LESBIAN, GAY, BISEXUAL, TRANSGENDER, QUEER+ INDIVIDUALS
LGBTQ+ Coloradans often face challenges and barriers in achieving a healthy life. While LGBTQ+ individuals have many of the same barriers as the general population in accessing affordable and quality behavioral health care, additional unique barriers may include lack of understanding, discrimination, stigma, violence and higher rates of health problems, which can drive worse health outcomes.

This brief provides a summary of available data on behavioral health prevalence as well as stakeholder feedback on the specific needs and barriers to care with special attention to the root causes of disparity for this priority population. Ideas to improve care including evidence-based practices and innovations within Colorado and nationally are also included.

Check marks specify indicators of the prevalence of behavioral health need among priority populations that are available and included in this brief. Boxes signify that the indicator does not exist specific to this population in the data:

- ✓ Prevalence of poor mental health (MH) and/or substance use disorders (SUD)
- □ Age adjusted drug overdose death rates per 100,000 people
- □ Age adjusted suicide death rates per 100,000 people

Check marks specify indicators of population experience with services among priority populations that are available and included in this brief.

- ✓ Percent of population receiving behavioral health care when they need it
- ✓ Percent of behavioral health providers who serve population
POPULATION ESTIMATE

In the U.S., the percentage of adults who are LGBTQ+ increased to 4.5 percent in 2017, up from 4.1 percent in 2016 and 3.5 percent in 2012.[1] Similarly, it is estimated that 4.6 percent or 200,000 Coloradans are LGBTQ+.[2]

PREVALENCE OF MENTAL ILLNESS AND SUD

Various findings raise concern about LGBTQ+ youth regarding risk for suicide. Risk for suicide is two to three times higher for LGBTQ+ individuals particularly during adolescence.[3] According to self-reported data in the Healthy Kids Colorado Survey (HKCS), youth who are Lesbian, Bi-sexual and Gay (LGB) have higher rates of suicidal thinking (development of a plan) and suicide attempts. Youth who identify as transgender have the highest risk with 40 percent admitting to suicidal thinking and 35 percent admitting to having attempted suicide.[4] Other concerns include higher use of tobacco, marijuana, alcohol and other drugs.[5] Youth who are LGB are also more than twice as likely to be bullied in school, experience higher rates of electronic bullying and many miss school days because of feeling unsafe.[6]

LGBTQ+ adults have higher rates of anxiety and depression (at almost three times the rate). LGBTQ+ adult “healthy days” are also worse for both physical and mental health than non-LGBTQ+ adults. One estimate suggests LGBTQ Coloradans experience higher rates of depressive disorder diagnosis than the general population (55 percent and 17.4 percent, respectively) and anxiety disorder diagnosis (50 percent and 17.7 percent, respectively).[7][8] Like youth, LGBTQ adults experience greater prevalence of suicide contemplation than the general public. However, among those with suicide contemplation, LGBTQ adults are less likely to attempt suicide than the general public.


There is a persistent lack of routine data collection on sexual orientation and gender identity, including the disparities that affect the LGBTQ+ population—leaving the challenges facing LGBTQ+ communities largely unmapped. Comprehensive and accurate data on the LGBTQ+ population are needed to help direct support toward the programs and policies that most effectively provide services to communities in greatest need. Collecting more and better data about sexual orientation and gender identity is essential to identify and meet the needs of LGBTQ+ individuals.
Improving access to behavioral health services that are sensitive to LGBTQ+ concerns, developmental issues and needs was identified as a primary concern. A national study published in 2017 found that sexual minority college students use mental health services at higher rates than their heterosexual peers but have high rates of unmet treatment need.[9]

LGBTQ+ adults have challenges when accessing mental health and SUD services. In a 2019 study, the lack of provider competence (understanding, training and knowledge about unique LGBTQ+ needs) contributed to access challenges.[10] These challenges are further exacerbated for transgender individuals with 34 percent reporting being denied coverage for certain medical services in 2018 (e.g., HIV medications, hormones, pre-exposure prophylaxis (PrEP)). Distance to competent providers is another significant barrier with most competent care services offered on the front range (Denver, Jefferson and Arapahoe Counties) with a few more rural locations (rural parts of El Paso and Archuleta Counties).

The LGBT Foundation reports 1 in 5 LGBT patients say their sexual orientation has been a factor in them delaying receiving health care. According to Ashley Spivak, co-founder of the sexual education website Cycles + Sex, “That number is even higher for trans and gender nonconforming people and queer people of color.”


Another significant concern for this population is the experience of professional services aimed at changing their sexual orientation (conversion therapy) which remains a risk for individuals seeking treatment. Nearly one in five LGBTQ+ individuals surveyed by One Colorado reported an experience of someone trying to change their sexual orientation or gender identity.[11] As seen with youth, transgender adults consider suicide (41 percent) at a prevalence far higher than the general population (6 percent).[12] In 2019, Colorado banned conversion therapy for youth, which is a positive step; however, there remains a gap in provider expertise in supporting individuals with identity concerns and individuals who face discrimination.[13]

Focus groups and interviews with LGBTQ+ adults (18 years and older) support the findings above. Trauma and anxiety can more often reside in any marginalized identity compared to the general population. This is thought to stem from the lack of representation in society, including media, schools and health care, that equip youth and adults to navigate challenges that come from being part of a marginalized community and from experiences of discrimination and even violent acts. Compounding this challenge is competent, accepting and available resources which are particularly a problem in smaller, rural communities.

Colorado’s 2018 study of youth suicide revealed concern in some communities about a lack of acceptance of youth who identify as LGBTQ+. Youth and adults described increased bullying of LGBTQ+ youth by both peers and adults within schools, a lack of response by schools and other youth-serving institutions and routine, systemic isolation of these young people. Additionally, stigma against or by specific populations was described as thwarting prevention initiatives; for example, discrimination against LGBTQ+ individuals limits the places and resources from which those youth seek help. Additionally, providers often lack LGBTQ+ competence and sensitivity to the intersecting identities that may add additional barriers (e.g., conflict with religion or being undocumented). For these individuals, it may feel like “coming out twice,” which adds complexity to accessing services.


CONTINUUM OF CARE NEEDS

There is a need for culturally sensitive LGBTQ+ services all along the continuum and across the life span, including not just a recognition for being “LGBTQ+-friendly” but also to be knowledgeable about the specific health risks and concerns that affect the community. According to Gay and Lesbian Medical Association Provider Directory, there are 95 “LGBTQ+-friendly” providers in Colorado, among which 35 are behavioral health providers.

There is a need to ensure parity around the cost of and access to services for LGBTQ+ individuals, as well as policies and education that providers and payors cannot discriminate (i.e., framing mental health conditions as “identity issues” rather than behavioral health diagnoses).

IDEAS TO BETTER ADDRESS THE NEEDS OF LGBTQ+ INDIVIDUALS

Many stakeholders suggested that there is a need for crisis services line staff who identify as LGBTQ+ or who are culturally competent and “queer friendly” as one stakeholder described it. With higher rates of suicide and substance use, the need for accessible crisis services is a primary concern. Another idea was the use of a LGBTQ+ navigator that could help individuals get connected to culturally competent services.

Provider patient forms should be required to collect expanded demographic options such as sexual orientation, gender identity, sex assigned at birth and relationship status. The Health Resources and Services Administration (HRSA) provides best practices in collecting these data. However, this information is still not collected by most behavioral health providers. Providers may also need additional training in understanding how this demographic data is central to engagement and treatment. When providers do not ask the questions, they immediately alienate individuals because it signals discomfort or stigma.

State agencies and accountable entities need to develop a more streamlined and accessible grievance process for LGBTQ+ consumers who have been denied behavioral health services.

State agencies and providers should work together to build an accessible and culturally competent provider network, including provider trainings and a process to identify what it means to be LGBTQ+ competent.

HIGHLIGHT: EVIDENCE BASED APPROACH FOR LGTBQ+

Queer-Informed Narrative Therapy (QINT)

One promising practice that is being tested within a LGBTQ+ community-based organization in California is QINT. QINT is an affirmative counseling approach that distinguishes people from problem. This model draws upon queer theory and narrative therapy practices. Narrative therapy is a practice that provides a respectful, non-blaming approach to therapy and recognizes the client as the expert. Queer theory helps narrative therapy rethink gender and sexuality by critiquing the predominantly accepted binary structure and addressing the lived realities of LGBTQ+ people. This intervention locates problems as systemically and culturally produced rather than an internal personal deficit and understands that mental distress can be an expected outcome of rampant systemic anti-LGBTQ+ discrimination rather than a personal failing. The approach of QINT emphasizes the need for culturally competent mental health providers to be advocates for LGBTQ+ people in their families, workplaces and within the health care system; in order for individuals to experience reduced mental distress, it is necessary for them to receive affirmative care in these key aspects of daily living.

Other promising practices being implemented and tested in California include locating mental health services within community-based organizations that already provide services within, for and by the specific community (i.e., LGBTQ+ services provided to LGBTQ+ individuals at LGBTQ+ community-based organizations by LGBTQ+ providers), and providing a continuum of social support services that work to prevent the worsening of behavioral health problems by reducing isolation and loneliness and strengthening connections with communities.