Journal of Pediatric Nursing (2012) **27**, 177–179

Deborah L. McBride, MSN, RN, CPN, CPON, CCRN

HOT TOPICS COLUMN

Column Editor: Deborah L. McBride, MSN, RN, CPN, CPON, CCRN

Homelessness and Health Care Disparities Among Lesbian, Gay, Bisexual, and Transgender Youth

Deborah L. McBride MSN, RN, CPN, CPON, CCRN*
Kaiser Permanente Oakland Medical Center, Oakland, CA

A NUMBER OF recent studies on lesbian, gay, bisexual, and transgender (LGBT) youth have come up with some startling statistics. One study reported that somewhere between 30% and 40% of homeless youths identify as LGBT (Corliss, Goodenow, Nichols, & Austin, 2011). Researchers from the Children's Hospital Boston and the Harvard Medical School suggest that this may be because LGBT youths are more often kicked out of their homes than straight youths, or even if they are not kicked out, they may feel so uncomfortable that they leave. The study identified two distinct groups that make up the population of homeless children and youths in the United States: (a) families with children and (b) unaccompanied youths. The first group has been estimated to be more than 1.5 million U.S. children living within families that lacked a permanent home during the period of 2005 and 2006. The second group was estimated to be an additional 575,000 to 1.6 million U.S. youths living without a home and without a family, unaccompanied on the streets or in a shelter (National Center on Family Homelessness, 2009). The researchers used data from the Massachusetts Youth Risk Behavior Survey, which contains information on homeless status and sexual orientation to estimate the prevalence of homelessness in sexual minority adolescents. The researchers defined homelessness as lacking a fixed, regular, and adequate nighttime residence. Several factors associated with greater risk for homelessness were found to occur more frequently in youths with minority sexual orientation than in heterosexual youths. The researchers documented a higher risk of familial maltreatment among LGBT individuals than among heterosexual individuals. This population also faces an increased likelihood of experiencing discrimination and victimization in school and community settings as well as diminished peer support.

One study reported that somewhere between 30 and 40 percent of homeless youths identify as lesbian, gay, bisexual or transgender.

The researchers report that after becoming homeless, youths with a minority sexual orientation appear to have greater risks and poorer outcomes than do their heterosexual counterparts (Corliss et al., 2011). Homeless LGBT youths experience more physical and sexual victimization and mental health problems such as depression, posttraumatic stress disorder, and suicidality than do homeless heterosexual youths. Lesbian and bisexual females who are homeless appear to be at an especially elevated risk for substance use and abuse compared with homeless heterosexual females. Sexual risk behaviors also appear to disproportionately impact sexual minority homeless adolescents. Studies have reported higher numbers of lifetime sexual partners, younger ages of sexual initiation, and higher rates of unprotected intercourse, survival sex, and HIV and other sexually transmitted infections among sexual minority homeless adolescents.

Professionals working with adolescents should be aware that minority sexual orientation status is linked to a greater vulnerability of being homeless. Relationships with family and risk for homelessness should be assessed among youths identifying themselves as LGBT and among youth who identify themselves as heterosexual, but report same-sex sexual partners. The term *LGBT* is used by many organizations to emphasize the diversity of gender identity-based cultures and is sometimes used to refer to anyone who

* Corresponding author: Deborah L. McBride, MSN, RN, CPN, CPON, CCRN.
E-mail address: jrm2@berkeley.edu.

0882-5963/$ – see front matter © 2012 Elsevier Inc. All rights reserved.
doi:10.1016/j.pedn.2011.11.007

is nonheterosexual instead of people who are exclusively homosexual, bisexual, or transgender. To recognize this inclusion, a popular variant adds the letter Q for those who identify as queer and are questioning their sexual identity, for example, LGBTQ.

A second study published recently showed that medical schools neglect gay and gender issues. Researchers from the Lesbian, Gay, Bisexual and Transgender Medical Education Research Group at Stanford University School of Medicine surveyed medical school deans in the United States and Canada and asked about the curriculum devoted to topics like gender identity, coming out as gay, and disparities in health care access for LGBT patients. Although nearly all the medical students were learning to ask patients about the gender of their sexual partners, most medical schools devoted 5 hours or less to teaching anything more than that simple question. Fully one third of schools allotted no time at all to these subjects (Obedin-Maliver et al., 2011). The study found that what little training medical students did receive—focusing on sexual behavior of HIV infections—ignores the many other complex health-related issues these patients often deal with. As documented in a report issued this year by the Institute of Medicine (2011), LGBT patients tend to be more isolated and have higher rates of chronic diseases like diabetes and high blood pressure. Because of the discrimination they face and fear, many also have difficulty gaining access to care and thus face an increased risk of suicide, substance abuse, and unaddressed domestic violence. The Stanford researchers conclude that these patients need to feel that they can tell their health care providers that they are gay and that their health care provider will accept them. Recently, the federal government has announced several initiatives to address disparities in LGBT health care access (Department of Health and Human Services, 2011), but this study confirms that most medical schools are lagging behind. Those schools that do integrate the material into standing courses, do so by offering electives or inviting outside experts to speak on topics like the use of hormones in transitioning from one gender to the other. At other schools, medical students discuss sexual identity issues with actors who have been trained to play the part, asking them whether they feel different from the identity assigned by society at birth, which helps students to eventually discuss these topics with real patients in a nonjudgmental but confident way. The researchers feel that these types of improvements could benefit all patients and help health care providers build a trusting relationship with LGBT patients (LGBT Medical Education Research Group, 2011).

A third study examined the patterns and correlates of same-sex sexual activity among U.S. youth. Investigators analyzed data on sexual attraction, identity, and behavior from 2,688 males and females (age range = 15–21 years) who participated in the National Survey of Family Growth in 2002. It found that overall, 15% of females and 5% of males reported sexual attraction to both sexes. Among those who described themselves as heterosexual, 5% of females and 2% of males reported same sexual experiences. Approximately 81% of female and 70% of male youth who reported attraction to same-sex individuals reported heterosexual sexual experiences. The researchers conclude that development of sexual identity during adolescence is dynamic, and the data show that attraction, identity, and behavior do not correlate perfectly. They recommend asking young people whether they are attracted to or have had sexual experience with individuals of the same, opposite, or both sexes to determine the appropriate risk reduction messages rather then asking them to label themselves as gay, straight, or bisexual (McCabe, Brewster, & Tillman, 2011). It is important for health care providers to realize that traditional sexuality labels do not apply to many adolescents and young adults because some self-described heterosexual youth report same-sex experiences, and most homosexual and bisexual youth report opposite sex experiences. These findings argue for the need to broaden the research agenda to examine the diversity of behaviors reported by youth of all sexual attractions and identities. They also argue for the need to expand reproductive health education programs to include information on same-sex sexual behaviors. Sexual experimentation is normative during adolescent and early adulthood, and the narrow focus of sexuality programs on vaginal intercourse needlessly restricts the information that youths receive, including critical information on health-related risks and protections associated with the alternative sexual activities in which many participate.

A number of tools exist to help health care providers care for LGBT patients. Kaiser Permanente's award-winning Provider's Handbook for Culturally Competent Care for Lesbians, Gays, Bisexuals and Transgendered Individuals is available on the Internet, which discusses homophobia and heterosexism in health care including descriptions of sexual practices and their associated risks. The King's County Public Health Department Web site lists recommendations for creating a welcoming office culture for LGBT patients (http://www.kingcounty.gov/healthservices/health/personal/glbt/CulturalCompetency.aspx). The Al Forney Center Web site lists resources for LGBT homeless youths in different cities including referrals to shelter services (http://www.aliforneycenter.org/resources.html). Finally, the National Runaway Switchboard (NRS) and Web site (http://www.1800runaway.org) operate a 24-hour crisis line (1800 RUNAWAY), and through a partnership with Greyhound lines, the NRS runs the Home Free program, a youth-initiated program of family reunification that provides a free bus ticket home. More needs to be done to reduce homelessness and to enhance support among lesbian, gay, and bisexual youths in the United States. Future research should focus on developing a more comprehensive understanding of the mechanism contributing to the higher risk of homelessness in this population, which could aid in the design of programs and policies to reduce sexual orientation health care disparities in youth.

References

Corliss, H. L., Goodenow, C. S., Nichols, L., & Austin, S. B. (2011). High burden of homelessness among sexual-minority adolescents: Findings from a representative Massachusetts high school sample. *American Journal of Public Health*, *101*, 1683–1689.

Department of Health and Human Services. (2011). Recommended actions to improve the health and well-being of lesbian, gay, bisexual and transgender communities. Retrieved November 23, 2011, from http://www.hhs.gov/secretary/about/lgbthealth.html.

Institute of Medicine. (2011). The health of lesbian, gay, bisexual and transgender people: Building a foundation for better understanding. Retrieved November 20, 2011, from http://www.iom.edu/Reports/2011/The-Health-of-Lesbian-Gay-Bisexual-and-Transgender-People.aspx.

LGBT Medical Education Research Group. (2011). Changing the face of medication education to improve care to lesbian, gay, bisexual, & transgender patients. Retrieved November 24, 2011, from http://med.stanford.edu/lgbt/.

National Center on Family Homelessness. (2009). State Report Card on Childhood Homelessness: America's Youngest Outcasts. Newton, MA. Retrieved November 24, 2011, from http://www.homelesschildrenamerica.org/findings.php.

McCabe, J., Brewster, K. L., & Tillman, K. H. (2011). Patterns and correlates of same-sex sexual activity among U.S. teenagers and young adults. *Perspectives on Sexual and Reproductive Health*, *43*, 142–150.

Obedin-Maliver, J., Goldsmith, E. S., Stewart, L., White, W., Tran, E., & Lunn, M. R. (2011). Lesbian, gay, bisexual, and transgender-related content in undergraduate medical education. *Journal of the American Medical Association*, *306*, 971–977.