

Adolescent Health Care Service and Systems: Issues of LGBT Youth

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Panel 4: Questions for Speakers

Based upon “*current evidence*”...

1. What structure & content of health care delivery to LGBTQ youth will produce optimal outcomes?
2. What models have achieved the best outcomes for LGBTQ youth?
3. What are promising future directions to improve the health care and health status of LGBTQ youth?
4. What are policy constraints to delivering care to LGBTQ youth?
5. What research is needed to address service delivery models and health care systems for LGBTQ youth?

Two Caveats...

1. Where's the data?? – “invisible population”

- Slew of risk behavior data
 - Mostly in urban males
- Paucity of data on health care delivery/services
 - Ex: HIV prevention data young MSM
- Limited # of clinician stakeholders for this pop.
 - Stigma and funding issues

2. LGBTQ Youth are not a *homogenous* group

- Issues of transgender youth more complicated
- Very little known about:
 - Young women, bisexual, questioning youth

Q1: Health Care Delivery

Structure and Content

- **Structure:**

- LGBTQ youth exist in all communities and practices
- Health care not just in specialized clinics/drop-in centers
- Private practices, schools, ERs, public health clinic, etc.
- “Cultural competence” in each of these setting

...Thus, the structure of the health care delivery System needs to be multi-faceted

Q1: Health Care Delivery

Structure and Content

- **Content:**
 - Most concerns not related to sexual minority status
 - Disproportionate risk for # negative health outcomes:
 - Substance use, mental health, homelessness, sexual risk
 - Interventions and health care delivery grounded in unique aspects of being LGBTQ (i.e. stigma)
 - Importance of “disclosure”??

Q1: Health Care Delivery

Content – *Role of Disclosure*

- Meckler (2006)

- N=131
- Youth conference
- 35% aware of LGBT identity

- Benson (In Press)

- N=429
- Community-based
- 49% aware of LGBT identity

- Is disclosure of sexual identity a meaningful marker of quality health care delivery?

- Perhaps more meaningful is the general lack of discussion of **sexual health topics** with teens.

Q2: Best Outcomes

Models of Care

- Little outcome data on extant models of health care delivery
- Most published “data” derived from review articles, book chapters, etc.
 - Anecdotal or Based Upon Clinical Experience
 - Often focused on wide range of areas:
 - Access, Environment, Confidentiality, Provider, etc.
- “One-Stop Shopping” Model of Care

Q2: Best Outcomes

Models of Care – One-Stop Shopping

- Chicago's Broadway Youth Center (BYC)
 - 4 initial community partners (now 8-10)
 - Heavily trafficked geographic area
 - Committed to created “sum” greater than individual parts
 - Each contribute staff, \$\$, resources
 - **Targets high-risk groups:** LGBTQ and homeless youth
 - Multitude of barrier-free services 6 days/wk; 1-8PM
 - Housing assistance, case management, HIV/STD testing medical care, counseling services, food/shower/laundry, GED and job training, mentorship program
 - Community space -- Youth owned and operated

Q2: Best Outcomes

Models of Care – BYC

- Open for two years (2004-2006)
 - 4000-5000 youth served annually
 - >500 medical clients/year
 - >90% report difficulty accessing care elsewhere
 - 1500 HIV/STD screens annually in youth 12-24
 - >70% return rate; very successful rapid testing pilot
 - 25-30 newly diagnosed HIV+ youth/year
 - Annual prevalence 1.4%
 - Annual prevalence in young gay/bisexual men 2.3%
 - 100% linked to case management and medical care

Q3: Promising Future Directions

- **Health Care Delivery**

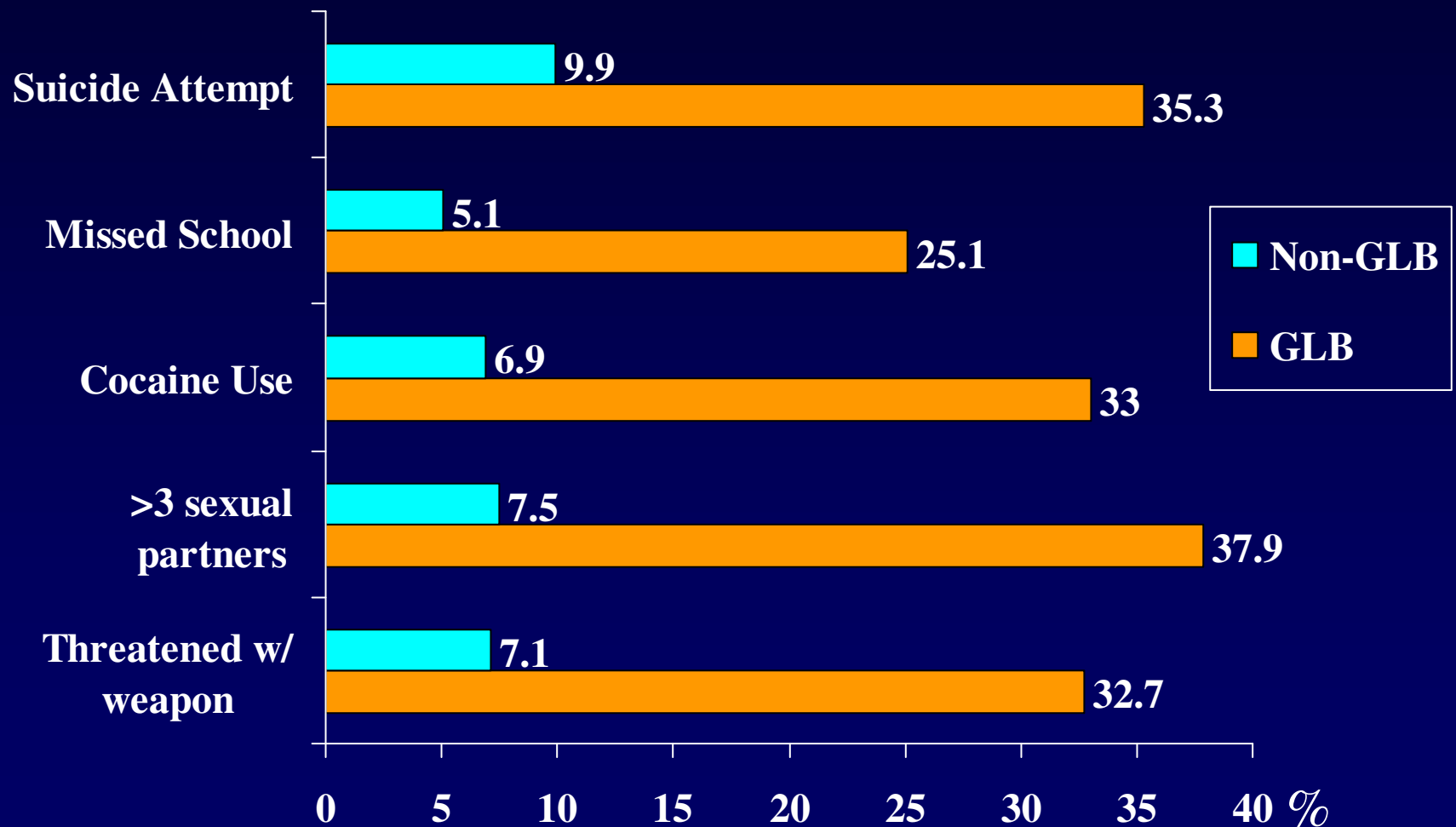
- Decreasing stigma in health care environment
- Improve cultural competency of providers and staff
- Training issues for providers
 - 1998 study of Washington DC pediatricians (East et al)
 - Multiple misconceptions about LGBT youth
 - Most had reservations about approaching sexual orientation
 - 68% did not include ? about sexual orientation in their histories
- Will training be enough –
 - Moral/ religious mores -- “refusal” cases

- **Health Care Status**

- Moving beyond discussions of risk

Risk Behaviors of LGB Youth

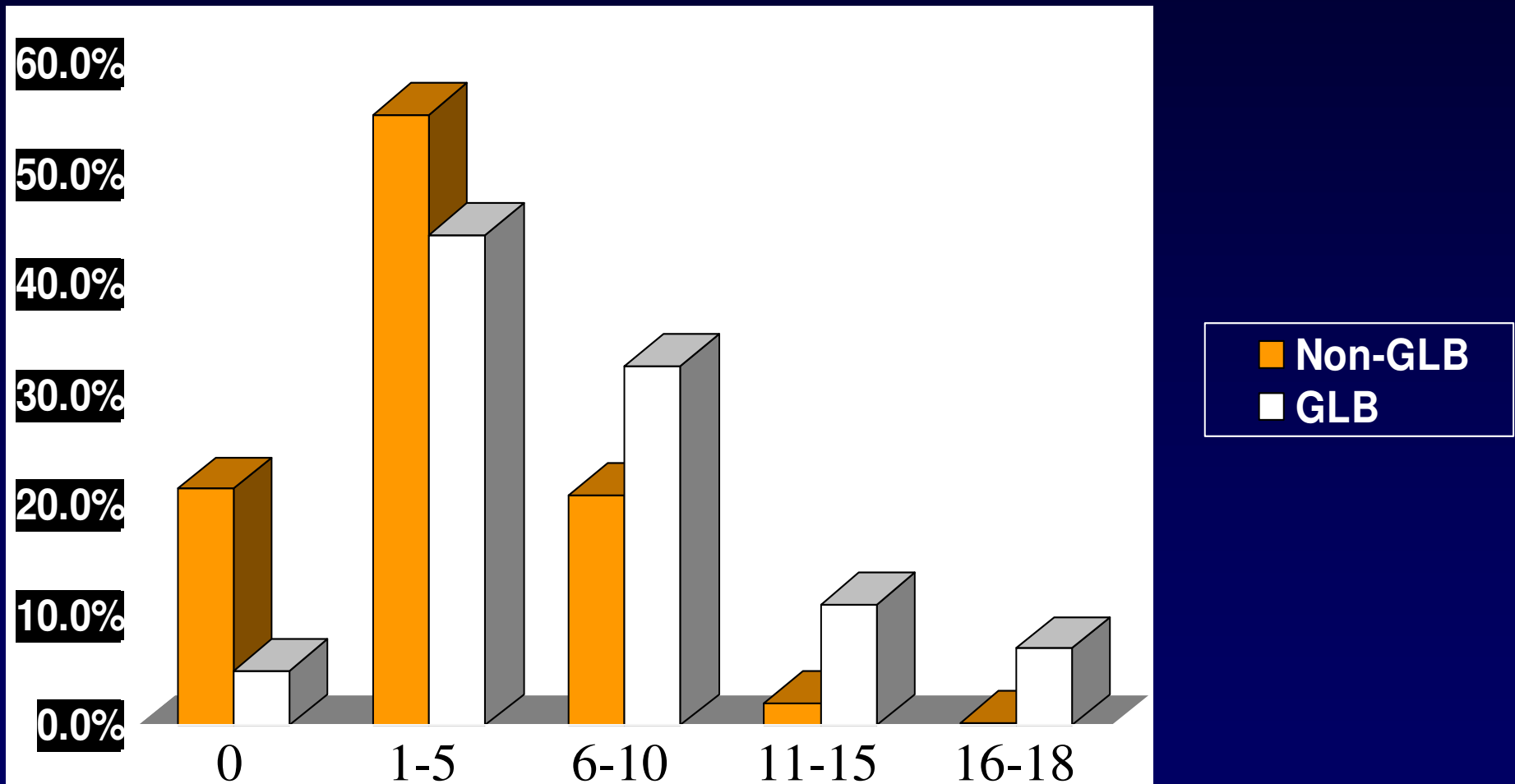
Massachusetts YRBS Data



*R Garofalo, et al. *Pediatrics*: May 1998

“SYNDEMICS”

Co-Occurring Risk Behaviors



Number of Co-Occurring Risk Behaviors Each Student Engaged In

*R. Garofalo et al. *Pediatrics*: May 1998

Changing Our View of LGBT Youth: Seeing the Glass Half-Full

Spectrum of Dysfunction

- Suicide
- Depression
- Substance Use
- Homeless
- HIV

Vs.

Strengths Perspective

- Pride
- Self-Determination
- Resilience

Q4: Policy Constraints

- **Federal Statutes and Financing**
 - HIPAA Language and Implementation
 - Health Care Financing —→ Where's the “*Safety Net*”
- **State Laws and Statutes**
 - Governing consent and confidentiality
 - Ex: Illinois statute for mental health and substance use services
 - LGBT youth very real concerns about advertent and inadvertent disclosure
 - Not just for clinical services but research participation
 - Moral imperative to advocate for inclusion

Q5: What Research is Needed?

Where's the Data

1. Move beyond research with small, non-population based samples from one geographic area
 - Multi-site research incl. women, racial/ethnic minorities
 - Utility & feasibility of novel sampling techniques (i.e. RDS)
 - Consider alternative mediums for data collection (i.e. Internet)
2. Funding specific to health care delivery and models of care
 - Not just “spectrum of dysfunction research” – HIV, drugs, suicide
- 3. Advocate for inclusion of sexual identity measures on large national survey instruments!!!!**
 - As a demographic variable, not risk behavior
 - Ex: Curious and ? misleading use of the AddHealth Data set

Thank!!

The National Academies
The National Research Council and Institute of Medicine
Committee on Adolescent Health Care Services and Models
of Care
Board of Children Youth, and Families