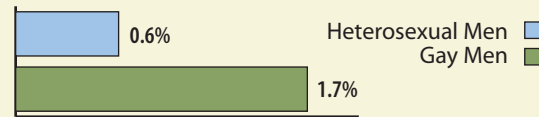
- activity limitation caused by disability;
- obesity;
- diabetes;
- heart disease;
- high cardiovascular disease risk; and
- asthma.²

A similar study from Boulder, Colorado, found that LGB youth were twice as likely to be overweight than their heterosexual counterparts (12% compared with 6%).¹ Obesity in the LGB population has been identified by the U.S. DHHS and GLMA as a risk factor for other health-related concerns.^{33, 15, 34} Local data from the Pulse found that 36 percent of MSM and 56 percent of WSW self-reported being overweight or obese. Older LGBT adults also experience higher rates of disability than non-LGBT older adults. Nearly one half of LGBT elders are living with a disability.⁵¹

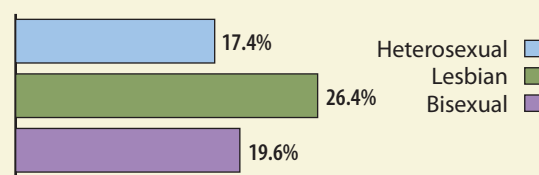
SGM experience disproportionately higher rates of HIV and STIs.^{23, 34} Less than one percent (0.6%) of the general U.S. population is living with HIV, while

Disparities in Health Outcomes

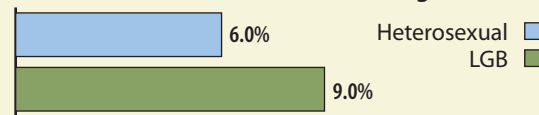
Percent of Men who are Underweight**



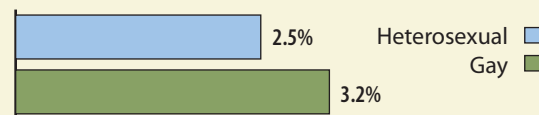
Percent of Women who are Obese**



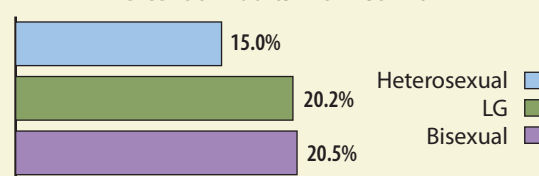
Percent of Adults with Cancer Diagnosis*



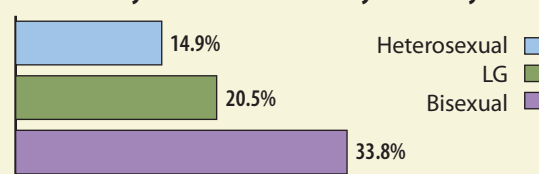
Percent of Men with Heart Disease**



Percent of Adults with Asthma**



Percent of Adults Living with Activity Limitation Caused by Disability**



* J Krehely, "How to Close the LGBT Health Disparities Gap," Center for American Progress, 2009.

** KJ Conron, MJ Mimiaga & SJ Landers, "A Population-Based Study of Sexual Orientation Identity and Gender Differences in Adult Health," American Journal of Public Health, 100, 10, (2010):1953-1960.

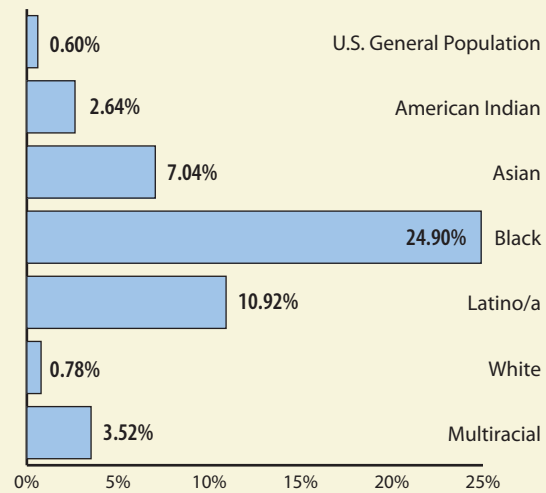
2.64 percent of transgender individuals are living with HIV.²⁶ When transgender individuals' responses were categorized according to race and ethnicity, Black, Latino, and American Indian transgender individuals reported higher rates of HIV (24.9%, 10.9% and 7.0% respectively).²⁶ Among MSM in an urban area of Missouri, 11.7 percent are living with HIV. This same local survey found that 2.3 percent of WSW have STIs.¹⁶ According to the Centers for Disease Control and Prevention, from 2006 to 2009, there was a 21 percent increase in the incidence of HIV among young people ages 13-29. This increase was predominantly among young MSM (34%), and most notably among young African-American MSM (48%).⁵⁴

Disparities in negative health behaviors, such as alcohol abuse and higher smoking rates, contribute to disparate health outcomes among LGBT populations.

Sexual minorities report higher rates of asthma, a finding that may be related to higher rates of smoking and living in urban areas. In Missouri, nine percent of residents statewide report currently having asthma. The Pulse found that nearly 19 percent of WSW and 12 percent of MSM reported currently having asthma.¹⁶ Additionally, the GLMA released a publication indicating that transgender individuals receiving hormone treatments must be cautious when drinking alcohol, as the combination increases one's risk of liver damage.³²

Health factors such as social and economic influences have been found to impact both physical and mental health outcomes. Self-identification as LGBT is not a risk factor for suicide, but experiences of stigma and discrimination are associated with depression and anxiety, low self-esteem, and social isolation. These are considered risk factors for suicidal ideation. LGB adults are more likely to experience psychological distress and more likely to need medication for emotional support than their heterosexual counterparts.¹ LGBT individuals are more likely to report suicidal ideation than non-LGBT community members. Gay men are 4.5 to 7.6 times more likely to experience depression than their heterosexual peers, according to a 2004 study.⁴ LGB youth are more than three times as likely to report suicide attempts as non-LGB youth (35% compared to 10%).¹ When examining mental health outcomes according to race and ethnicity, LGB Asian/Pacific Islanders and LGB African-Americans are most likely to experience psychological distress (25% and 23%, respectively).¹ Additionally, transgender individuals are significantly more likely to report suicidal ideation (50%) than LGB community members (5%) and non-LGBT individuals (2%).¹ A 2002 study found that 12 percent of gay men had attempted suicide, compared to 3.6 percent of their heterosexual counterparts. Additionally, 21 percent of gay men had made a suicide plan

HIV Infection Among Trans Population, By Race, Compared to U.S. General Population²⁶



JM Grant et al., "Injustice at Every Turn: A Report of the National Transgender Discrimination Survey," National Center for Transgender Equality & National Gay and Lesbian Task Force, 2011.

according to the same study.⁴ Risk of suicide is highest among youth, particularly when they identify as gay, lesbian, or bisexual yet remain “closeted” to family or friends.

These disparities in suicidal ideation and attempts, depression, and psychological distress are linked to alienation, isolation, and victimization, and are associated with societal discrimination and harassment felt by members of LGBT communities.^{3, 55} Rates of attempted suicide also are linked to education and household income levels, as rates are higher for those earning less than \$10,000 annually and those who have not completed college or graduate school.²⁶ The National Transgender Discrimination Survey found that individuals with families who accepted them were less likely to use substances to cope; attempt suicide; be incarcerated; work in the underground economy; and experience homelessness.²⁶

Gay males are more than twice as likely to experience disordered eating and body image disturbances compared to heterosexual males.⁵⁶ Transgender women also report higher rates of eating disorders and self-mutilation.²³ Isolation, social rejection, and lack of family connectedness are associated with vulnerability for disordered eating among young gay men.⁵⁶ Contrastingly, social connectedness, positive and affirming messages, parental support, and meaningful intimate relationships are associated with protective factors against psychological distress and mental health issues in LGBT youth and adults.^{48, 57, 58}

LGBT individuals experience some health outcomes at similar or lesser rates than the general population. Despite these lower rates, SGM may not be receiving adequate services to meet those needs. Intimate partner violence (IPV) occurs in both same-sex and different-sex families. Eleven percent of women in same-sex relationships experience partner violence, while nearly one in four women in the U.S. will experience domestic violence in their lifetimes.⁵⁹ A Missouri survey found that 7.8 percent of MSM and 11.9 percent of WSW had experienced partner violence. Overall, lesbian couples are more likely to seek relationship counseling than heterosexual couples. But Black and Latina women experiencing partner violence in same-sex relationships have been found to keep the violence from their children, and are less likely to seek support from the outside.⁶⁰ When domestic violence shelters and counseling services do not intentionally offer services to SGM, LGBT individuals may not receive needed care and may remain vulnerable to injury.

SGM are more likely to report sexual assault and sexual violence in their lifetimes than non-LGBT individuals.^{2, 16} The Massachusetts Behavioral Risk Factor Surveillance Survey (BRFSS) from 2001 to 2008 found that non-LGB individuals reported an average of 12.1 percent of lifetime victimization from sexual assault (5.9% of men, 18.1% of women), while gay men and lesbian women reported lifetime sexual assault rates of 18.9 percent and 34.7 percent, respectively. The same survey found that bisexual men and women also reported higher rates of lifetime sexual assault (15.3% men, 57.3% women).² A separate survey found that 64 percent of transgender individuals reported lifetime sexual assault due to bias.²⁶

Policies Impacting Health

Current Policies

Existing laws and the absence of laws protecting the rights of SGM impact individual and community health. This section focuses on state and local policies currently impacting health equity for LGBT Missourians.

Medical Decision-making

Currently in Missouri, when an individual is sick, a same-sex partner can make medical decisions on his or her behalf if previously authorized through a durable power of attorney directive. As Missouri law stands, if an individual becomes incapacitated, the same-sex partner or spouse cannot make decisions on behalf of the incapacitated partner without the power of attorney. Same-sex partners are treated as legal strangers in medical decision-making.⁶¹ Missouri is one of 18 states not recognizing same-sex relationships for medical decision-making. Nineteen states have medical decision-making laws inclusive of same-sex couples, while 13 others have limited recognition of same-sex couples.⁶² The denial of a same-sex couple's relationship during times of illness can lead to increased stress and trauma for the family and less than optimal care for the patient. In 2010, President Barack Obama issued a federal order to allow same-sex couples visitation rights when a partner is hospitalized. This policy also allows same-sex parents limited access to family medical leave to care for their children.⁶³

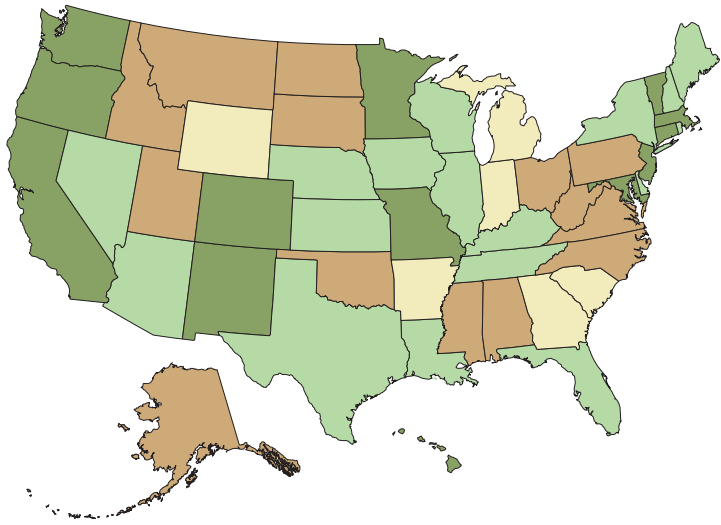
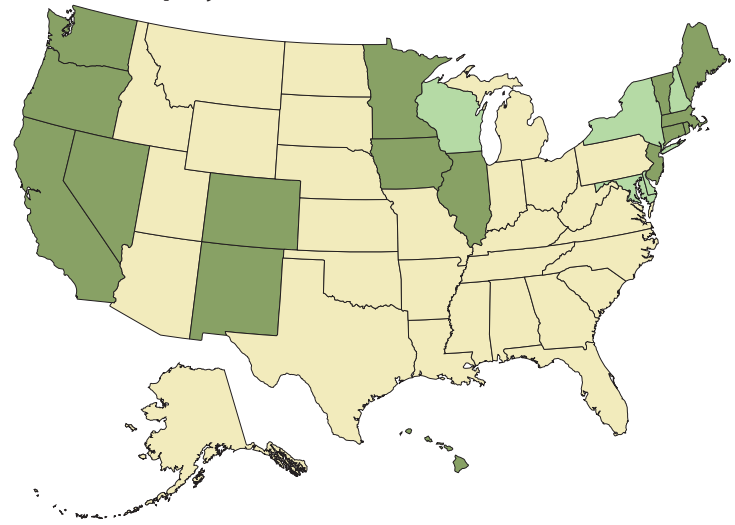
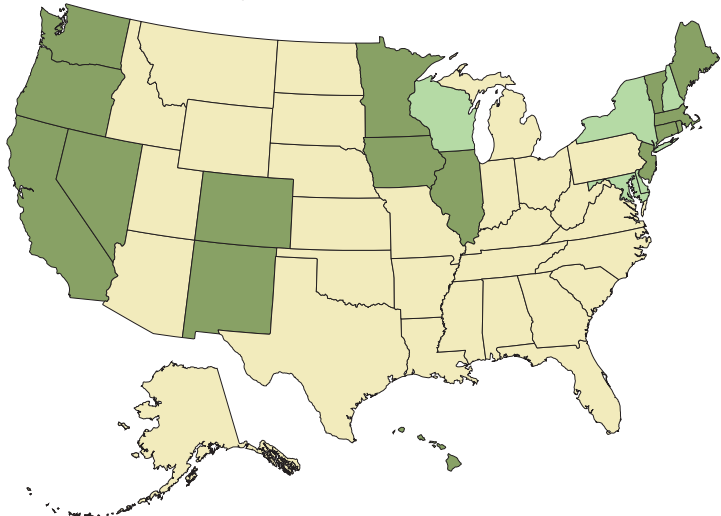
Medical Leave

In 1993, the Family Medical Leave Act (FMLA) was signed into law by President Bill Clinton. This law allows individuals to take up to 12 weeks of unpaid medical leave for personal or family illness to care for a child or accommodate pregnancy, adoption, placement of a child in foster care, or military service. In 2010, clarification on the FMLA definition of "son or daughter" was issued by the Deputy Administrator. According to the clarification, same-sex partners of parents who lack a legal or biological relationship but act in the place of parents, will be considered parents under FMLA.⁶⁴ This clarification has significant meaning for same-sex families. Under the law, however, employers can require documentation from an employee to prove the family relationship. In states such as Missouri, where domestic partner registries are not available in most cities or counties, documentation requirements may keep same-sex families from benefitting from FMLA.

Birth Certificates and Documentation

Documentation is also a concern when presenting identification that does not correspond to an individual's gender presentation. Missouri law allows an individual to change his or her sex on a birth certificate when providing a certified court order of a name change and sex change by surgical procedure.

Without undergoing a surgical transition, gender minorities cannot change their gender markers to match their gender identity and expression on state identification cards. Many insurers do not cover transition surgeries. Those that do, often require proof of a psychiatric diagnosis of Gender Identity Disorder prior to the surgery. For some trans individuals, surgery is unnecessary, unwanted, or unaffordable. These requirements can be burdensome and prevent transgender individuals from having documents that correspond to their gender identities. Identification documents are required to open a bank account, begin a new job, travel, and in some cases, vote

Hate Crime Laws**Employment Non-Discrimination Laws****Housing Non-Discrimination Laws**

- Law covers sexual orientation and gender identity
- Law covers only sexual orientation
- Law does not cover sexual orientation and gender identity
- No law

Movement Advancement Project, 2012.

and purchase cold medicine. Inaccurate identification documents can make individuals more vulnerable to discrimination in health care and employment settings.⁶⁵ Based on recommendations from the World Professional Association for Transgender Health, the U.S. Department of State announced in 2010 that sexual reassignment surgery would no longer be a requirement for changing the gender marker on a U.S. passport.⁶⁶ In place of the surgery requirement, individuals seeking to change the gender marker must present certification from a physician stating that the person has completed clinical treatment for gender transition. If the individual is in the process of transitioning, a request may be made for a limited validity passport.⁶⁶

Victimization and Discrimination Laws

Thirteen states and the District of Columbia have hate crime laws that cover sexual orientation and gender identity; Missouri is one of those states. While LGBT individuals are included in hate crime protections, they are not protected from discrimination in housing, employment, and public services. In Missouri, no law protects individuals from losing a job because they identify as LGBT, or are perceived to be LGBT. Seven cities in Missouri have their own local ordinances to protect SGM from employment and housing discrimination.⁶⁷

Local Nondiscrimination Policies

Missouri cities and counties with nondiscrimination ordinances covering employment, housing and public accommodations for LGBT individuals:

- Clayton
- Columbia
- Kansas City
- Kirksville (housing only)
- Olivette
- Richmond Heights
- St. Louis City
- Unincorporated Jackson County
- University City

Missouri cities with domestic partner registries:

- Clayton
- Columbia
- Kansas City
- Olivette
- St. Louis City
- University City

PROMO, 2012

Safe Schools Laws

In educational settings, LGBT students are not listed as a group protected from bullying. Missouri LGBT students, though they experience higher than national average rates of physical assault because of actual or perceived sexual orientation, cannot expect to be protected in school settings.⁶¹ In fact, in recent years, some state bills have been proposed to curb teachers' ability to support or speak about sexual orientation, sexuality, or gender identity in any scenario outside heterosexual procreation. Such a bill was introduced in Missouri (HB 2051), proposing to ban any instruction, materials, or extracurricular activities that discuss sexual orientation. More than 20 percent of LGBT youth reported school bullying as the greatest problem in their lives, and another 26 percent of youth expressed that non-accepting families were the most troubling problem facing them.⁵⁰ Laws that prohibit teachers from discussing sexual orientation when a student is bullied, and that ban supportive extracurricular activities, may remove protective factors that promote students' mental and physical health.

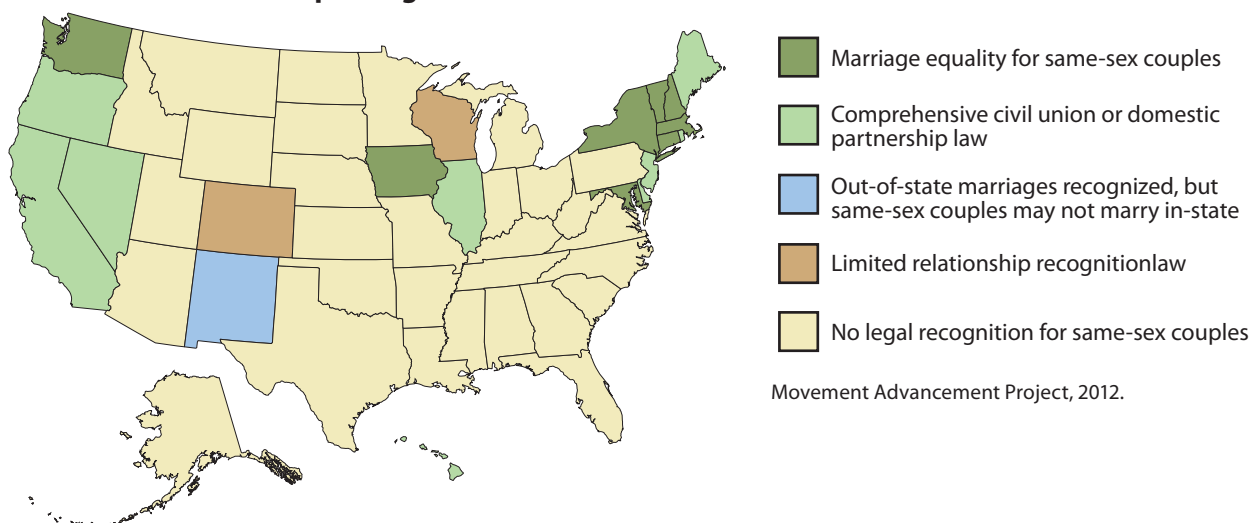
Marriage and Relationship Recognition

Same-sex couples cannot legally marry in Missouri.

Furthermore, the state does not recognize same-sex

marriages from other jurisdictions. In 2001, Missouri passed a statute specifying that it would recognize only marriages between a man and a woman, stating explicitly that it does not recognize marriage between persons of the same sex. The Missouri constitution was amended in 2004 to state the same.⁶¹ While there is no statewide recognition of same-sex couples' relationships, several cities have passed local domestic partner registries that allow same-sex couples to register in order to qualify for certain benefits, such as domestic partner health coverage.⁶⁷

Relationship Recognition Laws



Adoption Laws

Single LGBT adults are permitted to adopt children in Missouri, as state law specifies that any adult can petition to adopt. Same-sex couples, however, are not permitted under state law to jointly adopt.

Recommended Policies

This section will review federal, state, and local policy recommendations that can promote health equity.

Social and Economic Factors

Lack of access to health coverage and care, poorer clinical care, and limited prevention programs are all impacted by social and economic factors. Members of LGBT communities have poorer health outcomes due to minority stress from systemic discrimination. The identities and rights of SGM are regularly debated in legislative sessions. Young people report hearing frequent discriminatory remarks in schools. SGM experience high rates of violence and victimization based on their identities. Equal marriage rights, equal employment opportunities, and equal housing policies are nonexistent in many states and regions. These factors greatly impact the mental and physical health of LGBT individuals. Policy options that can improve health and reduce disparities faced by LGBT communities include social and economic factors such as relationship recognition and non-discrimination protections. These are inextricably linked to health outcomes.

Access to Care

When individuals do not have access to health insurance, they are more likely to delay needed prevention and care. The Affordable Care Act (ACA) allows states to expand Medicaid access to individuals with incomes at or below 133 percent of the federal poverty line. Additionally, most people in the U.S. will be required in 2014 to have health insurance or pay a penalty.

Recommended Policies Access to Care

- **Public insurance programs** include transition-related care.
- **Public insurance programs** reach out to enroll LGBT Missourians.
- **Legal recognition** of same-sex relationships.
- **Employer recognition** of same-sex relationships.
- **Employer non-discrimination** policies include sexual orientation and gender identity.
- **Domestic partner insurance** coverage required of employers offering health insurance plans.
- **End taxation of domestic partner insurance coverage.**

Recommended Policies

Clinical Care

- **Patient's Bill of Rights** include sexual orientation, gender identity, and gender expression.
- **Non-discrimination policies** include sexual orientation, gender identity, and gender expression.
- **Visitation policies** explicitly include same-sex couples and parents in definition of family.
- **Cultural Competency** trainings offered to staff and medical students include LGBT health care issues.
- **Intake forms** include sexual orientation and gender identity.
- **Office environments** are LGBT inclusive and affirming.

The expansion of health coverage has the potential to impact Missourians' health in positive ways, but additional policy changes are needed to make health insurance access more equitable for LGBT communities.

Public insurance programs and most private insurers do not cover transition-related care for transgender individuals. While many transgender Americans may qualify for public insurance, these individuals still have to pay out-of-pocket costs for necessary transition care. Including transition care in public insurance plans, and completing outreach to individuals who are eligible for Medicaid and Medicare, will help to ensure that LGBT Americans have the coverage and care they need.

Most Americans have health coverage through employer-sponsored insurance. LGBT Americans are less likely to be insured²⁴ and more likely to qualify for public insurance.¹³ Without employment protections for sexual orientation and gender identity, LGBT Americans, and those with nonstandard gender expression regardless of sexual orientation, experience higher rates of unemployment and underemployment.¹³ Unemployment and underemployment impact an individual's ability to access necessary health services. To eliminate disparities in access and coverage, businesses must protect workers based on sexual orientation, gender identity, and gender expression.

Equal marriage rights and legal recognition of domestic partner relationships through domestic partner registries are important steps in gaining access to employer-sponsored health coverage for LGBT Missourians and their partners. Eighty-nine percent of Fortune 500 companies offer domestic partner health insurance, and 33 percent offer transgender inclusive health coverage plans.⁶⁸ In a survey of the 50 largest

Fortune 500 companies and 50 largest federal government contractors, 92 percent stated that diversity policies and generous benefit packages were good for their businesses. More than half (53%) of those surveyed stated that their bottom lines were improved by prohibiting discrimination based on sexual orientation and gender identity, and by offering domestic partner benefits to their employees.⁶⁸

Under the ACA, small businesses are able, through a tax credit, to offer employer-sponsored health coverage to their employees. As more small businesses are offering coverage, it is important that they extend the right to coverage to all employees and their families, including those with domestic partners.

Currently, employees with insurance plans covering a domestic partner are taxed on the value of the coverage plan, meaning that same-sex couples earn less income after taxes than heterosexual couples. This tax can be a disincentive to having domestic partner coverage. Ending the tax on domestic partner insurance coverage will allow more Missourians access to employer-based health coverage.

Clinical Care

Discrimination in health settings discourages patients from seeking care. Following discrimination, or upon learning about others' negative experiences, LGBT patients may fear repeated discrimination and refrain from discussing their sexual orientation or gender identity with their medical providers.

Delaying care can have negative health consequences for LGBT Missourians. Medical providers and health organizations can prevent discrimination by implementing inclusive non-discrimination policies, and providing staff training on cultural competency and organizational policies. In order for all Missourians to receive

Recommended Policies *Prevention*

- **HIV prevention programs** focus on the whole person.
- **HIV treatment** through Medicaid is available prior to disability from AIDS.

Recommended Policies *Health Behaviors*

- **State and federally funded programs** are LGBT affirming, including substance abuse treatment facilities, mental health facilities, foster and juvenile justice facilities, and homeless and domestic violence shelters.
- **Health and human service organizations** implement non-discrimination policies protecting LGBT clients and staff.
- **Support clean air and tobacco control policies.**

Recommended Policies

Health Outcomes

- Collect **demographic data** for LGBT populations.
- Voluntary **HIV/AIDS and STI screenings** are mandatory services covered by Medicaid for ages 13+.
- **Employment non-discrimination policies** include sexual orientation and gender identity.
- **School anti-bullying policies** protect against bullying based on sexual orientation, gender identity, and gender expression.
- **School district anti-harassment and non-discrimination policies** protect LGBT students, teachers, and their allies.
- Domestic partner relationships are granted **equal marriage rights** and legal recognition.
- **Housing non-discrimination policies** protect on the basis of sexual orientation, gender identity, and gender expression.

patient-centered, culturally competent care, non-discrimination policies must include sexual orientation, gender identity, and gender expression.

On January 18, 2011, and July 1, 2011, equal visitation rights for LGBT families went into effect in hospitals participating in Medicaid and Medicare, and those accredited by the Joint Commission, respectively. According to these regulations, hospitals are expected to allow patients to select their visitors. Additionally, visitation discrimination based on sexual orientation and gender identity is not permitted.

In an effort to decrease variability in how staff members interpret requirements, hospitals are electing to amend their visitation policies to explicitly include same-sex couples and parents in the definition of family. Visitation policies that explicitly include same-sex families decrease the likelihood that staff biases will impact families' rights to visit their loved ones receiving care.

Ensuring that staff members are culturally competent in their practices is critical to reducing disparities in clinical care for LGBT community members. This can be accomplished by requiring that all staff participate in cultural competency trainings that include LGBT health care issues.

To help patients feel welcomed in medical settings, it is important that office materials and displays include individuals and families from diverse backgrounds, including SGM. Intake forms that include sexual orientation and gender identity are also important in ensuring that office environments are affirming and inclusive to all patients.

Prevention

Public health prevention strategies targeting behavioral change can play a significant

role in educating LGBT community members about disparities in smoking and substance use, and disparities in risky behaviors. Education can play a role in prevention; however, without targeting structural inequalities and systemic discrimination, LGBT communities will continue to face disparate levels of illness resulting from stress and unhealthy coping behaviors.

Clinicians in HIV prevention have found that when prevention efforts focus solely on negative behaviors (e.g., failure to use condoms, failure to test), they limit their audience and are less effective.⁶⁹ Strategies that promise to be more effective focus on individuals' strengths. Promoting more than HIV prevention, these strength-based approaches emphasize the importance of intimacy and healthy sexual relationships. They focus on the whole person, rather than on the disease.

Some HIV prevention programs are limited in their approaches, due to federal requirements that no sexual orientation or behavior be promoted in HIV prevention programs that receive federal funding. Laws that limit HIV education to disease-centric, negative behavior-focused methods also limit programs' ability to respect individuals and create lasting change. For prevention programs to be most effective, they must be permitted to emphasize the whole person, address relationships and intimacy, and promote healthy sexuality.

Policies promoting early treatment coverage of HIV help to lower viral loads, thereby reducing the number of new infections and improving the quality of life for people already living with HIV. Currently, Medicaid coverage is not available for childless adults living with HIV until they qualify for Supplemental Security Income, which is granted to those living with disabilities.⁷⁰ When childless adults who have HIV but have not yet progressed to AIDS are given access to Medicaid for treatment, it allows these individuals earlier access to intervention. Earlier interventions increase savings and stretch limited resources, enabling more adults living with HIV/AIDS to receive care.

Health Behaviors

Disparities related to smoking and substance use, disordered eating, and suicidal ideation have been linked to stress caused by systemic discrimination and structural inequalities in a society. Individuals looking to alter their behaviors sometimes are referred to substance abuse treatment or mental health facilities. Facilities that are meant to be therapeutic, safe, and rehabilitative can be unsafe places for SGM. When there are no policies and procedures ensuring that organizations protect LGBT persons, individuals seeking support and treatment may face discrimination and victimization from other clients and staff. Health and human service organizations can help ensure that their facilities are affirming by implementing non-discrimination policies, requiring staff training in cultural competency with LGBT populations, and creating welcoming environments for all clients.

Health Outcomes

While local and national surveys have documented disparate health outcomes for LGBT individuals, additional research is needed to better communicate the health needs and resiliencies of LGBT individuals across the country. To date, no nationally representative random survey has been conducted to examine LGBT health disparities at the national level. To increase understanding of and funding for LGBT health equity, health surveys and health providers must begin to collect demographic data on sexual orientation, gender identity, race and ethnicity, geographic location, and socioeconomic status when conducting health surveys.

The highest increases in HIV infection rates are among young African-American gay and bisexual men and transgender women of color. This is particularly true among young adults ages 13-29 years. Some policies to decrease disparities in HIV transmission among young gay and bisexual males recommend that voluntary screenings for HIV/AIDS and other STIs should be covered by Medicaid for all adults ages 13 and older.⁷⁰

Poor health outcomes resulting from prejudice, unequal access to care, employment and housing discrimination, and income inequalities can be addressed through social and economic policies that promote equal rights and protections for SGM. Equal protections from discrimination, harassment, and bullying are needed in Missouri's schools, businesses, housing, and public spaces. The right to marry and the right to legal recognition of domestic partner relationships promise to improve mental health outcomes and reduce disparities.

Conclusion

As LGBT health research progresses, the evidence of disparate health outcomes among LGBT community members is convincing. Existing studies demonstrate that LGBT health disparities stem from:

- differences in access to health coverage;
- a lack of cultural competence;
- limited access to and use of preventive care;
- unhealthy behaviors; and
- social and economic systems that do not support and protect individuals.

Opportunities exist for policies to better protect and promote the health and well-being of all Missourians, regardless of their sexual orientation or gender identity. This paper recommends policies to address the determining factors of health disparities at multiple levels. The challenge remains for schools, medical providers, employers and public agencies to acknowledge the presence of LGBT individuals in our communities and to address the factors that are contributing to their health needs.

Endnotes

1. J Krehely, "How to Close the LGBT Health Disparities Gap," Center for American Progress, 2009.
2. KJ Conron, MJ Mimiaga, & SJ Landers, "A Population-Based Study of Sexual Orientation Identity and Gender Differences in Adult Health," *American Journal of Public Health*, 100, 10, (2010):1953-1960.
3. Institute of Medicine (IOM), "The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding," The National Academies Press, 2011.
4. M. Barker, "Gay and Lesbian Health Disparities: Evidence and Recommendations for Elimination," *Journal of Health Disparities Research and Practice*, 2, 2, (2008):91-120.
5. J McElroy & K Everett, "Out, Proud and Healthy Project: SGM Health Behaviors and Access to Care," (PowerPoint presentation), April 27, 2012.
6. Robert Graham Center, "Policy Studies in Family Medicine and Primary Care: Primary Care Physicians by State," Robert Graham Center, September 2009.
7. GLMA Provider Directory, Missouri, Available at https://glmaimpak.networkats.com/members_online_new/members/dir_provider.asp
8. "Snapshot: Advancing Transgender Equality," MAP, 2011.
9. PS Gehi & G Arkles, "Unraveling Injustice: Race and Class Impact of Medicaid Exclusions of Transition-Related Health Care for Transgender People," *Sexuality Research and Social Policy, Journal of NSRC*, 4, 4, December 2007.
10. The Henry J. Kaiser Family Foundation, "Inside-OUT: A Report on the Experiences of Lesbians, Gays, and Bisexuals in America and the Public's Views on Issues and Policies Related to Sexual Orientation," 2001.
11. A DelPercio, (Edited by E Kahn & T Sullivan), "Healthcare Equality Index Survey 2011: Creating a National Standard for Equal Treatment of Lesbian, Gay, Bisexual, and Transgender Patients and Their Families," Human Rights Campaign Family Foundation Project, 2011.
12. J Obedin-Maliver et al., "Lesbian, Gay, Bisexual, and Transgender-Related Content in Undergraduate Medical Education," *JAMA: The Journal of the American Medical Association*, 306,9, (2011):971-977.
13. R Abelda et al., "Poverty in the Lesbian, Gay, and Bisexual Community," The Williams Institute, 2009.
14. Center for American Progress, Family Equality Council, & Movement Advancement Project, "All Children Matter: How Legal and Social Inequalities Hurt LGBT Families," Executive Summary, October 2011.
15. Gay and Lesbian Medical Association (GLMA), "Top Ten Things Transgender Persons Should Discuss with their Healthcare Provider."
16. "The PULSE/LGBT Community Health Assessment, Kansas City, Missouri," City of Kansas City, 2006.
17. VG Thomas, "Explaining Health Disparities Between African-American and White Populations: Where Do We Go From Here?" *Journal of the National Medical Association*, 84,10, (1992):837-840.
18. U.S. Department of Health and Human Services (DHHS), "Eliminating Health Disparities: Strengthening Data on Race, Ethnicity, and Primary Language in the United States," DHHS, November 2005.
19. "Health Policy Brief: Achieving Equity in Health." Health Affairs, Robert Wood Johnson Foundation, October 6, 2011.
20. O Carter-Pokras & C Baquet, "What is a Health Disparity?" *Public Health Reports*, 117, September-October 2002.
21. J Krehely, "How to Close the LGBT Health Disparities Gap: Disparities by Race and Ethnicity," Center for American Progress, 2009.
22. DHHS, "Negotiated Rulemaking Committee on the Designation of Medically Underserved Populations and Health Professional Shortage Areas," DHHS, October 31, 2011.
23. SS Spicer, "Healthcare needs of the transgender homeless population," *Journal of Gay & Lesbian Mental Health*, 14, 4, (2010):320-339.
24. American Psychiatric Association, "Diagnostic and statistical manual of mental disorders (4th ed., text rev.)," 2000.
25. CV Johnson, MJ Mimiaga, & J Bradford, "Health care issues among lesbian, gay, bisexual, transgender and intersex (LGBTI) populations in the United States: Introduction," *Journal of Homosexuality*, 54, 3, (2008):213-224.

26. JM Grant et al., "Injustice at Every Turn: A Report of the National Transgender Discrimination Survey," National Center for Transgender Equality & National Gay and Lesbian Task Force, 2011.
27. K Shelton & EA Delgado-Romero, "Sexual Orientation Microaggressions: The Experience of Lesbian, Gay, Bisexual, and Queer Clients in Psychotherapy," *Journal of Counseling Psychology*, 58,2, (2011):210-221.
28. J Lubsen, "Mental Health Disparities Impacting the LGBT Community" (Power Point presentation), February 17, 2012.
29. The Joint Commission, "Advancing Effective Communication, Cultural Competence, and Patient- and Family- Centered Care for the Lesbian, Gay, Bisexual, and Transgender (LGBT) Community: A Field Guide," October 2011.
30. L Kelley et al., "A Critical Intervention in Lesbian, Gay, Bisexual, and Transgender Health: Knowledge and Attitude Outcomes among Second-Year Medical Students," *Teaching and Learning in Medicine*, 20, 3, (2008):248-253.
31. HL Corliss, MD Shankle, & MB Moyer, "Research, Curricula, and Resources Related to Lesbian, Gay, Bisexual, and Transgender Health in U.S. Schools of Public Health," *American Journal of Public Health*, 97, 6, (2007):1023-1027.
32. GLMA, "Top Ten Things Lesbians Should Discuss with their Healthcare Provider."
33. Health Resources and Services Administration, Maternal and Child Health Bureau, "Women's Health USA 2011," DHHS, 2011.
34. GLMA, "Top Ten Things Gay Men Should Discuss with their Healthcare Provider."
35. Robert Wood Johnson Foundation (RWJF), "2012 County Health Rankings and Roadmaps," 2012.
36. "Missouri Census Snapshot: 2010," The Williams Institute, 2011.
37. MV Lee Badgett et al., "Bias in the Workplace: Consistent Evidence of Sexual Orientation and Gender Identity Discrimination," The Williams Institute, 2007.
38. JM Madera, "The cognitive effects of hiding one's homosexuality in the workplace," *Industrial & Organizational Psychology*, 3, 1, (2010):86-89.
39. "Tolerance for Gay Rights at High-Water Mark," Gallup Poll, May 2007.
40. S Robers, J Zhang, & J Truman, "Indicators of School Crime and Safety: 2011 (NCES 2012-002/NCJ 236021)," National Center for Education Statistics, U.S. Department of Education, and Bureau of Justice Statistics, Office of Justice Programs, U.S. Department of Justice, 2012.
41. JG Kosciw et al., "The 2009 National School Climate Survey: The Experiences of Lesbian, Gay, Bisexual and Transgender Youth in our Nation's Schools," GLSEN, 2010.
42. GLSEN, "School Climate in Missouri," GLSEN, 2011.
43. K Van Wormer & R McKinney, "What Schools Can Do to Help Gay/Lesbian/Bisexual Youth: A Harm Reduction Approach," *Adolescence*, 38, (2003):151.
44. P Griffin & ML Ouellett, "Going Beyond Gay-Straight Alliances to Make Schools Safe for Lesbian, Gay, Bisexual, and Transgender Students," *The Policy Journal of The Institute for Gay and Lesbian Strategic Studies*, 6, (2002):1.
45. ME Eisenberg & MC Aalsma, "Bullying and Peer Victimization: Position paper for the Society for Adolescent Medicine," *Journal of Adolescent Health*, 36, 2005.
46. M Fleming & K Towey, eds, "Educational Forum on Adolescent Health: Youth Bullying," American Medical Association, May 2002.
47. ST Russell et al., "Lesbian, Gay, Bisexual, and Transgender Adolescent School Victimization: Implications for Young Adult Health and Adjustment," *Journal of School Health*, 81, (2011):5.
48. NS Quintana, J Rosenthal, & J Krehely, "On the Streets: The Federal Response to Gay and Transgender Homeless Youth," Center for American Progress, June 2010.
49. GT DiFulvio, "Sexual Minority Youth, Social Connection, and Resilience: From personal struggle to collective identity," *Social Science & Medicine*, 72, (2011):1611-1617.
50. Human Rights Campaign, "Growing up LGBT in America: HRC Youth Survey Report Key Findings," Human Rights Campaign, June 2012.
51. KI Fredriksen-Goldsen, HJ Kim, & J Goldsen, "The Health Report: Resilience and Disparities among Lesbian, Gay, Bisexual and Transgender Older Adults," SAGE, March 2011.

52. J McElroy, K Everett, & I Zaniletti, "An Examination of Smoking Behavior and Opinions About Smoke-free Environments in a Large Sample of Sexual and Gender Minority Community Members," *Nicotine and Tobacco Research*, 13, 6, (2011):440-448.
53. One Colorado Education Fund, "Invisible: The State of LGBT Health in Colorado," 2012.
54. National Black Justice Coalition, "Out on the Hill: 2011 Key Federal Policies and Initiatives for the LGBT Community," National Black Justice Coalition, 2011.
55. "Talking about Suicide and LGBT Populations," Movement Advancement Project (MAP) and The Gay and Lesbian Alliance Against Defamation, 2011.
56. DM Ackard et al., "Factors Associated With Disordered Eating Among Sexually Active Adolescent Males: Gender and Number of Sexual Partners." *Psychosomatic Medicine*, 70, (2008):232-238.
57. BL Needham & EL Austin, "Sexual orientation, parental support, and health during the transition to young adulthood," *Journal of Youth & Adolescence*, 39, 10, (2010):1189-1198.
58. H Goldhammer and KH Mayer, "Focusing on Sexual Health Promotion to Enhance Preventive Behaviors among Gay Men and Other Men Who Have Sex with Men: Report from a State-of-the-Art Conference," *AIDS Behavior*, 15, S1-S8, 2011.
59. U.S. Department of Justice, "Extent, Nature, and Consequences of Intimate Partner Violence," U.S. Department of Justice, Office of Justice Programs, National Institute of Justice, 2000.
60. RF Oswald, CA Fonseca & JL Hardesty, "Lesbian mothers' counseling experiences in the context of intimate partner violence," *Psychology of Women Quarterly*, 34, 3, (2010):286-296.
61. Human Rights Campaign, "State Laws and Legislation, Missouri."
62. MAP, "Equality Maps: Medical Decision-Making Policies by State."
63. MAP, "The Momentum Report- 2011 Edition: An Analysis of Key Indicators of LGBT Equality in the U.S.," August 2011.
64. United States Department of Labor, "Wage and Hour Division, Administrator's Interpretation No. 2010-3. Clarification of the Definition of "son or daughter" under Section 101(12) of the Family Medical Leave Act (FMLA)."
65. National Center for Transgender Equality, "ID Documents and Privacy."
66. U.S. Department of State, "New Policy on Gender Change in Passports Announced," (Press Release), July 9, 2010.
67. PROMO, "Issues, Local Issues, Regional Information," PROMO, 2012.
68. Human Rights Campaign, "Corporate Equality Index 2012."
69. H Goldhammer, KH Mayer, "Focusing on Sexual Health Promotion to Enhance Preventive Behaviors among Gay Men and Other Men Who Have Sex with Men: Report from a State-of-the-Art Conference," *AIDS Behavior*, 15, S1-S8, 2011.
70. National Black Justice Coalition, "Out on the Hill: 2011 Key Federal Policies and Initiatives for the LGBT Community," 2011.



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