INTRODUCTION

Dane County, Wisconsin, is home to a vibrant LGBTQ+ community. While an estimated 2.8% of Wisconsin residents identify as LGBTQ+,
1 local and national sources suggest that this proportion is much greater in Dane County, and the Madison metropolitan area is often cited as one of the most LGBTQ+-friendly in the nation. 2 However, a closer look reveals that Dane County’s LGBTQ+ population experiences barriers to well-being, and that those barriers are often even more pronounced for those who identify as part of other marginalized groups. This profile aims to provide a context for understanding the experiences, assets, and challenges encountered by LGBTQ+ people and communities in Dane County, and to offer recommendations for collaborative efforts to improve conditions so that all LGBTQ+ people in Dane County can achieve their full health potential.

The City of Madison enjoys a wealth of community-building and health-supporting options for LGBTQ+ people. There is a thriving network of LGBTQ+ clubs, organizations, activist groups, athletic events and queer sports organizations that reflect the resilience and diversity of the community. Madison boasts openly LGBTQ+ members of the Senate (Tammy Baldwin) and Congress (Mark Pocan). Many community leaders, including business owners, entrepreneurs, executives and artists, are openly LGBTQ+. These public figures represent clear strength and resiliency, even among those members of the LGBTQ+ community who suffer the greatest disparities at the hands of discriminatory and unequal systems.

The acronym LGBTQ+ refers to Lesbian, Gay, Bisexual, Transgender, and Queer or Questioning. Incorporating the ‘plus’ into this broad definition allows those who identify with other sexual orientations (e.g. pansexual, intersex, agender) to be included.
Despite progress toward equality for people identifying as LGBTQ+, national data suggest that members of the LGBTQ+ population continue to experience worse physical and mental health outcomes than their heterosexual or cisgender peers. In the fall of 2016, the National Institutes of Health (NIH) announced the formal designation of sexual and gender minorities (SGM) as a health disparity population for NIH research. Economic and social conditions, along with policies and laws, profoundly shape health outcomes, and people who identify as LGBTQ+ disproportionately experience worse health in part because of these conditions and structural impediments.

For example, Wisconsin has a mixed legal protections landscape. In 1982, Wisconsin became the first state to enact legislation prohibiting discrimination based on sexual orientation in employment, housing and public accommodations. Then, in 2006, voters passed a referendum to amend the Wisconsin Constitution to invalidate same-sex marriages or any substantially similar legal statutes, which was then overridden in 2015 when same-sex marriage was legalized nationally. Although no state has explicit laws against discrimination based on gender identity, Dane County and the City of Madison have enacted policies banning discrimination based on gender identity. In 2015, Wisconsin Assembly Bill 469 was introduced, which would require public school students to use bathrooms and changing rooms that correspond to the gender assigned to them at birth rather than the gender with which they currently identify. Additionally, Wisconsin is one of four states currently suing the United States Department of Human & Health Services over the expansion of healthcare non-discrimination to include transgender individuals. These policies, which have gained national traction as human rights violations, threaten to dismantle public liberties and continue to support inequitable circumstances for the LGBTQ+ population.

INTRODUCTION

TO INFORM THE PROFILE

In Spring 2016, staff from Public Health Madison Dane County (PHMDC) conducted sixteen community interviews with health care providers, non-profit organizations and LGBTQ+ advocates in Dane County. Goals of these interviews were to highlight community programs and advocacy groups that support LGBTQ+ health and to better understand local health inequities, including gaps in comprehensive health care in Dane County.
This profile provides a summary of challenges and opportunities to improve LGBTQ+ health in Dane County, as well as a thorough literature review of national, state and local LGBTQ+ Health and Wellness data.

This profile also highlights the large number of Dane County assets and LGBTQ+ advocacy groups who work to protect the rights of this marginalized population. Community interviews revealed a number of local support systems and LGBTQ+ specific assets. Community interviewees also noted an increased sensitivity to the LGBTQ+ population, both locally and nationally. Further assets include the collaborative university network and statewide survey analysis projects that provide momentum for policy-based action.

The LGBTQ+ community is an increasingly visible population united by shared socio-cultural history and resiliency. Its people are diverse, international, and intergenerational, with members representing every race, ethnicity, age, income, ability, and geographic location. The term LGBTQ+ is used in scientific literature and media to collectively refer to populations that include people who identify as lesbians, gay men, bisexual, transgender and gender expansive persons as well as individuals who do not conform to gender identity norms. Cisgender (often abbreviated to cis) is defined as “of, relating to, or being a person whose gender identity corresponds with the sex the person had or was identified as having at birth.” Each LGBTQ+ population group presents its own unique health concerns and opportunities for resiliency. Sexual minority groups are often referred to using the umbrella term “LGBTQ+” because of common experiences related to inequity and prejudice, along with a common historical pattern of social stigmatization, discrimination and victimization.

Research indicates that people identifying as LGBTQ+ face specific health risks and weaker protective factors for behavioral health than their heterosexual and cisgender peers. These include:

**BARRIERS TO ACCESSING HEALTH CARE**
- Lack of culturally specific care
- Limited availability of services
- Healthcare provider discrimination
- Data collection systems biased toward heterosexual orientations and traditional gender identities (as categorized by biological male & female definitions)

**BEHAVIORAL HEALTH RISKS**
- Accumulated stress from social stigmatization and marginalization
- Cardiovascular disease, diabetes, and asthma
- Mental illness, including depression and anxiety
- Increased likelihood of tobacco use, alcohol use, and illicit drug use

At the same time, researchers suspect LGBTQ+ health disparities and inequities are underestimated because most data tracking and survey research systems have lacked the necessary sexual orientation and gender identity information to ascertain risk.
Research indicates that LGBTQ+ individuals are likely to experience poorer health outcomes than their heterosexual and cisgender peers. Identifying as LGBTQ+ has been linked to higher rates of psychiatric disorders, substance abuse, and suicide. LGBTQ+ communities also more frequently experience violence and victimization. Families that demonstrate social acceptance of sexual orientation and gender identity help to positively impact the mental health and personal safety of LGBTQ+ individuals.

In Wisconsin, the Youth Risk Behavior Survey (YRBS) collects data on Sexual Orientation and Gender Identity (SOGI) and the Behavioral Risk Factor Survey (BRFSS) collects data on sexual orientation. Data from these surveys are available only at a statewide level, not by county.

**LGBTQ+ YOUTH**
The YRBS shows that in Wisconsin, LGBTQ+ youth are more likely than non-LGBTQ+ youth to:

- try and regularly use tobacco
- try cocaine, inhalants, and heroin
- report feeling depressed
- consider, plan, and attempt suicide
- feel unsafe at school

**LGBTQ+ ADULTS**
LGBTQ+ adults in Wisconsin are less likely than heterosexual adults to:

- have health insurance
- have seen a dentist in the past year

**LGBTQ+ OLDER ADULTS**
Discrimination against LGBTQ+ older adults (aged 50 and older) has long been documented. Though there is a dearth of local data regarding this age group, national health disparities include the following:

- LGBTQ+ older adults have higher rates of mental health issues, disability, disease and physical limitation than their heterosexual and cisgender counterparts
- LGBTQ+ older adults have a higher prevalence of engaging in risky health behavior, such as smoking, excessive alcohol consumption compared to non-LGBTQ+ older adults
- LGBTQ+ older adults face high rates of housing and employment discrimination as well as physical and verbal abuse in relation to their sexual and gender identity
- Elderly LGBTQ+ individuals face additional barriers to health because of isolation and a lack of social services and culturally competent providers
LGBTQ+ health demands targeted attention from public health professionals and health care providers to address a number of population-specific inequities, including:

- LGBTQ+ youth are 2 to 3 times more likely to attempt suicide\(^{30}\)
- LGBTQ+ youth are 3 to 4 more likely to be homeless\(^{31\,32\,33}\)
- Lesbians are less likely to get preventive services for cancer\(^{34}\)
- Gay men are at higher risk of HIV and other STDs, especially among communities of color\(^{36}\)
- Transgender individuals have a high prevalence of HIV/STDs,\(^{37}\) victimization,\(^{38}\) mental health issues,\(^{39}\) and suicide\(^{40}\) and are less likely to have health insurance than heterosexual or LGB individuals\(^{41}\)
- LGBTQ+ populations have the highest rates of tobacco,\(^{42}\) alcohol,\(^{43}\) and other drug use\(^{44\,45}\) and other drug use\(^{46\,47\,48}\)

DATA GAPS

Few data systems or health surveys collect comprehensive LGBTQ+ health related data. The US Department of Health and Human Services has made SOGI data collection a strong focus of their Healthy People 2020 objectives, recognizing it as a national concern.\(^{49}\) Community-specific data collection is pivotal to understanding LGBTQ+ needs and inequities. Collecting data using questions that appropriately measure all LGBTQ+ identities and reporting those data effectively will ultimately guide priority planning and give voice to LGBTQ+ experiences.
MENTAL HEALTH

According to the National Institute of Mental Health, nearly 21% of adults meet the criteria for mood disorder (defined as "a category of mental disorders in which the underlying problem primarily affects a person’s emotional state") and 30% meet the criteria for anxiety at some point over their lifetime. In comparison, LGB populations have shown significantly higher rates of mood and anxiety disorders.

Systematic discrimination impacts mental health among LGBTQ+ individuals, which can lead to psychological distress due to, among other factors, broken social ties and family alienation. A negative policy environment can also amplify stress. In fact, one study revealed the prevalence of anxiety and substance disorders among individuals identifying as LGB to be higher in states that enacted institutional discrimination bans on marriage equality as opposed to states that did not. Additional studies have identified an inverse relationship between discrimination and emotional well-being.

In 2013, in the state of Wisconsin:

Dane County data mirrors state data. Among all community interview participants, the number one health concern for LGBTQ+ populations was mental health. More specifically, interviewees identified elevated levels of anxiety, depression and substance abuse, but they also revealed the need for mental health care providers trained in LGBTQ+-specific issues. The absence of culturally competent and compassionate care prevents many individuals from accessing health services.
ACCESS TO HEALTH CARE

National data indicates that LGBTQ+ communities face inequities in the quality and frequency of their health care and access to culturally competent and comprehensive health services. Throughout the U.S., heterosexual adults are more likely to be covered by health insurance (82% coverage) than those who do not identify as heterosexual (77% coverage).[^57]

Community interview respondents felt that identifying as LGBTQ+ placed them at a higher risk for experiencing gaps in comprehensive physical and mental health care. Reasons for these gaps included limited transportation, insurance barriers, and an unwelcoming medical community. These experiences placed them at higher risk of sexually transmitted infections, anxiety/depression, substance misuse, and unaddressed or untreated trans-related health issues.

SPECIFIC EXAMPLES OF MEDICAL PROVIDER AND HEALTH & HUMAN SERVICE SYSTEM INSENSITIVITY AND DISCRIMINATION EXPERIENCED IN THE MADISON COMMUNITY[^58]

- Denial of access/visitation of family members in hospital or surgical centers
- Gender-specific presumptive questioning about relationship status and family make-up
- Use of non-preferred pronouns with the patient and/or in the hallway with other providers
- Being chastised for not taking birth control when it is irrelevant to a person in a same-sex relationship
- Prejudice by an administrator in charge of birth certificate completion since there was no “father” to put on the certificate of the same-sex couple
- Denial of service due to a person’s gender expression or sexual orientation
- Lack of provision of services needed by the transgender community

Once, I had a trans female patient turned away from a local OB-Gyn office when she made an appointment asking for help with concern for wound infection after a gender confirmation surgery. Her documentation had her as F, so it wasn’t until she showed up at the clinic that she wouldn’t be seen, presumably because the provider didn’t know how (or want to) care for a surgically created vulva or vagina? I ended up treating her myself, which was fine, but it was humiliating and frustrating for the patient.

– Dr. Ronni Hayon, University of Wisconsin
Department of Family Medicine and Community Health
HOMELESSNESS

LGBTQ+ youth make up 7% to 8% of the United States population. LGBTQ+ homelessness, particularly among youth, is an increasing concern in the U.S. Between 20% and 40% of the estimated 575,000 – 1.6 million unaccompanied homeless youth in the U.S identify as LGBT. According to a June 2015 report, roughly 20% of youth utilizing homeless services identified as gay or lesbian, 7% as bisexual and 2% as questioning their sexuality.

Homeless populations and particularly homeless youth experience significantly increased likelihoods of engaging in risky coping behaviors (survival sex, theft, drug use). National surveys of agencies that provide services to youth who are homeless reveal that the chief factor contributing to LGBTQ+ youth homelessness is family rejection and “being forced out of the family home because of the youth’s LGBT status.” These surveys indicate that nearly seven in ten (68%) of their LGBT homeless clients experienced family rejection and over half (54%) experienced abuse in their family.

Homelessness in and of itself is a trauma, but homelessness isn’t typically a trauma by itself, usually there’s something that’s happened: domestic violence, eviction, loss of a job, argument about lifestyle. Kids can probably handle one trauma, but then they lose their home, their relationships and their safety net. If the first trauma doesn’t affect them, the second one typically knocks them off their feet.

– Jani Koester, Madison Metropolitan School District Transition Education Program

The fact that LGBTQ+ youth are 3 to 4 times as likely to be homeless than their non-LGBTQ+ peers is totally unacceptable. This is a public health crisis that has been relatively overlooked due to a lack of support, resources, and access to care. We (all) need to be paying attention and contributing in efforts to drive the numbers down.

– Robin Matthies, Briarpatch Youth Services
**UNSUPPORTIVE COMMUNITIES**

Additional surveys reveal similar findings regarding discrimination in places outside of the home. In 2013, the Gay, Lesbian & Straight Education Network (GLSEN) conducted its eighth National School Climate Survey, which collects data related to the experience of LGBTQ+ youth in U.S. secondary schools. A total of 162 respondents were attending schools in Wisconsin. Their responses suggest Wisconsin high schools can make significant improvements in creating safe environments for LGBTQ+ students.

<table>
<thead>
<tr>
<th>SCHOOL CLIMATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wisconsin results from 2013 GLSEN National School Climate Survey</td>
</tr>
<tr>
<td>• Majority of students have heard anti-LGBTQ+ remarks (e.g. “that’s so gay”)</td>
</tr>
<tr>
<td>• Nine in ten students have heard homophobic remarks (e.g., “fag” or “dyke”) at school regularly (more than once per day)</td>
</tr>
<tr>
<td>• Most LGBTQ+ students have been victimized at school</td>
</tr>
<tr>
<td>• Eight in ten were called names or threatened based on their sexual orientation</td>
</tr>
<tr>
<td>• Six in ten were called names or threatened based on their gender expression</td>
</tr>
<tr>
<td>• Only 10% of Wisconsin students attended a school with a comprehensive anti-bullying/harassment policy that included specific protections based on sexual orientation and gender identity/expression</td>
</tr>
</tbody>
</table>

In 2008, the National Center for Transgender Equality (NCTE) and the National LGBTQ+ Task Force launched a nationwide study on anti-transgender discrimination in the United States. The survey asked questions related to respondent’s experiences of discrimination and abuse at home, in school, in the public sphere, in the workplace, as well as with landlords, doctors, and public officials. Regional results from the Midwest (which consisted of 1292 respondents) indicate that traumatic experiences are common.

<table>
<thead>
<tr>
<th>TRANSGENDER DISCRIMINATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regional results from a 2008 U.S. study on anti-transgender discrimination</td>
</tr>
<tr>
<td>• 91% of trans people had experienced harassment or mistreatment on the job</td>
</tr>
<tr>
<td>• Those who expressed a transgender identity or gender non-conformity while in grades kindergarten through twelve reported alarming rates of harassment (79%), physical assault (37%) and sexual violence (11%)</td>
</tr>
<tr>
<td>• Survey respondents experienced blatant housing discrimination, as well as housing instability</td>
</tr>
<tr>
<td>• 64% were verbally harassed or disrespected in a place of public accommodation or service, including hotels, restaurants, buses, airport and government agencies</td>
</tr>
</tbody>
</table>
HATE CRIMES

Targeted discrimination is often motivated by hateful attitudes towards the sexuality or gender identity of LGBTQ+ community members. The majority of violent acts against the LGBTQ+ community are classified as hate crimes. These crimes occur in a variety of places, whether on the streets, at school or work, at home, or through lack of protective legislation.

According to an analysis of data collected by the Federal Bureau of Investigation, members of the LGBTQ+ community are the most likely targets of hate crimes in America. Recent research indicates that 25%, or nearly one in four, trans people has faced a targeted assault, and the most susceptible groups are trans women and trans people of color.

Finding accurate and comprehensive hate crime data remains challenging, however, in part because victims are fearful of revealing their sexual orientation and gender identities to law enforcement. In fact, a recent report by the Bureau of Justice Statistics found that the majority of hate crimes are not reported to the police.
INTERSECTING IDENTITIES AND LAYERED HEALTH PROBLEMS

GENERAL
The experience of “layered health problems” was commonly mentioned in community interviews and is supported by emerging health inequity research. Data indicates that negative health outcomes occur at a more frequent rate for LGBTQ+ individuals who are also members of communities of color, experiencing poverty, living with a disability or some combination thereof.

LGBTQ+ PEOPLE OF COLOR
People of color who are LGBTQ+ or in LGBTQ+ families may find affinity with communities that possess strong pride and cultural tradition but also experience disadvantages in employment and housing opportunities, economic mobility, and access to resources such as health care and quality education. This is true throughout the nation, and is of particular concern in Dane County, where dramatic racial inequities exist across many indicators.

The negative ways in which race and LGBTQ+ identity intersect was a common theme in community interviews. One interviewee summed this up by saying “When mental health concerns, poverty, and blackness converge, it is a recipe for profiling and bad social situations, particularly for LGBTQ+ populations”. [Dr. Karma Chavez] Others who were interviewed mentioned a lack of family acceptance experienced by LGBTQ+ people, especially youth, of color, while some noted that there has been noticeable improvement in this area due in part to the work of culturally specific community-led organizations.

When mental health concerns, poverty, and blackness converge, it is a recipe for profiling and bad social situations, particularly for LGBTQ+ populations.

– Dr. Karma Chavez, University of Wisconsin School of Communication Arts

Joanne Lee (of Madison) sits with a picture of her transgender son Skylar, who committed suicide last year. Since, she’s committed herself to advocacy on behalf of trans youth.
LGBTQ+ OLDER ADULTS

LGBTQ+ older adults (50 years+) make up a significant (and growing) share of the overall LGBTQ+ population. One study estimates that there are “over 2.4 million LGBT older adults in the United States, with the expectation that this number will double to over 5 million by 2030”. While tasked with all of the standard challenges of aging, LGBTQ+ older adults also often face an array of unique inequities that make a rewarding, healthy life even more difficult to achieve.

Research shows that LGBTQ+ older adults are more likely to be single, childless and estranged from their biological families, which leads to a heavier reliance on friends and community members as their chosen family. However, laws, official policies and institutions too often do not honor these relationships and frequently fail to provide equal protections for them. This has resulted in inequities in federal safety net programs, greater experiences of discrimination and substandard treatment of LGBTQ+ older adults. This lack of institutional recognition has also resulted in higher rates of social isolation among LGBTQ+ older adults, which can further lead to increased rates of depression, poverty, re-hospitalizations, delayed care seeking, poor nutrition and premature mortality. Additional social challenges include; fewer options for receiving informal caregiving, financial instability, housing discrimination, prejudice events, internalized stigma, expectations of rejection and concealment of sexual and gender identity for fear of abuse or discrimination. Furthermore, LGBTQ+ older adults are reportedly more likely to feel unwelcome in, or be unwelcome in, community and healthcare settings.

UNINSURED/LOWER INCOME

The reports Paying an Unfair Price: The Financial Penalty for Being LGBT in America and Paying an Unfair Price: The Financial Penalty for LGBT People of Color in America, detail three major ways in which LGBTQ+ people face economic disadvantages and outlines the systemic ways that these disadvantages are exacerbated specifically for people of color, due in part to our nation’s history of racialized economic exclusion:

- Legal discrimination (manifesting in barriers to employment, housing, health care, credit, and transgender persons’ ability to access documentation of their gender identity)
- Lack of recognition of LGBT families (manifesting in limited access to or unequal cost of insurance, safety-net programs, inheritance and social security benefits, and unfair taxation)
- Educational barriers (including unsafe school environments and barriers to financial aid)
The ability for LGBTQ+ people, families and communities to reach their full health potential is compromised by laws, policies, and systems that influence the conditions and opportunities shaping health outcomes. The legalization of same-sex marriage, both in Wisconsin in 2014 and nationwide via Supreme Court decision *Obergefell vs. Hodges.*\(^7^9\) in 2015, offered public recognition of and legal protections for same-sex couples. In Wisconsin, it offered the right for same-sex couples who already had children before they could legally marry, to adopt their own children by step-parent adoption. These rights are two among many rights and protections needed to ensure the well-being of the LGBTQ+ population. This section summarizes some of the areas of need most commonly identified in community interviews, along with those mentioned in related literature.

**GENDER IDENTITY PROTECTIONS**

Wisconsin was the first state (in 1982) to pass non-discrimination legislation for people who are lesbian, gay and bisexual\(^8^0\), but provides no such protections for people who are transgender. Although Wisconsin law protects Wisconsin residents from discrimination in employment, housing or public accommodations on the basis of sex and sexual orientation, gender identity is not a protected status. However, the City of Madison\(^8^1\) and Dane County\(^8^2\) (along with Milwaukee) do have transgender protections in place regarding employment, housing and public accommodation discriminations\(^8^3\) that far exceed those in other Wisconsin jurisdictions.

**HEALTH CARE COVERAGE AND SYSTEM ISSUES**

Wisconsin adults who identify as LGBTQ+ are less likely to have health insurance than those who are heterosexual and cisgender (23% uninsured compared with 18%)\(^8^5\). A potential reason for this may relate to the lived experience of LGBTQ+ people in healthcare settings. Community partner interviews highlighted a number of recent discriminatory and exclusionary experiences that took place in Dane County healthcare settings. Experiences were both explicit (e.g. denying service to someone due to their gender expression or sexual orientation, or making derogatory comments based on the same) or implicit (e.g. avoiding eye contact, not asking important questions related to gender, sexual behavior, etc., due to lack of comfort or training/not knowing how to phrase questions). Unfortunately, this type of discrimination is more likely to be experienced by vulnerable members of the community who may not know their rights or be able to advocate effectively.\(^8^6\)

Other challenges to LGBTQ+-specific health care include inconsistent coding and payment for services that often lead to diminished continuity of care and subsequent increased risks for poor health outcomes.

---

University of Wisconsin medical students from PRIDE in Healthcare have created a LGBT Friendliness Kit for Primary Care Physicians, which provides education and concrete guidance to physicians in order to create a welcoming environment for the LGBTQ+ community.\(^8^4\)
A family physician interviewed for this project indicated that, as of the writing of this profile, most health plans serving Dane County “consistently and specifically” deny coverage for gender-related services, including hormone therapy and surgery. Persons covered by state-administered health care plans, Medicaid, or who are covered under state employee plans, are unable to access these services. This is due to the fact that state regulations prohibit coverage by Medicaid and many other plans follow Medicaid as a matter of course.

Such automatic or categorical denial of coverage, however, are now illegal for insurance companies that must follow the Affordable Care Act of 2010 as articulated in regulations issued May 2016 by the Health and Human Services Office of Civil Rights. These regulations have an effective date of July 18, 2016.\(^{88}\) The Wisconsin Department of Employee Trust Funds has concluded that these regulations apply to all plans under its jurisdiction, including state employee plans and some local government plans and it will end categorical denials as of January 1, 2017.\(^{89}\) Most private plans serving Dane County should reach the same conclusion and end categorical denials of coverage.

It will likely take time for these rules to be enforced, however, and some insurance companies may deny services on an individual basis claiming they are not medically necessary or do not meet other insurance contract terms.\(^{90}\) Thus, persons covered by state-administered health care plans, including those using Medicaid or Medicare or who are covered under state employee plans, may continue to be unable to access these services. The Human Rights Campaign has published a list\(^{91}\) of private companies that do provide coverage for transition care.

While a common perception might be that covering gender-related services would be prohibitively expensive for insurers, those that have provided this coverage have found costs to be negligible, especially when compared to the costs associated with untreated gender identity disorder, including stress-related physical illness, depression and substance abuse problems.\(^{92}\)
FAMILY LAW
The legalization of same-sex marriage, both in Wisconsin in 2014 and nationwide via Supreme Court decision Obergefell v. Hodges in 2015, offered public recognition of and legal protections for same-sex couples. In Wisconsin, as in other states, active cases are still determining whether and under what circumstances married same-sex parents can be listed on a child’s birth certificate. Adoption law currently allows same-sex parents who already had children before they could legally marry to adopt their own children by step-parent adoption.

YOUTH IDENTITY, AUTONOMY, AND ACCEPTANCE
Many LGBTQ+ young people experience a lack of acceptance by their own families. As minors, this may place them in positions of being unable to access needed health care, services and networks of support. Since many health care decisions require parental consent, young people with unsupportive families may not have access to mental health care, hormone therapy and other necessary services. In Wisconsin, the age of consent for most health care and mental health services is eighteen years, which means that parents must authorize treatment and are able to access their children’s health records up to this age. Due to confidentiality concerns, youth who do obtain parental consent to receive these services may be reluctant to fully disclose their status or details about their specific challenges. These barriers are magnified in families living in poverty and without access to culturally-specific services.

REPRESENTATION, CULTURAL SPECIFICITY
Interviews and a review of the literature revealed additional policy and system-level issues that reinforce inequities. Examples include 1) generalized lack of competence and inadequate training when it comes to interacting with and supporting LGBTQ+ people, 2) a lack of comprehensive, inclusive sexual and health education and other curricula in schools and 3) a need for broader language definitions and expanded cultural competencies for expectant parents and families related to youth sexuality and gender expression.

Across all sectors, including education, employment, health care, law enforcement and government, LGBTQ+ people report interacting with few, LGBTQ+ officials and representatives. This is especially true for LGBTQ+ people of color. In fact, LGBTQ+ people, especially adults and students of color, are more likely to interact with the criminal justice system and school discipline systems than their straight, cisgender and white peers. These factors likely make isolation worse and may impact LGBTQ+ people and their families throughout the lifespan and across all of the social determinants of health.

No single policy solution will address these inequities, but a common theme is the need for community-led solutions and dedicated resources. Increased collection and coordination of LGBTQ+ specific data, targeted efforts to hire and promote LGBTQ+ people in all sectors, and creation of environments that foster safety and self-expression, will continue to support the ability for LGBTQ+ people to self-determine and achieve their own health and well-being.
Despite national hardship, Dane County, and the City of Madison specifically, are home to a significant number of LGBTQ+ advocacy groups who work to protect the rights of this marginalized population.

Community interviews revealed a large number of local support systems and LGBTQ+ specific assets, including health-supporting organizations. These range from the long-running Parents, Families and Friends of Lesbians and Gays (PFLAG) chapter to the newly formed Transgender Health Coalition, from the intersectional work being done by GSAFE for youth and schools to the variety of services and social clubs provided by OutReach LGBT Community Center, Alianza Latina and the University of Wisconsin LGBT Campus Center.

An increasing number of business owners, entrepreneurs, executives and artists are coming out and the Out Professional Engagement Network (OPEN), a networking group for LGBTQ+ people in the area, consistently highlights the excellent progress that Dane County has made. OurLives, a community monthly magazine, highlights the many ways in which Madison-based LGBTQ+ people find success, blaze trails, innovate, and fight for improvement and equity where challenges remain.

Even among those members of Madison’s LGBTQ+ community who suffer the greatest disparities at the hands of discriminatory and unequal systems, there is remarkable strength and resiliency.

For example, Freedom, Inc. and the Young Gifted and Black Coalitions are both largely queer run and led. The Trans Health Coalition was put together from the grassroots by trans people intent on making sure the unique challenges faced by that community were properly documented and addressed by mainstream researchers and providers. The AIDS Resource Center of Wisconsin (ARCW) is supporting people with HIV/AIDS and Briarpatch has specific LGBTQ+ youth outreach program that have made incredible progress with at-risk and homeless queer teens.

“–Emily Mills, Our Lives Magazine
No simple solution will improve health outcomes for LGBTQ+ individuals residing in Dane County. Supporting LGBTQ+ health will require ongoing efforts to build understanding, assess and evaluate policies and practices, and enact new models for the delivery of culturally competent services and health care. For all members of the LGBTQ+ community to achieve their full health potential, many entities must work collaboratively to ensure this progress continues.

A review of research literature and community partner interviews shaped the following recommendations. Rather than an exhaustive list of ideas and concepts identified, these represent places to start.

**HEALTH CARE PROVIDER TRAINING AND EDUCATION**

a. Create health care environments that offer LGBTQ+ affirming care across the lifespan
   - Understand gender affirmation treatment, including medical and surgical care
   - Employ trans-inclusive language and terminology at all health care organizational levels
   - Screen and identify early risk for mental and behavioral health challenges
   - Promote mental and emotional well-being among LGBTQ+ people, especially in primary care settings
   - Adopt and discuss a nuanced and comprehensive understanding of the complexity of gender identity and expression with expectant and parenting families

b. Develop and promote opportunities for LGBTQ+ youth to pursue health care careers

c. Assure access to health care providers who offer culturally-specific care, especially to low-income LGBTQ+ people who lack comprehensive insurance coverage

**MENTAL HEALTH CARE**

a. Increase access to mental health services for LGBTQ+ population
   - Expand pool of mental health care providers and programs providing sexual orientation- and gender identity-affirming care for LGBTQ+ people

b. Identify pathways to increasing mental health care access
   - Create living resource(s) to guide LGBTQ+ people seeking mental health care

**LGBTQ+ COLLABORATIVE**

a. Develop a Dane County LGBTQ+ Health Collaborative
   - Include community members, employers, health care providers and other invested stakeholders, such as academic partners, school personnel, organizational advocates
   - Instate annual meetings and progress reports to measure accountability and progress

b. Provide ongoing oversight, assessment and advocacy for the implementation of strategies that promote accessible, affordable and quality health care for LGBTQ+ people
PHMDC RECOMMENDATIONS

DANE COUNTY SCHOOL DISTRICTS

a. Implement nondiscrimination policies that include sexual orientation, gender identity, and gender expression
b. Implement school and anti-bullying laws
c. Create welcoming and inclusive school classrooms that acknowledge and affirm the sexual orientation and gender identity of every student and family
   • Build student information systems allowing students and families to specify a student’s gender marker, preferred name, and pronouns
   • Provide all gender bathrooms/facilities that provide options without stigmatizing any students, staff or family members
   • Develop procedures and forms that demonstrate a non-binary understanding of gender and sexual orientation
d. Expand Human Growth & Development curricula to include age-appropriate gender expansive language and education
e. Encourage systematic public school staff training and education that builds the capacity of teachers and others to affirm the diversity of sexual orientation, gender identity, and gender expression of all students.

FUND AND SUPPORT COMMUNITY ORGANIZATIONS

a. Provide funding and technical assistance for LGBTQ+ focused organizations, with particular focus on those that serve lower income and communities of color
b. Prioritize funding for community-based solutions
c. Employ transgender-inclusive strategies to create community organizations that are welcoming and inclusive of LGBTQ+ people

POLICY

a. Implement a statewide non-discrimination policy that includes sexual orientation, gender identity and gender expression
b. Decriminalize and/or re-classify crimes of poverty that are survival tactics (e.g. sex work, small thefts) and provide affordable access to legal services
c. Provide long-term, sustainable solutions to homelessness among youth and adults
d. Encourage work environments where LGBTQ+ employees are able to be “out”, strive for LGBTQ+ inclusion on boards and in outreach efforts

DATA COLLECTION

a. Expand data collection efforts to include sexual orientation and gender identity information (SOGI) across all health care arenas, schools, and organizations that collect intake information
b. Integrate SOGI collection into meaningful use requirements for electronic health records
c. Ask age-specific questions to LGBTQ+ older adults so elder health information can be captured
Efforts to improve well-being among LGBTQ+ people are not new, but developments during the last several years, including national and local attention to LGBTQ+ health, have laid a promising foundation for change. This LGBTQ+ Health and Wellness Profile intends to provide local elected leaders, government agencies, community organizations, health care systems, community advocates and LGBTQ+ community members with information, inspiration, and ideas for addressing the health needs of all LGBTQ+ residents of Dane County. It also offers guidance for PHMDC to address LGBTQ+ health inequities and continue forging collaborative and ongoing relationships with community partners.

THANK YOU TO OUR COMMUNITY RESPONDENTS:
- Betsy Bazur-Leidy, PATH clinic
- Stephanie Budge, UW Department of Counseling Psychology
- Karma Chavez, UW Department of Communication Arts
- Baltazar De Anda-Santana, Alianza Latina
- Patrick Farabaugh, Our Lives Magazine
- Molly Herrmann, Wisconsin Department of Public Instruction
- Sheri Hohs, Madison Metropolitan School District
- Out Professional Engagement Network
- Owen Karcher, Transgender Youth Resource Network
- Robin Matthes and June Paul, Briarpatch Youth Services
- Christian Merino, Alianza Latina
- Emily Mills, Our Lives Magazine
- Kathy Oriel, UW Department of Family Medicine
- Craig Roberts, University Health Services
- Justice Robinson, Journey Mental Health Services
- Steve Starkey and Angie Rehling, OutReach
- Kabzuag Vaj, Freedom Inc
- Caroline Werner, OutReach
- All staff, GSAFE

THANK YOU TO OUR REVIEWERS AND EDITORS:
- Sarah Davis, Center for Patient Partnerships
- Jennifer Edgoose, Department of Family Medicine and Community Health
- Mari Gasiorowicz, Department of Health Services
- Ronni Hayon, Department of Family Medicine
- Mary Michaud, Public Health Madison Dane County

THANK YOU TO OUR GENEROUS FUNDERS:
- Out Professional Engagement Network (OPEN) Community Grant


7 https://en.wikipedia.org/wiki/Constitutional_amendment


McLaughlin KA, Hatzenbuehler ML, Keyes KM. Responses to discrimination and psychiatric disorders among black, Hispanic, female, and lesbian, gay, and bisexual individuals. Am J Public Health. 2010;100(8):1477-84.


58 Compiled by Davis. S, Center for Patient Partnerships, patientpartnerships.org including from an interview with Dr. Ronni Hayon, profile informants, and the LGBT Friendliness Kit for Primary Care Physicians, Available at: http://uwmedstudents.com/wp-content/uploads/2015/08/LGBT-Friendliness-Kit_easyduplex_ver-1.5.pdf and community respondents.


Durso, LE, & Gates, GJ. (2012). Serving our youth: Findings from a national survey of service providers working with lesbian, gay, bisexual, and transgender youth who are homeless or at risk of becoming homeless. The Williams Institute with True Colors Fund and The Palette Fund.


Stotzer, R.: Comparison of love Crime Rates Across Protected and Unprotected Groups, Williams Institute, 2007–06.


Available at: http://uwmedstudents.com/wp-content/uploads/2015/08/LGBT-Friendliness-Kit_easyduplex_ver-1.5.pdf and community respondents


http://etf.wi.gov/boards/agenda-items-2016/gib0712/item3a.pdf


“Memo on Health Benefits for Transgender State Employees in Wisconsin,” Pamela E. Oliver, PhD Conway-Bascom Professor of Sociology Alexander Hanna M.S. Sociology, January 23, 2015.


