

LGBT Community Health Needs Assessment of the Coachella Valley

prepared for



by



funded by



August 2013

Acknowledgements

This study was funded by the Desert Healthcare District. Without their support, this study would not have been possible.

HARC would like to thank intern Jonathan Lo for his assistance in the creation of this report.

HARC would also like to thank all of the people who participated in the key informant interviews and focus groups that helped to create and fine-tune the survey. Additionally, HARC would like to thank the hundreds of people that participated and passed the survey on to others. Without all of you, this report would not be possible.

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Table of Contents

Executive Summary	1
Introduction	5
Methods	6
Developing the Survey Tool	6
Recruitment	6
Participants	7
Analysis	9
Quantitative Analyses	9
Categorical Data Analysis	9
Continuous Data Analysis	10
Qualitative Analyses	10
Results	11
Demographics	12
Sexual Orientation	12
Gender Orientation	13
Gender	14
Age	15
Race and Ethnicity	17
Education	19
Income	20
Employment	21
Geographic Location	23
Seasonal Residents	25
Summary of Demographics	26
Healthcare Coverage and Utilization	27
General Health	27
Healthcare Coverage	29
Recent Healthcare Utilization	30
Quality of Local Healthcare	31
Summary of Healthcare Coverage and Utilization	32
Physical Fitness	33
Physical Activity	33
Fast Food Consumption	34
Body Mass Index (BMI)	35
Summary of Physical Fitness	36
Substance Use, Misuse, and Abuse	37
Smoking	37
Drinking	38
Prescription Drug Misuse	41
Illicit Drug Use	42
Addiction	45
Summary of Substance Use, Misuse, and Abuse	46
Sexual Health	47
Summary of Sexual Health	52
Violence	53

Physical Violence.....	53
Sexual Violence	55
Treatment for Victims of Violence.....	56
Summary of Violence	57
Chronic Illness	58
High Blood Cholesterol	59
Hepatitis	59
HIV	60
Cancer	60
High Blood Pressure/Hypertension.....	61
Heart Disease/Heart Attack.....	61
Diabetes.....	62
AIDS	62
Summary of Major Disease	64
Mental Health.....	65
Mental Health Disorders.....	65
Other Mental Health Concerns	67
Suicide.....	71
Self-Esteem.....	73
Summary of Mental Health.....	74
Isolation, Loneliness, and Social Support.....	75
Isolation.....	75
Loneliness	77
Social Support.....	79
Summary of Isolation, Loneliness, and Social Support.....	89
LGBT-Specific.....	90
Outness.....	90
Availability of Culturally Appropriate Health Services	94
Most Needed Health Services.....	99
Positive Aspects of Being LGBT.....	103
Summary of LGBT-Specific.....	105
Transgender-Specific	106
Demographics	106
Transition	108
Letters of Support	108
Surgery.....	109
Hormone Replacement Therapy.....	110
Availability of Transgender-Specific Healthcare Services.....	111
Transgender-Specific Summary.....	112
Future Research	113
Conclusion	116

List of Tables

Table 1. Initial Sample by LGBTTS Categories	8
Table 2. Final Sample by LGBTTS Categories	8
Table 3. Sexual Orientation	12
Table 4. Gender Orientation	13
Table 5. Gender by LGBTTS Category	14
Table 6. Age Comparison – Under 50 and Over 50	16
Table 7. Race	17
Table 8. Employment by LGBTTS Category	22
Table 9. Location	23
Table 10. General Health by LGBTTS Category	28
Table 11. BMI by LGBTTS Category	36
Table 12. Drinking in Past Month	39
Table 13. Hallucinogen Use by LGBTTS Category	43
Table 14. Marijuana Use by LGBTTS Category	44
Table 15. Recent Illicit Drug Use by LGBTTS Category	44
Table 16. Sexual Activity by LGBTTS Category	47
Table 17. Type of Sexual Activity by LGBTTS Category	48
Table 18. Physical Intimate Partner Violence by LGBTTS Category	54
Table 19. Barriers to Seeking Treatment for Violence	56
Table 20. Chronic Illness Diagnoses	58
Table 21. High Blood Cholesterol by LGBTTS Category	59
Table 22. Hepatitis by LGBTTS Category	59
Table 23. HIV by LGBTTS Category	60
Table 24. Cancer by LGBTTS Category	60
Table 25. High Blood Pressure/Hypertension by LGBTTS Category	61
Table 26. Heart Disease/Heart Attack by LGBTTS Category	61
Table 27. Diabetes by LGBTTS Category	62
Table 28. AIDS by LGBTTS Category	62
Table 29. Average Number of Major Disease Diagnoses by LGBTTS	64
Table 30. Mental Health Disorder Diagnoses	65
Table 31. Barriers to Seeking Treatment for Mental Health Concerns	69
Table 32. Transportation Barriers	76
Table 33. Primary Sources of Social Support	79
Table 34. Relationship Status by LGBTTS Category	81
Table 35. Pet Status	82
Table 36. Relationship to Family of Origin	83
Table 37. Relationship to Family of Origin – NA Removed	83
Table 38. Religion by LGBTTS Category	84
Table 39. Out or Not Out	90
Table 40. Out or Not Out – NA Removed	91
Table 41. Outness by LGBTTS Category	93
Table 42. LGBT Welcoming Services	94
Table 43. LGBT Welcoming Services – NA Removed	95
Table 44. Welcoming Healthcare Providers by LGBT Category	96
Table 45. Welcoming Crisis Intervention Services by LGBT Category	96

Table 46. Welcoming Pharmacy Services by LGBT Category	97
Table 47. Welcoming Social Services by LGBT Category	97
Table 48. Most Needed Health Services for the LGBT Community.....	100
Table 49. Need for Primary Care by LGBT Category.....	101
Table 50. Need for Mental Health Services by LGBT Category.....	101
Table 51. Need for Specialty Care by LGBT Category.....	102
Table 52. Positive Aspects of Being LGBT.....	103
Table 53. Availability of Local Transgender Health Services.....	111

List of Figures

Figure 1. Age	15
Figure 2. Race	18
Figure 3. Ethnicity	18
Figure 4. Education	19
Figure 5. Income	20
Figure 6. Employment	21
Figure 7. Map of Coachella Valley	24
Figure 8. Seasonal Residents	25
Figure 9. General Health	27
Figure 10. Healthcare Coverage	29
Figure 11. Recent Healthcare Utilization	30
Figure 12. Quality of Local Healthcare	31
Figure 13. Physical Activity	33
Figure 14. Fast Food Consumption	34
Figure 15. Body Mass Index (BMI)	35
Figure 16. Smoking Frequency	37
Figure 17. Drinking in Past Month	38
Figure 18. Amount of Drinking in Past Month	39
Figure 19. Number of Drinks Consumed per Drinking Day	40
Figure 20. Prescription Drug Misuse	41
Figure 21. Illicit Drug Use	42
Figure 22. Concern Regarding Addiction	45
Figure 23. Years of Recovery for Participants Who Have Completed Treatment	46
Figure 24. Number of Sexual Partners in Past Year	49
Figure 25. Gender of Partners	49
Figure 26. Frequency of STD Status Inquiry	50
Figure 27. Frequency of Use of Protection During Sexual Intercourse	51
Figure 28. Physical Intimate Partner Violence	53
Figure 29. Sexual Intimate Partner Violence	55
Figure 30. Major Disease – Total Disease Burden	63
Figure 31. Prevalence Rates for the Top Three Mental Health Disorders	66
Figure 32. Total Mental Disorder Diagnoses	67
Figure 33. Mental Health Concerns in Past Year	68
Figure 34. Suicidal Ideation	71
Figure 35. Suicide Attempts	72
Figure 36. Self Esteem	73
Figure 37. Frequency of Leaving the Home	76
Figure 38. Loneliness	77
Figure 39. Average Loneliness Score by LGBTs Category	78
Figure 40. Relationship Status	80
Figure 41. Influence of Religion	85
Figure 42. Use of Support Groups	86
Figure 43. Caregiving Responsibilities	87
Figure 44. Outness Score	92
Figure 45. Importance of Low-Cost LGBT-Specific Counseling Services in CV	99

Figure 46. Significant Differences in Positive Aspects	104
Figure 47. Gender Orientation of Transgender Participants	106
Figure 48. Gender of Transgender Participants	107
Figure 49. Sexual Orientation of Transgender Participants.....	107
Figure 50. Transition Status of Transgender Participants.....	108
Figure 51. Access to a Mental Health Professional to Provide Letters of Support	109
Figure 52. Hormone Use of Transgender Participants.....	110

Executive Summary

This report describes the results of a health needs assessment of the LGBT community in the Coachella Valley, California. The study had four primary goals:

- Describe the local LGBT population demographically
- Describe the current health and wellness status of the local LGBT community
- Identify health and wellness needs in the local LGBT community
- Describe the current availability of culturally competent health services

An online survey utilizing snowball sampling was conducted for approximately seven weeks in the spring of 2013. The survey contained 76 close-ended questions and one open-ended question. The survey was open to any adult resident that lived in the Coachella Valley year-round or as a seasonal resident. The final sample included 769 participants, who were divided into the following groups for analysis:

- 547 gay
- 117 lesbian
- 54 straight
- 31 bisexual
- 20 transgender

Demographics

The majority of participants are older gay men who do not identify as transgender. Over 80% of participants are age 50 or older. Over 90% of participants are white, non-Hispanic. Education levels are very high; the majority of participants have at least a 4-year college degree. Income level is relatively varied across the sample. The majority of participants are permanent residents of Palm Springs.

Healthcare Coverage and Utilization

Overall, most participants rate their health as “good”, “very good”, or “excellent”. Bisexual participants appear to have worse self-rated health than other participants, while straight participants have better self-rated health than most participants.

The vast majority of participants have health insurance, and over 80% of participants have seen a healthcare provider within the past six months. About 70% of participants rate local healthcare services as “good quality”.

Physical Fitness

On average, participants are physically active between four and five days per week. Approximately half of participants eat fast food one or more days per week, which puts them at risk for obesity. Results indicate that over two-thirds of participants are overweight or obese at the present time. This obesity rate is on par with local and national rates of obesity.

Substance Use, Misuse, and Abuse

Less than 15% of participants smoke cigarettes. Approximately three-quarters of participants have consumed alcohol in the past month. However, in-depth analysis shows that the majority of participants are imbibing one to two drinks when they choose to drink, a level that is more likely

to have health benefits that health damages. Very few participants have engaged in binge drinking in the past month. Approximately 22% of participants have engaged in prescription drug misuse by consuming a drug prescribed to someone other than themselves.

The majority of illicit drug use has occurred more than a year ago, indicating that most participants are not current drug users. Approximately one quarter of participants used an illicit drug within the past year; the vast majority of these used marijuana.

Approximately 11% of participants have previously undergone treatment for substance abuse. A quarter of these participants do not consider themselves to currently be in recovery. Of those who are currently in recovery, most have been in recovery for over a decade.

Sexual Health

On average, over 70% of participants have been sexually active within the past year. Gay participants are more likely than other participants to be sexually active. Gay participants are also more likely to be sexually active with more than one partner, as are bisexual participants (to a lesser degree). Lesbian, straight, and transgender participants are more likely to be sexually active with just one person.

The majority of participants who had had sexual intercourse with multiple partners in the past year had done so only with males, and reported less than 10 partners in the past year. About half of these participants regularly inquired about a partner's STD/HIV status prior to engaging in sexual relations with them. Additionally, the percentage of participants who are sexually active with multiple partners that "always" use protection is less than 20%. Thus, it is clear that many gay participants are engaging in extremely risky sexual behavior: unprotected sex with multiple partners without inquiring about STD status prior to intercourse.

Violence

About 22% of participants had experienced physical violence from an intimate partner. This rate is distinctly higher than comparable rates in the county and state as a whole. Lesbians have experienced especially high rates of physical intimate partner violence (nearly 35%). Approximately 21% of participants experienced physical violence from someone other than an intimate partner.

Approximately 6% of participants have experienced sexual violence from an intimate partner. Rates of sexual violence from someone other than an intimate partner are approximately 11% across all participants.

Of those who experienced violence, approximately 41% talked to a mental health professional about what happened. Reasons for not speaking to a mental health professional about the violent incident included embarrassment and a lack of knowledge about where to go for services. Additionally, several participants stated that they did not seek out a mental health professional because they did not feel the need, or because the solution had been resolved by ending the relationship (in reference to intimate partner violence, usually).

Chronic Illness

The most common chronic illnesses are high cholesterol, arthritis, and hepatitis. Less than 20% of participants have no chronic illness diagnoses whatsoever. In fact, the majority of participants have been diagnosed with more than one chronic illness.

In this sample, only gay and bisexual participants have been diagnosed with HIV and AIDS. Overall, gay and bisexual participants have more chronic illnesses than their lesbian, straight, or transgender counterparts.

Mental Health

Approximately half of participants have been diagnosed with one or more mental health disorders. The top three most commonly diagnosed disorders include depression, anxiety, and panic. These are the same three most common for the general population in the Coachella Valley, however, prevalence rates in this study seem to be much higher than in the general population.

About 40% of participants have experienced some emotional, mental, or behavioral problems that concerned them within the past year. This is more than twice the prevalence rate for such problems in the general adult population in the Coachella Valley. About 60% of these individuals sought professional help for the problem. Barriers to seeking help included the expense associated with seeking help, a lack of insurance, a lack of knowledge about where to go, and a conscious choice to not seek treatment.

Over a quarter of participants have seriously considered suicide at some time. This rate is more than double the rate of suicidal ideation in the County and State. About a third of participants who had considered suicide had also attempted suicide.

In contrast, overall self-esteem scores were relatively high. Over half of participants had self-esteem scores in the top quartile of possible scores, and over 100 participants scored the absolute highest possible score on the self-esteem scale.

Isolation, Loneliness, and Social Support

About one-third of participants currently live alone. However, over 80% of participants leave the home to visit friends and family once a week or more. Only about 4% of participants experience transportation problems that keep them from getting to their destinations.

Loneliness levels were similar to those in other communities, indicating a “normal” amount of loneliness. Lesbian and straight participants had particularly low levels of loneliness scores, indicating that they are satisfied with the amount of social contacts they have.

Most participants receive their social support from friends, spouses/significant others, and pets. About one-third of participants currently identify as “single” and do not have a spouse or significant other. About one-third of participants do not currently live with a pet.

Most participants have close and supportive relationships with the relevant family members in their lives, including parents, siblings, and children (when applicable). The exception to this was extended family members; a neutral relationship with these family members was more common.

A little over half of participants identified as religious or spiritual. For most of these people, religion was a positive or neutral influence in their lives, indicating it was probably a source of social support. Most participants do not currently attend formalized support groups, nor do they indicate a desire to do so.

LGBT-Specific

Overall, the majority of LGBT participants are 100% out to the people in their lives. Gay participants in particular are highly likely to be out to all of the relevant people in their lives. Over 95% of participants are out to their healthcare provider. However, it is worth noting that several participants were not out to any of the relevant people in their lives.

Opinions were generally mixed as to the current availability of LGBT-welcoming health services. Overall, transgender participants felt that services needed to be more welcoming. This may potentially indicate that local healthcare services are adequately welcoming to non-normative sexual orientations, but not to non-normative gender orientations.

The three most needed health services for the LGBT community included primary care, mental health care, and specialty care. The majority of participants felt that having low-cost mental health services available for the LGBT community was important in the Coachella Valley.

The list of positive aspects of being LGBT resonated with many participants. Overall, “authentic self and honesty” and “increased empathy and compassion for others” were consistently listed by all groups as a positive aspect of being LGBT. While the majority of participants identified with several positive aspects of being LGBT, it is worth noting that 12 participants selected “I cannot think of anything positive about being LGBT”.

Transgender-Specific

Transgender participants present an especially diverse group: the transgender participant group represents all genders and all sexual orientations. In addition to this diversity, the transgender participants have a very diverse experience as well. Some are currently on HRT, others will be on HRT in the future, and still others have no intention of using HRT. This underscores the fact that the transition process is not identical for all transgender people. Results indicate that there is a serious lack of transgender-specific services in the Coachella Valley, even including simple everyday care.

Additional Themes

Analysis of the open-ended question at the end of the survey described several types of services that the LGBT community needed and/or wanted. These included services for the deaf, for lesbians and/or women in general, for youth, for seniors (including LGBT-specific assisted living homes), and services related to socialization.

Introduction

Previous research has shown that lesbian, gay, bisexual, and transgender (LGBT) individuals experience unique health experiences and disparities (IOM, 2011). To date, virtually no research has been conducted to assess these health experiences and disparities in the Coachella Valley.

In 2012, the LGBT Community Center of the Desert (the Center) obtained a grant from the Desert Healthcare District (DHCD) to conduct a health needs assessment of the lesbian, gay, bisexual, and transgender (LGBT) community in the Coachella Valley. The Center and DHCD established that the health needs assessment had four primary goals:

- Describe the LGBT population demographically
- Describe the current health and wellness status of the LGBT community
- Identify health and wellness needs in the LGBT community
- Describe the current availability of culturally competent health services

The Center partnered with a local nonprofit research organization, the Health Assessment Resource Center (HARC) to develop and conduct the assessment.

Methods

Developing the Survey Tool

Initial development of the health needs assessment began with a literature review that covered funding opportunity announcements, peer-reviewed journal articles, and reports from similar needs assessments conducted in other communities. This literature review provided the researchers with context for the type of health topics covered in other assessments, as well as those that would likely provide valuable information to the field as a whole.

Based on this information, HARC and the Center developed a structured interview script. Key informant interviews were conducted with six prominent members of the LGBT community in the Coachella Valley. These interviews provided a local perspective on the major health issues and needs for this particular population.

The information gathered from these interviews was used to design an online survey. Six focus groups were held to obtain feedback on the proposed survey, each with a relevant target population: LGBT seniors, gay men, healthcare providers of the LGBT community, lesbian women, LGBT people of color, and transgender people. Feedback from these focus groups was used to adapt and refine the survey instrument. The instrument underwent further changes based on feedback from senior leadership at the Center.

The final tool included 77 questions, although not all participants answered all questions. The questions were predominately close-ended questions. Several of the questions allowed for a selection of an “other” responses, with a space to specify. The only truly open-ended question was the final question of the report, which asked, “Is there anything else you think we should know in order to have an accurate picture of LGBT health and wellness in the Coachella Valley?”

Recruitment

The finalized online survey was launched live on SurveyMonkey on Monday, April 22nd, 2013. The survey was publicized via a variety of methods, including email campaigns from both HARC and the Center, Facebook posts, and Twitter posts. Participants were urged to take the survey and to pass it on to others (otherwise known as a “snowball” recruitment technique). While this non-random design does not allow for generalization to the LGBT community as a whole, it was extremely effective in reaching a large number of LGBT individuals in a relatively short time period.

The finalized survey was designed to target adults that lived in the Coachella Valley for a period of one month or more. Survey design staff felt that the health of LGBT youth should be addressed separately from adults, and therefore the recruitment was targeted only at individuals over the age of 18. Similarly, given the Center’s focus on providing services to local residents, recruitment was only aimed at individuals who were likely to access services in the Coachella Valley, that is, permanent residents and “snowbirds”, or seasonal residents that spend several

months living in the Coachella Valley. Recruitment was designed to screen out individuals who do not live in the Coachella Valley and those who live in the Coachella Valley on weekends and holidays only. Heterosexual non-transgender adults were not screened out, as it was reasoned that they would provide comparison data for the LGBT sample.

Participants

The online survey was subsequently closed on Tuesday, June 4th, having been open for approximately seven weeks. A total 996 participants began the survey. Fifty of these participants (~5%) were ineligible to participate, as they did not reside in the Coachella Valley. An additional 82 participants indicated they were part-time residents of the Coachella Valley; 15 of these were disqualified as they were “weekenders” or “vacationers”, the remaining 67 were retained as they indicated that they lived in the Coachella Valley between 1 month and 11 months (“snowbird”). Additionally, two other individuals were disqualified as they were under the age of 18. Thus, a total of 927 participants began the survey.

During data cleaning, all participants who did not specify their sexual orientation were removed, as were all of those who did not specify their gender orientation. This allowed for all responses to be accurately categorized by sexual orientation and gender orientation. This resulted in a total sample size of 774 individuals with data that was considered complete enough for analysis. Thus, a total of about 83% of participants who began the survey subsequently completed the survey. This is a very high completion rate, especially given the length of the survey.

For comparison purposes, the majority of the findings in this report are segregated by sexual orientation and gender orientation. In the survey, as in life, these two orientations are not mutually exclusive—that is, an individual with a gender orientation of “transgender” can have a sexual orientation of “gay”, “lesbian”, “bisexual”, or “heterosexual”. However, in order to compare statistically significant differences between the L, G, B, and T groups, these categories must be created in a mutually exclusive fashion. Thus, for the purposes of this report, sexual orientation and gender orientation were used together to categorize individuals into mutually exclusive L, G, B, T, and “straight” (i.e., heterosexual, non-transgender) groups. This means that the “transgender” category reported in these results contains a) data from those individuals whose gender orientation is transgender, and b) data from those individuals whose sexual orientation is “other” and who specified a sexual orientation that is trans-related (“transgender”, “transsexual”, “trans”, etc.). The data from these individuals are not represented in the “gay”, “lesbian”, “bisexual”, or “straight” categories. In this method, the “straight” category contains data only from those individuals whose sexual orientation is “heterosexual” and whose gender orientation is “not transgender”.

While this method of grouping is rigid and not completely reflective of the complexity of sexual orientation and gender orientation in the real world, it does allow for useful statistical comparisons that would otherwise be impossible. Using this method, the sample was comprised as described in Table 1.

Table 1. Initial Sample by LBTS Categories

LGBTS Category	Number of Participants	Percent of Sample
Gay	547	70.7%
Lesbian	117	15.1%
Straight	54	7.0%
Bisexual	31	4.0%
Transgender	20	2.6%
Other sexual orientation	5	0.6%
Total	774	100.0%

Those individuals who listed their sexual orientation as “other” and their gender orientation as “not transgender” described their sexual orientation like so:

- Asexual
- private
- gay female
- asexual
- don't care anymore

Due to the relatively low number of participants categorized as “other” and “not transgender” ($n = 5$), there would not be sufficient sample size to conduct analyses with these individuals at a fine-grained level. Thus, they were removed from the sample. The final sample is illustrated in Table 2.

Table 2. Final Sample by LBTS Categories

LGBTS Category	Number of Participants	Percent of Sample
Gay	547	71.1%
Lesbian	117	15.2%
Straight	54	7.0%
Bisexual	31	4.0%
Transgender	20	2.6%
Total	769	100.0%

Analysis

Quantitative Analyses

Descriptive statistics were used to measure overall levels of health in the sample for each indicator. For each indicator, follow-up analyses then assessed whether statistically significant differences exist between the LGBTTS categories. The type of analyses used to assess potential significant differences varied on the type of data presented (categorical or continuous).

Categorical Data Analysis

The majority of the health indicators covered in this survey were categorical in nature; response options included, “yes” or “no”, or “often”, “sometimes” or “never”, etc. Chi-square analyses were used to assess potential significant differences in these categorical indicators.

A significant chi-square statistic indicates that one or more significant differences between groups exist. For example, a statistically significant difference in obesity would indicate that one or more of the LGBTTS groups are significantly different than others. To ascertain where this significant difference lies, average response rates were examined to determine which particular group is significantly more obese (or less obese) than others. If a significant difference exists, this means that the overall average rate of obesity does not accurately represent the rates of obesity in each of the five groups, and that rates should be reported for each group individually.

A non-significant chi-square statistic indicates that the groups do not significantly differ from each other, and thus, the results for the overall sample are roughly equivalent to that of any individual group. That is, if there is no statistically significant difference between groups, the response rate for the entire sample is an accurate representation of the rates in each individual group.

In this report, response rates by individual LGBTTS category are broken down only on items where a significant difference exists. For items where there is no significant difference between LGBTTS categories, the overall sample responses can be assumed to be representative of all LGBTTS categories equally.

Chi-square analysis is a particularly robust method when assessing groups of different size (such as in this case, where the “gay” group far outnumbers the other groups). However, if the results are heavily skewed (e.g., overall 97% reported “yes” and 3% reported “no”) or if the number of participants in any particular group is especially small (such as when “drilling down” to look in depth at further sub-populations, such as only those participants who smoke cigarettes every day), statistical analyses of differences between groups can become unreliable. This occurs because expected cell sizes in cross-tabulation become too small. Because the results are unreliable, it is inappropriate to interpret a significant difference (or lack thereof) between categories. Thus, in this report, in instances where cell sizes were too small to reliably interpret, no significant differences (or lack thereof) were reported or assumed.

Continuous Data Analysis

A limited number of health indicators included in this study were continuous rather than categorical (e.g., “how many times per week do you eat fast food?” or “how many sexual partners have you had in the past year?”). For these indicators, an analysis of variance (ANOVA) was used to assess whether a statistically significant difference existed between LGBT categories.

Qualitative Analyses

The majority of the items on this survey were quantitative in nature. Occasionally, participants could select an “other” selection and further specify the details. These brief open-ended responses were qualitatively analyzed for themes, which are reported alongside the close-ended results of the same question.

The final question on the survey was the only truly open-ended question. A total of 250 participants chose to respond to this open-ended question and contribute their additional thoughts about the health of the LGBT community in the Coachella Valley. These responses were qualitatively analyzed, and the themes extracted from that analysis are presented at the end of the results section of this report.

Results

For the majority of this report, quantitative results are compared by LGBTs categories to explore statistically significant differences. Additionally, when possible, results from the sample (sometimes referred to as the “current study”) are compared to local and regional data from other sources. While the statistical significance is not compared between the current study’s data and the data from other sources, this information is provided to give the reader context for prevalence rates in the region. All other data sources presented in this report are random samples, and thus, can be assumed to be representative of the region. These additional data sources include HARC’s 2010 Community Health Monitor (Coachella Valley), the US Census Bureau’s 2010 Census data (Riverside County and the state of California), the US Census Bureau’s American Community Survey 2007-2011 5-year estimates (Riverside County and the state of California), and UCLA’s 2009 California Health Interview Survey (CHIS; Riverside County and the State of California). The data gathered from these additional sources is the most recent data that is currently available at the time of this report’s publication.

Where applicable, the quantitative findings are supplemented with quotes from participants. These quotes are used to illustrate the findings in the participants’ own words, and are culled responses to the final open-ended question. A qualitative analysis of all responses to the final open-ended question is presented at the end of the results section.

Demographics

This demographics section is intended to give the reader an accurate description of the sample in the current study. As the current study was not a random sample, it is worth noting that these demographics should not be interpreted as representative of the Coachella Valley LGBT community as a whole. The statistics presented in this section are simply describing the population of the study, not the entire Coachella Valley LGBT population.

Sexual Orientation

In order to assess sexual orientation, participants were asked, “How would you describe your sexual orientation?” Participants could only select one response option, and were given the following responses: gay, lesbian, bisexual, heterosexual or straight, other.

When examining sexual orientation alone (that is, not combined with gender orientation for categorization), the breakdown of the sample is illustrated in Table 3. The majority of the sample (71.5%) identified their sexual orientation as “gay”.

Table 3. Sexual Orientation

Sexual Orientation	Number of Participants	Percent of Sample
Gay	550	71.5%
Lesbian	125	16.3%
Heterosexual or straight	57	7.4%
Bisexual	34	4.4%
<i>Other</i>	3	0.4%

For more detailed information on the sexual orientation of transgender participants specifically, please see the “Transgender Specific” section of the report.

Gender Orientation

To assess gender orientation, participants were asked, “How would you describe your gender orientation?” Participants could select one of the following response options: not transgender (I identify with my birth gender), transgender (female-to-male, FtM, transgender male, or transman), transgender (male-to-female, MtF, transgender female, or transsexual), or transgender (not exclusively male or female).

The majority of the sample (97.4%) did not identify as transgender. Of those participants that did identify as transgender, about 50.0% identified as male-to-female, as illustrated in Table 4. For more detailed information on transgender participants, see the “Transgender Specific” section of the report.

Table 4. Gender Orientation

Gender Orientation	Number of Participants	Percent of Sample
Not transgender – I identify with my birth gender	749	97.4%
Transgender (male-to-female, MtF, transgender female, or transwoman)	10	1.3%
Transgender (not exclusively male or female)	8	1.0%
Transgender (female-to-male, FtM, transgender male, or transman)	2	0.3%

Gender

To assess gender, participants were asked, “What gender do you identify with?” Participants could select one of the following response options: male, female, not exclusively male or female, or intersex.

As illustrated in Table 5, the majority of the sample (73.2%) identified their gender as male. Due to the low number of individuals who identified as “not exclusively male or female” or “intersex”, cell sizes are too small to ascertain statistically significant differences in gender between LGBTs groups. However, the breakdown of gender by LGBTs groups is presented in Table 5, simply to illustrate that gender identity is not static across LGBTs categories. That is, there are males in every one of the LGBTs categories, as well as females in every one of the LGBTs categories. This diversity underscores the concept that gender orientation does not always predict gender identity.

Table 5. Gender by LGBTs Category

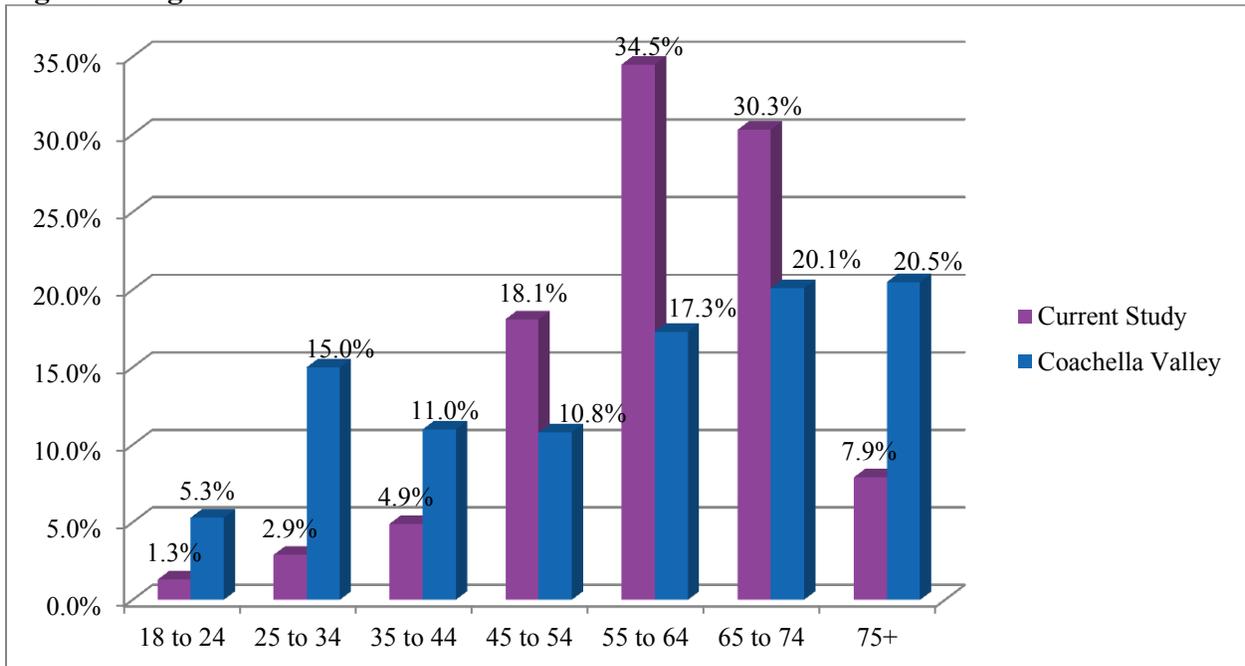
LGBTs Category	Gender				Total
	Male	Female	Not exclusively male or female	Intersex	
Gay	98.2% (536)	1.6% (9)	0.0% (0)	0.2% (1)	71.6% (546)
Lesbian	0.9% (1)	96.6% (113)	2.6% (3)	0.0% (0)	15.2% (117)
Straight	16.7% (9)	79.6% (43)	3.7% (2)	0.0% (0)	7.0% (54)
Bisexual	45.2% (14)	51.6% (16)	3.2% (1)	0.0% (0)	4.0% (31)
Transgender	10.0% (2)	60.0% (12)	20.0% (4)	10.0% (2)	2.6% (20)
Total	73.2% (562)	25.1% (193)	1.3% (10)	0.4% (3)	100.0% (768)

Age

Participants were asked to self-report their age. Participant ages ranged from 18 to 86. The median participant age was 61. This is very similar to Coachella Valley as a whole, where the median age is 59 (HARC, 2010). However, it is considered quite “old” in comparison to the broader geography; the median age in Riverside County is 34, and the median age in the state of California is 35 (U.S. Census Bureau, 2010).

As illustrated in Figure 1, over 60% of participants in the current study are between the ages of 55 and 74, and would be considered “seniors”. In contrast, the age of the Coachella Valley as a whole is more evenly distributed, despite still having a relatively high median age

Figure 1. Age



Note. $n = 768$. Coachella Valley data in this graph are from the HARC 2010 Community Health Monitor.

There was a significant difference in age by LGBT category, $\chi^2(4) = 23.412, p < .001$. Table 6 demonstrates that each group of participants is more likely to be over 50 than to be younger than 50. However, this trend is especially strong for the gay participants (86.6% are age 50 or over). As illustrated in Table 6, the “youngest” overall category is the transgender category, with only 60% of the sample falling into the “50 and over” category.

Table 6. Age Comparison – Under 50 and Over 50

LGBTS Category	Age		Total
	Under 50	50 and older	
Gay	72 (13.2%)	474 (86.6%)	546 (71.1%)
Lesbian	28 (23.9%)	89 (76.1%)	117 (15.2%)
Bisexual	6 (19.4%)	25 (80.6%)	31 (4.0%)
Transgender	8 (40.0%)	12 (60.0%)	20 (2.6%)
Straight	16 (29.6%)	38 (70.4%)	54 (7.0%)
Total	130 (16.9%)	638 (83.1%)	768 (100.0%)

Race and Ethnicity

In this study, race and ethnicity were assessed using the U.S. Census Bureau’s 2010 question formatting. Prior to the two questions, there is a note to the participant which reads, “These next two questions ask about race and ethnicity. For this survey, Hispanic origins are not races.”

The first question assesses race: “What is your race? Check all that apply.” Potential response options include “white”, “black/African American”, “American Indian or Alaska Native”, “Asian”, “Native Hawaiian or other Pacific Islander”, or “other (please specify)”.

The second question assesses ethnicity: “Are you of Hispanic, Latino, or Spanish origin?”. Participants can select one of the following response options: “no, not of Hispanic, Latino, or Spanish origin”, “Yes, Mexican, Mexican American, Chicano”, “Yes, Puerto Rican”, “Yes, Cuban”, or “Yes, another Hispanic, Latino, or Spanish origin”.

Race

As per the protocol established by the US Census Bureau, participants were free to select more than one race as applicable. A total of 11 participants identified with multiple races. The individual races are broken down in Table 7.

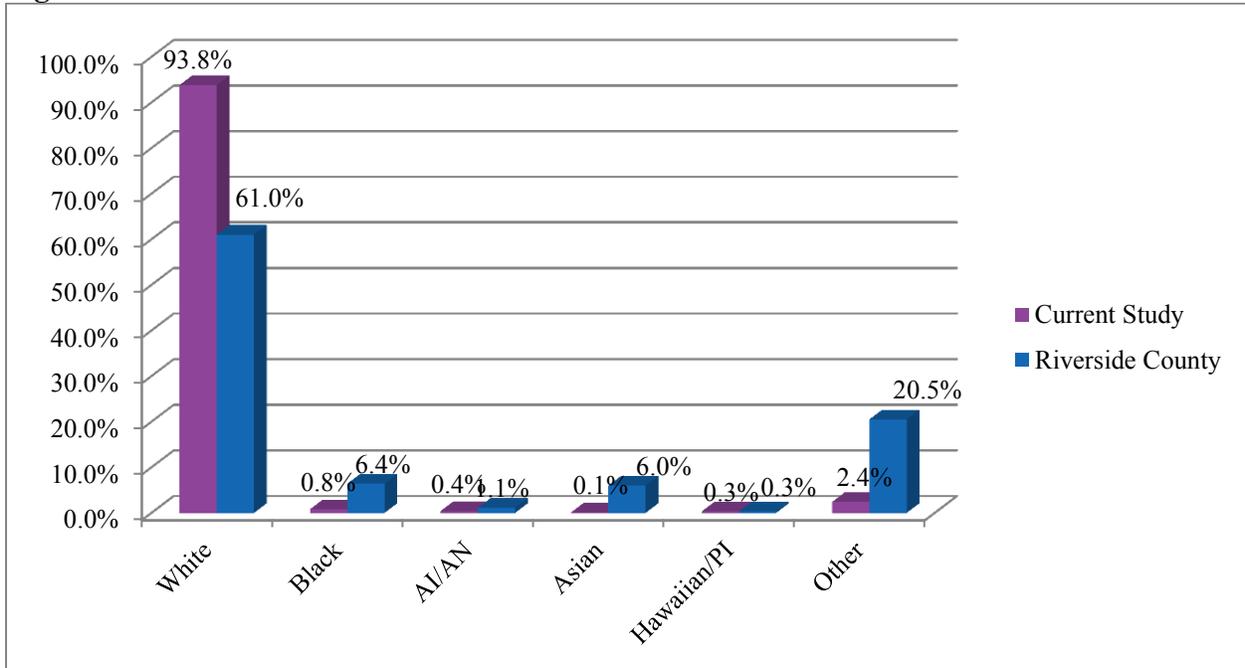
Table 7. Race

Race	Number of Participants
White	732
Black	10
American Indian/Alaskan Native	10
Hawaiian or other Pacific Islander	3
Asian	1
<i>Other</i>	18

Eighteen participants indicated that their race was “other”. Several responses listed a race identified as Hispanic, Latino, or Mexican. Several other responses used the “other” selection to indicate that they identified as multi-racial, bi-racial, or mixed race.

For those individuals that selected one primary race category, white/Caucasian was by far the most commonly selected. As illustrated in Figure 2, the sample in the current study is much more racially homogenous than Riverside County as a whole, which has more diversity. Cell sizes were too small to break race out by LGBT categories.

Figure 2. Race

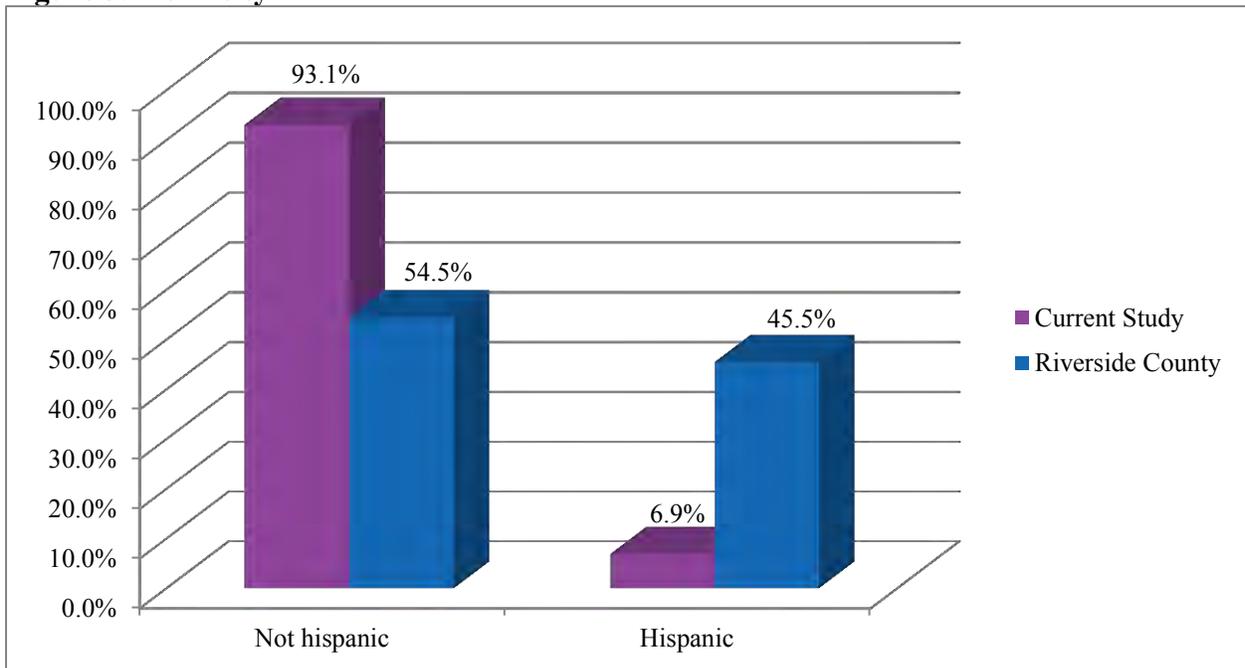


Note. $n = 751$. Riverside County data presented in this graph are from the 2010 Census.

Ethnicity

As illustrated in Figure 3, this sample is predominately non-Hispanic. This is distinctly different than the relatively even split in Riverside County. Due to the heavy skew towards non-Hispanic ethnicity, cell sizes are too low to assess statistical differences between LGTBs categories.

Figure 3. Ethnicity



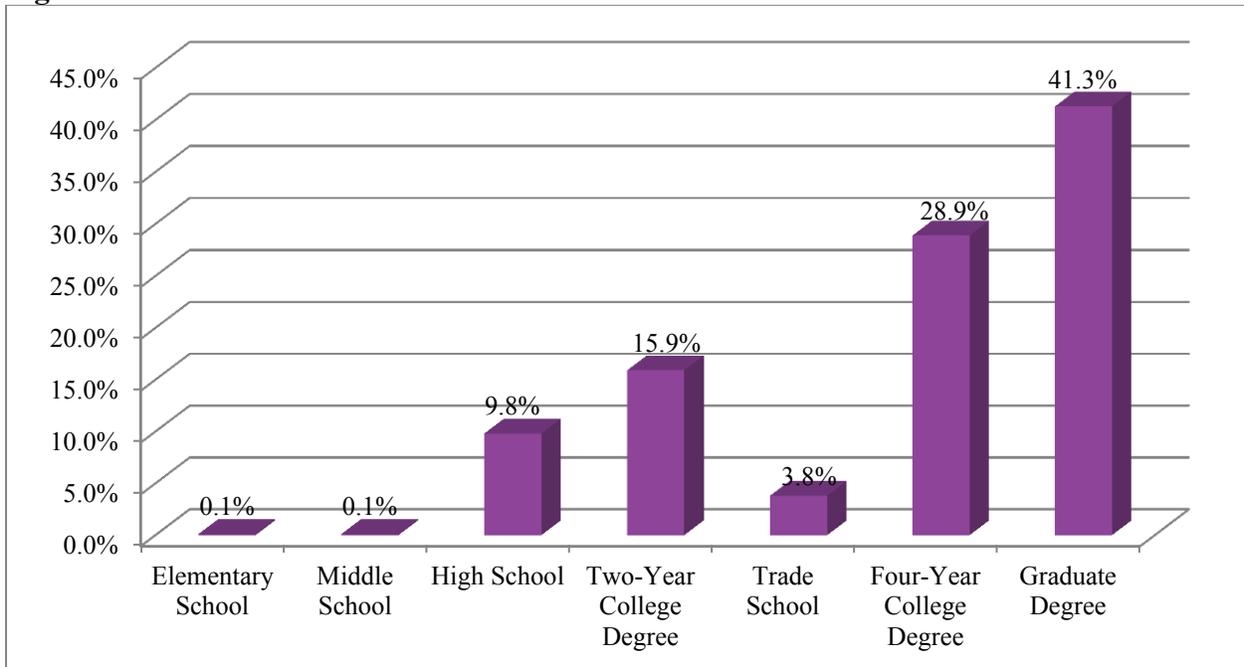
Note. $n = 749$. The Riverside County data presented in this graph are from the 2010 Census.

Education

Participants were asked to indicate the highest level of education they had achieved. As illustrated in Figure 4, results show that the majority of participants (70.2%) have at least a four-year college degree.

Overall, this is a very highly educated sample. The exact text of the question regarding education is not directly parallel to either the HARC Community Health Monitor or the CHIS survey, so precise comparisons cannot be made. However, general comparisons can be made with caution. While 70.2% of participants in the current study have a four-year college degree or higher, the rate is roughly 43.8% in Coachella Valley (HARC, 2010), 23.3% in Riverside County, and 33.9% in the state of California (CHIS, 2009). Thus, even though not precisely comparable, it is clear that this sample is more highly educated than much of the general population in the region.

Figure 4. Education



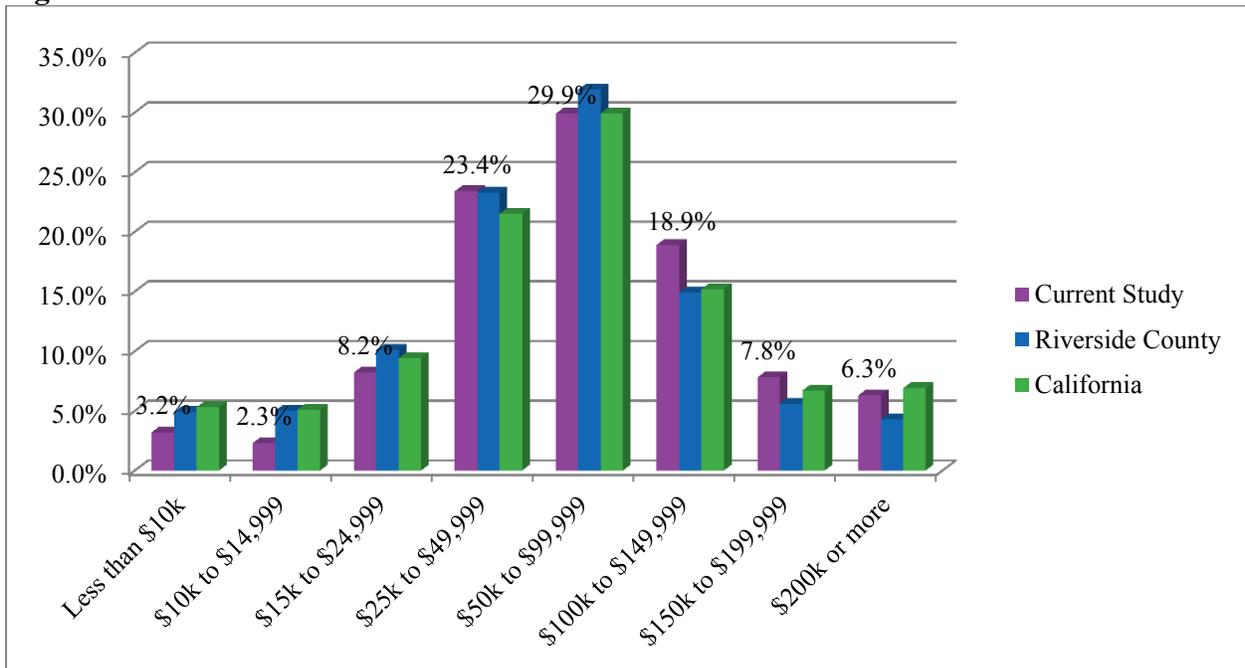
Note. $n = 767$.

In order to assess potential significant differences in education between the LGBT categories, education was combined into four categories: 1) high school equivalency or less, 2) 2-year college degree or trade school, 3) 4-year college degree, 4) graduate degree. Results of a chi square showed no significant differences in the four levels of education by LGBT categories, $\chi^2(12) = 18.548, p > .05$.

Income

Participants were asked to report their household income before taxes. Results showed that participants' income was fairly evenly distributed, as illustrated in Figure 5. Overall, about a third of participants made less than \$50,000 per year, another third made between \$50,000 and \$100,000 per year, and the final third made \$100,000 or more per year. As illustrated in Figure 5, the pattern of income distribution is similar to that in the county and state as a whole.

Figure 5. Income



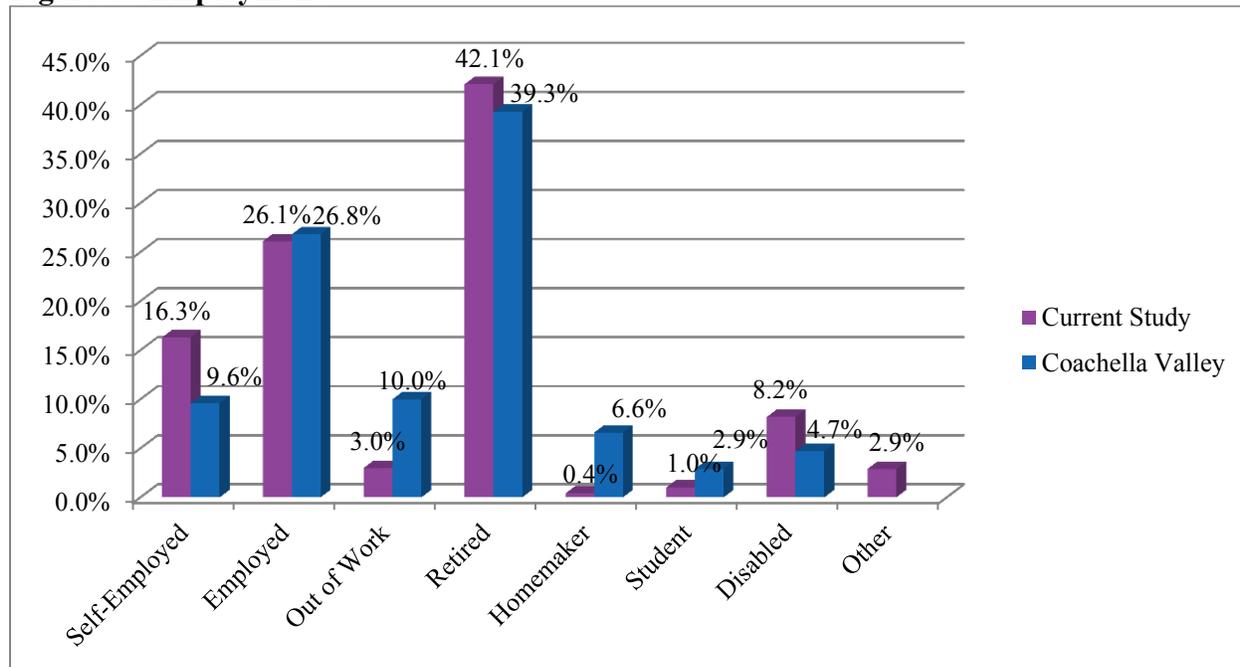
Note. $n = 752$. Riverside County and California data in this graph are from the 2007-2011 American Community Survey 5-Year Estimates.

There were no significant differences in income by LGBTs categories, $\chi^2(8) = 8.511, p > .05$, indicating that income patterns are consistent across all LGBTs groups.

Employment

Participants were asked to indicate their employment status using a scale from HARC’s Community Health Monitor. As illustrated in Figure 6, a large proportion of the current study is retired, which is similar to the Coachella Valley as a whole and appropriate, given the large proportion of the sample that is over 65 years of age (a typical benchmark for retirement age).

Figure 6. Employment



Note. $n = 769$. Coachella Valley data in this graph are from the HARC 2010 Community Health Monitor.

A total of 22 participants indicated that their employment status was something other than the seven categories of employment that were presented. The majority of these “other” responses indicated that participants fell into two categories, rather than just one. For example:

- “Retired w/ part time job”
- “Student and employed for wages”
- “Semi-retired”
- “Work on-campus as an international student”

In order to examine potential differences in employment status by LGBTTS category, the following three categories were created: 1) employed (self-employed or employed for wages), retired, and other (out of work, homemaker, student, disabled, or other). Results indicated a statistically significant difference in employment status by LGBTTS category, $\chi^2(8) = 47.784, p < .001$. As illustrated in Table 8, participants in the straight category appear to be significantly more likely to be currently employed instead of retired or other employment statuses. In contrast, for participants in the L, G, B, and T categories, participants are fairly evenly split between the “employed” category and the “retired” category, with a small number in the “other” category.

Table 8. Employment by LBGBTS Category

LGBTS Category	Employment Status			Total
	Employed	Retired	Other	
Gay	38.1% (204)	46.7% (250)	15.1% (81)	71.6% (535)
Lesbian	50.9% (57)	41.1% (46)	8.0% (9)	15.0% (112)
Bisexual	46.7% (14)	36.7% (11)	16.7% (5)	4.0% (30)
Straight	84.6% (44)	15.4% (8)	0.0% (0)	7.0% (52)
Transgender	38.9% (7)	50.0% (9)	11.1% (2)	2.4% (18)
Total	43.6% (326)	43.4% (324)	13.0% (97)	747 (100.0%)

Geographic Location

Participants were asked to list their zip code. Using the official zip code look-up tool of the United States Postal Service (<https://tools.usps.com/go/ZipLookupAction!input.action>), these zip codes were transformed into cities. As illustrated in Table 9, all of the nine cities in the Coachella Valley are represented in this sample. Additionally, 24 individuals whose zip codes did not fall within the nine cities were included in the sample. Some of these zip codes were for unincorporated areas in the Coachella Valley (e.g., Thousand Palms, $n = 7$). Others were snowbirds that listed their primary home's address, but indicated they lived in the Coachella Valley for at least one month or more per year (e.g., Portland, OR, $n = 3$). Some others were outlying cities which are not strictly considered to be within the Coachella Valley, but where residents may well utilize services in the Coachella Valley, as it is the closest major metropolitan area (e.g., Yucca Valley, $n = 2$).

Table 9. Location

City	Number of Participants	Percent of Sample
Palm Springs	440	57.6%
Cathedral City	126	16.5%
Palm Desert	52	6.8%
Rancho Mirage	51	6.7%
Desert Hot Springs	34	4.5%
Indio	21	2.7%
La Quinta	8	1.0%
Indian Wells	4	0.5%
Coachella	4	0.5%
<i>Other</i>	<i>24</i>	<i>3.1%</i>
Total	764	100.0%

The majority of participants (57.6%) came from the city of Palm Springs, where the Center is located. From there, participation appeared to decrease as a function of geographic distance from the Center—that is, those cities closest to the Center had higher participation rates than those cities farther from the Center.

The sample as a whole was heavily located in Western Coachella Valley—in fact less than 5% of the overall sample came from Eastern Coachella Valley. For reference, Figure 7 shows the nine cities of the Coachella Valley, with the LGBT Community Center of the Desert represented by a star.

Figure 7. Map of Coachella Valley



Note. Image from www.visitgreaterpalmsprings.com, the location of the LGBT Community Center of the Desert was added.

Seasonal Residents

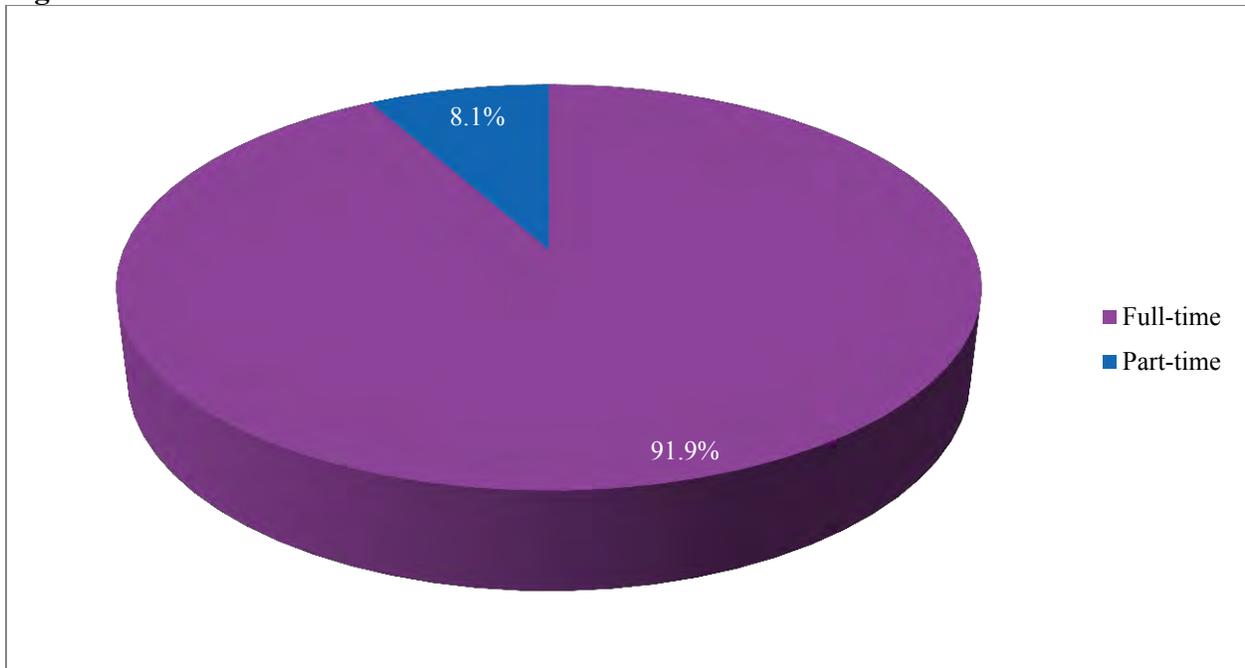
Coachella Valley as a whole has many seasonal residents. These residents typically live in Coachella Valley during the cooler winter months from about November to April. As the bulk of this data collection was conducted in May, it would be unusual to have a high rate of snowbird participation. However, it is certainly possible that some participants were not full-time residents.

Thus, in order to measure seasonal residents, the first question on the survey asked, “Do you live in the Coachella Valley?” Response options included “Yes, I am a full-time resident that lives in the Coachella Valley year-round”, “Yes, I am a part-time (seasonal) resident of the Coachella Valley”, and “No, I do not live in the Coachella Valley”.

Participants who indicated they were a part-time resident of the Coachella Valley were subsequently asked, “Which of these situations best describes your living situation in the Coachella Valley?” Response options included, “I live in the Coachella Valley some weekends and/or holidays (weekender)”, “I live in the Coachella Valley for 30 days or less (vacationer)”, or “I live in the Coachella Valley between 1 month and 11 months of the year (snowbird)”. Only those who indicated “snowbird” in response to this question were qualified to take the survey; weekenders and vacationers were filtered out.

As illustrated in Figure 8, about 8.1% of the total sample reported being a “snowbird” and living in the Coachella Valley for less than the full year.

Figure 8. Seasonal Residents



Note. $n = 769$.

Summary of Demographics

Results showed that the majority of participants are older gay men who do not identify as transgender. Most participants identify as white, non-Hispanic. Education levels are very high; the majority of participants have at least a 4-year college degree. However, income levels span the entire range, and are fairly evenly distributed across the range of possibility. The majority of the sample are permanent residents of Palm Springs, and there is an even split between individuals that are currently employed and those who are now retired, which is reflective of the age of the sample.

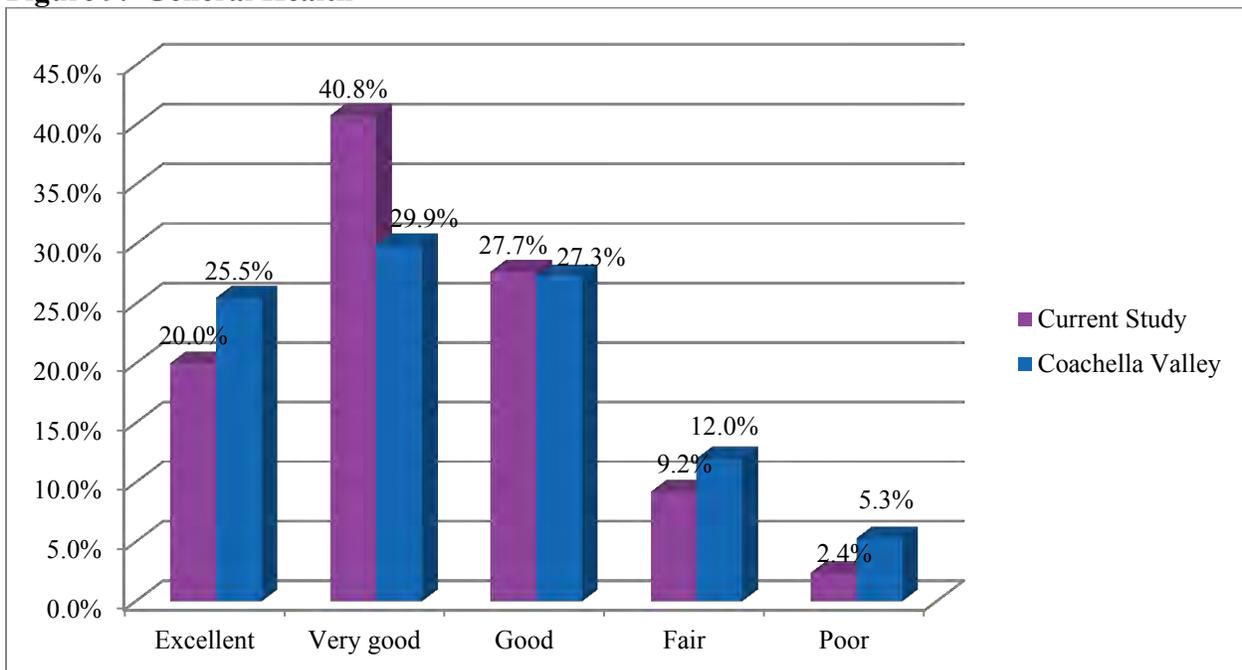
Healthcare Coverage and Utilization

General Health

Feeling healthy is an important part of complete and total wellness. To this end, participants were asked, “How would you rate your overall health?” Response options ranged from “excellent” to “poor”.

As illustrated in Figure 9, the majority of participants in the sample (60.8%) rate their health as “excellent” or “very good”. This is a positive indicator of the health of the sample overall. The general trend of self-rated health seems to follow that of self-rated health in the Coachella Valley, as per HARC’s 2010 Community Health monitor.

Figure 9. General Health



Note. $n = 765$. The Coachella Valley data in this graph are from the HARC 2010 Community Health Monitor.

There was a statistically significant difference in general health rating by LBGTBS category, $\chi^2(12) = 28.73, p < .01$. As illustrated in Table 10, bisexual participants seem to have an especially high rate of “fair or poor” health (nearly 20%), while straight participants have an especially low rate of “fair or poor” health (0%). Gay, lesbian, and transgender participants have rates on par with the average overall (between 10 and 12%).

Table 10. General Health by LBGBTS Category

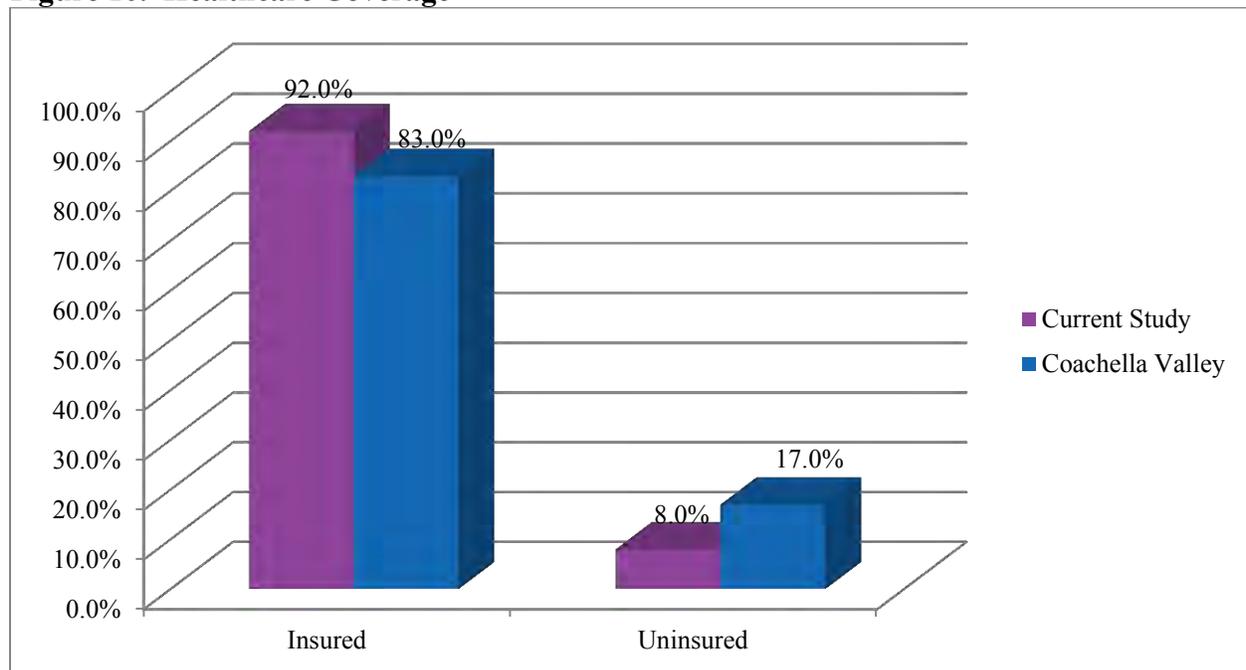
LGBTS Category	General Self-Rated Health				Total
	Excellent	Very Good	Good	Fair or Poor	
Gay	17.8% (97)	40.3% (219)	29.8% (162)	12.1% (66)	71.1% (544)
Lesbian	20.7% (24)	44.8% (52)	22.4% (26)	12.1% (14)	15.2% (116)
Bisexual	22.6% (7)	22.6% (7)	35.5% (11)	19.4% (6)	4.1% (31)
Straight	38.9% (21)	42.6% (23)	18.5% (10)	0.0% (0)	7.1% (54)
Transgender	20.0% (4)	55.0% (11)	15.0% (3)	10.0% (2)	2.6% (20)
Total	20.0% (153)	40.8% (312)	27.7% (212)	11.5% (88)	100.0% (765)

Healthcare Coverage

Previous research has established that the presence of health insurance is critical to maintaining health and wellness. For example, adults without health insurance are much less likely to receive preventive services and much more likely to delay or forgo important physician visits, effective therapies, and needed prescription medications (Institute of Medicine, 2009). Uninsured adults are more likely to suffer poor health outcomes related to cancer, heart disease, stroke, and asthma, and are more likely to suffer from premature death from these same health problems (Institute of Medicine, 2009).

In order to assess healthcare coverage, participants were asked, “Do you have ANY kind of health insurance coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare, Medi-Cal (IEHP) or the VA?” Results showed that as a whole, the vast majority of participants have some type of health insurance, as illustrated in Figure 10. Part of this high level of coverage may be due to the fact that a large proportion of the sample is over the age of 65, and therefore eligible for Medicare. Due to this high degree of skew, it was not possible to examine statistically significant differences by LGBT categories.

Figure 10. Healthcare Coverage



Note. $n = 765$. The Coachella Valley data in this graph are from the HARC 2010 Community Health Monitor.

Participants' concluding comments confirmed that lack of healthcare coverage was a major barrier to maintaining positive health for this community. For example:

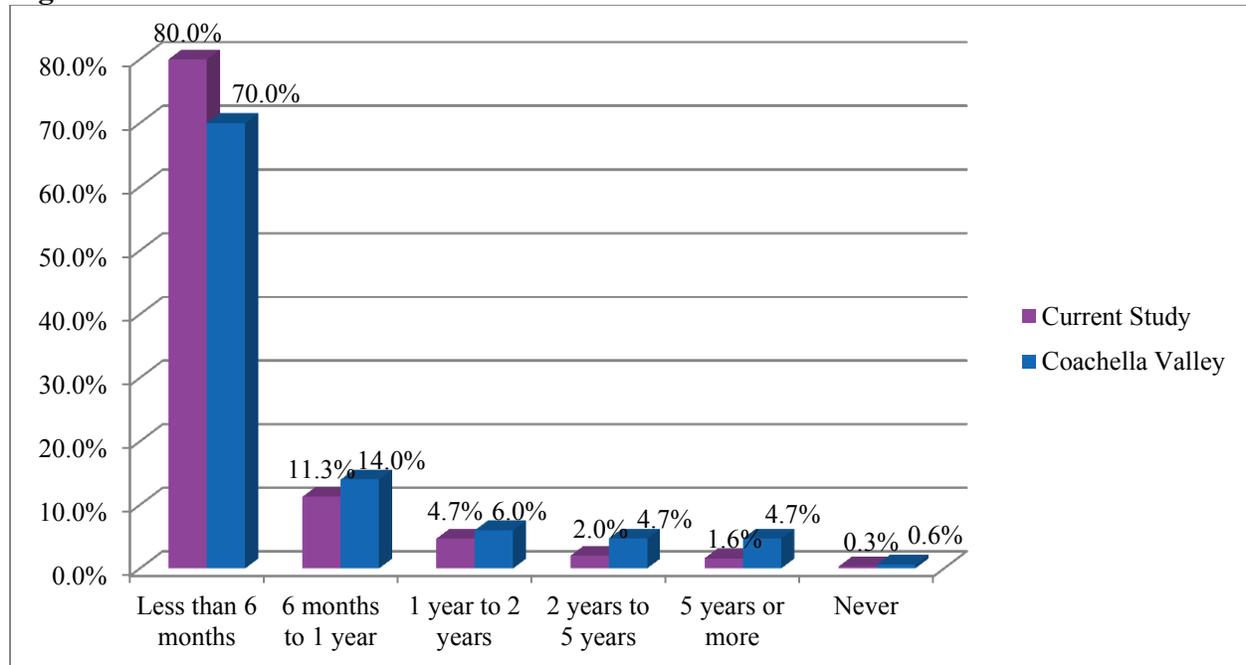
- “Access to Healthcare resources for those without health care insurance and stable employment is very limited.”
- “We need health care that is affordable for people who don't have health coverage through an employer. Prescription coverage needs to be a part of the health insurance and it needs to have more affordable co-pays”

Recent Healthcare Utilization

Frequent utilization of healthcare is an important factor to protecting and maintaining good health. Even if an individual is not sick or in poor health, regular visits to a healthcare provider can provide important preventive tests and care that will prevent more serious health problems later in life.

In order to assess how frequently participants visited healthcare providers, participants were asked, “About how long has it been since you last visited a doctor, family doctor, nurse practitioner, or other healthcare provider, such as specialists?” Results showed that the majority of participants (80.0%) have been to a healthcare provider within the past six months. As illustrated in Figure 11, this is a higher rate than that of Coachella Valley adults as a whole, but the visitation patterns look remarkably parallel between the current study and the Coachella Valley.

Figure 11. Recent Healthcare Utilization



Note. $n = 767$. The Coachella Valley data in this graph are from the HARC 2010 Community Health Monitor.

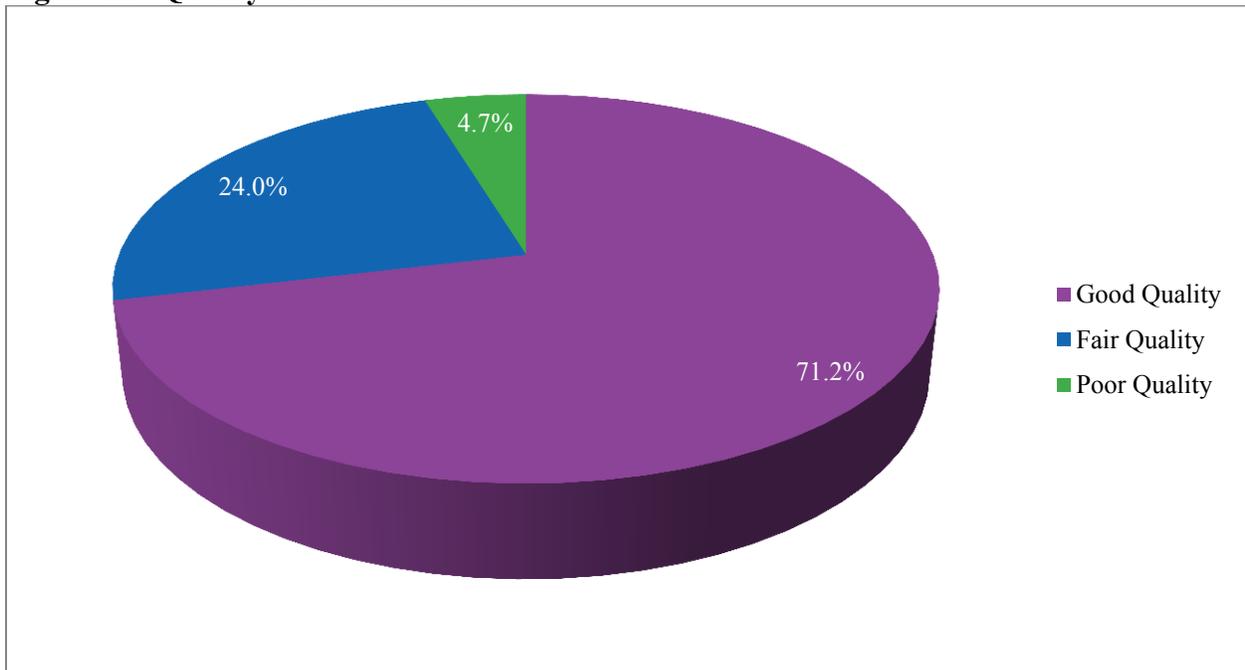
In order to examine potential differences in utilization by LGBTs category, last visit to a healthcare provider was dichotomized into “6 months or less” and “more than 6 months”. Results indicated that there were no significant differences between the LGBTs categories, $\chi^2(4) = 5.136, p > .05$. Thus, it is safe to say that the majority of participants have visited a healthcare provider within the past six months.

These results are encouraging, as it appears that most of the sample are accessing healthcare providers with some frequency, and thus, are likely receiving the important preventive care and routine check-ups that are crucial to continued well-being.

Quality of Local Healthcare

Participants were asked to rate the quality of the healthcare they had received in the Coachella Valley. A total of 38 participants (approximately 5.0% of the sample) indicated that they had never received healthcare in the Coachella Valley and thus were removed from analyses. Overall, respondents indicated they received good quality healthcare in the Coachella Valley, as illustrated in Figure 12.

Figure 12. Quality of Local Healthcare



Note. $n = 730$.

Ratings of healthcare quality did not significantly differ by LGBT category, $\chi^2(8) = 12.323, p > .05$. Thus, general trends in opinions about the quality of local healthcare appear to be the same across LGBT categories.

Several of the responses to the final open-ended question addressed the issue of quality of local healthcare. Similar to the quantitative results, the majority of these comments were positive in relation to local care. For example:

- “I have found the Coachella Valley healthcare community is generally very welcoming to the LGBT community.”
- “I think the Coachella Valley is doing a pretty good job regarding health & wellness in the LGBT community especially with organization like The Center becoming involved more and more. We are very fortunate to live in a liberal and welcoming community.”
- “All of my health care experiences in the CV (it isn't a valley, by the way, it is a graben) have been entirely favorable. Most of my providers are openly gay or at least gay-friendly, Both my husband and I have been treated with equality and respectfully (thus far) by all major health care institutions.”

However, as illustrated in the quantitative findings, not all experiences were positive. For example:

- “As a whole I find the number and quality of medical providers here to be sub standard from what I am accustomed to.”
- “I am concerned that there exists medical practitioners who are very antagonistic and negative about gay people. One never knows if the level of treatment one is receiving is in fact compromised by negative, primarily religious, feelings about being gay. That is actually the scariest thing of all - not knowing if one is safe in the hands of medical care givers.”

Summary of Healthcare Coverage and Utilization

Overall, most participants rate their health as “good”, “very good”, or “excellent”. Bisexual participants appear to have worse self-rated health than other participants, while straight participants have better self-rated health than most participants.

The vast majority of participants have health insurance. This high rate of insurance coverage may be due to the age of participants—many are over the age of 65 and therefore eligible for Medicare.

The majority of participants (80%) have seen a healthcare provider within the past six months, indicating they are likely visiting their healthcare provider frequently. This increases the likelihood that participants are receiving important preventive care that can improve health and quality of life.

Finally, most participants rate local healthcare services as “good quality”. Less than 5% of participants feel that Coachella Valley healthcare quality is “poor”.

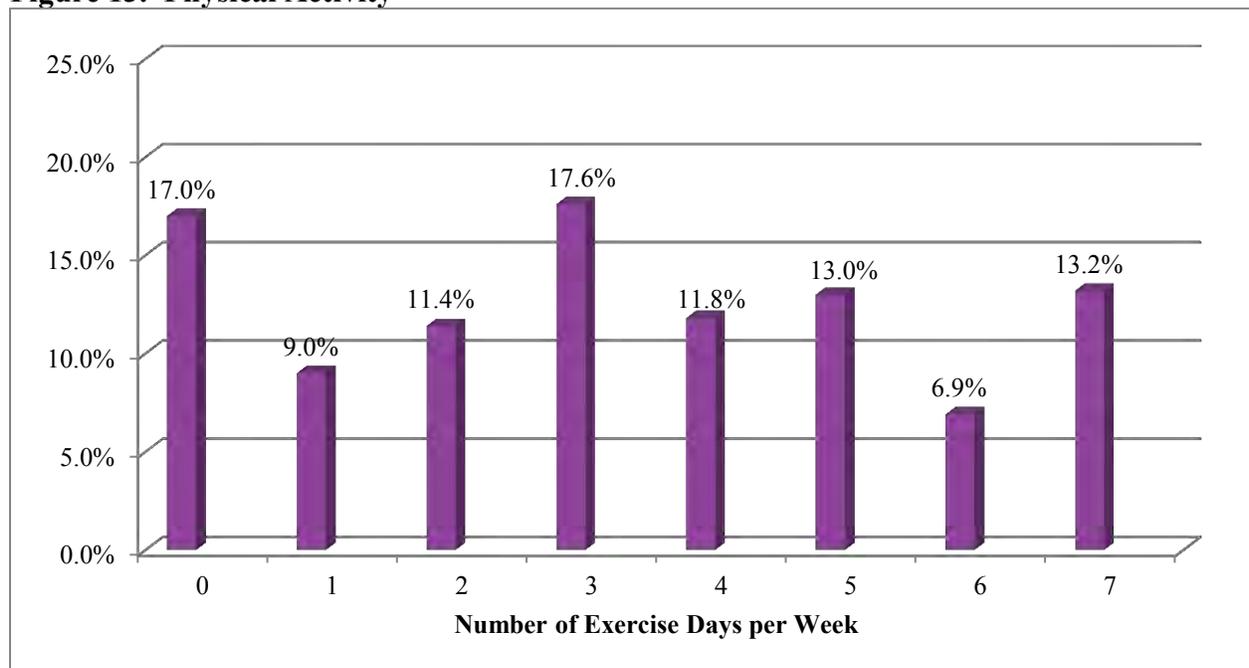
Physical Fitness

Physical Activity

Physical activity is an important component of health. Regular physical activity has been linked to lowered risk of heart disease, diabetes, high blood pressure, depression, and anxiety (CDC, 2011). Regular physical activity results in increased bone and muscle strength, increased lean muscle, and decreased body fat. The CDC recommends that adults do at least 150 minutes of moderate-intensity aerobic activity each week, accompanied by muscle-strengthening activities on 2 or more days per week (CDC, 2011).

To assess physical activity, participants were asked, “During the last 7 days, on how many days did you participate in any physical activities or exercises such as running, weight-lifting, or walking for exercise?” As illustrated in Figure 13, exercise habits varied widely across the sample.

Figure 13. Physical Activity



Note. $n = 763$.

Results of an ANOVA demonstrated no significant difference in the number of exercise days by LGBTTS category, $F(4) = .426, p > .05$. On average, most participants exercised between four and five times per week; this number did not significantly vary by LGBTTS category. While the number of days exercised does not directly translate into minutes exercised (nor does it specify types of physical exercise), it is likely that individuals who are exercising four to five days per week are getting the recommended amount of physical activity. Thus, the data supports the conclusion that the majority of the sample is getting adequate physical exercise.

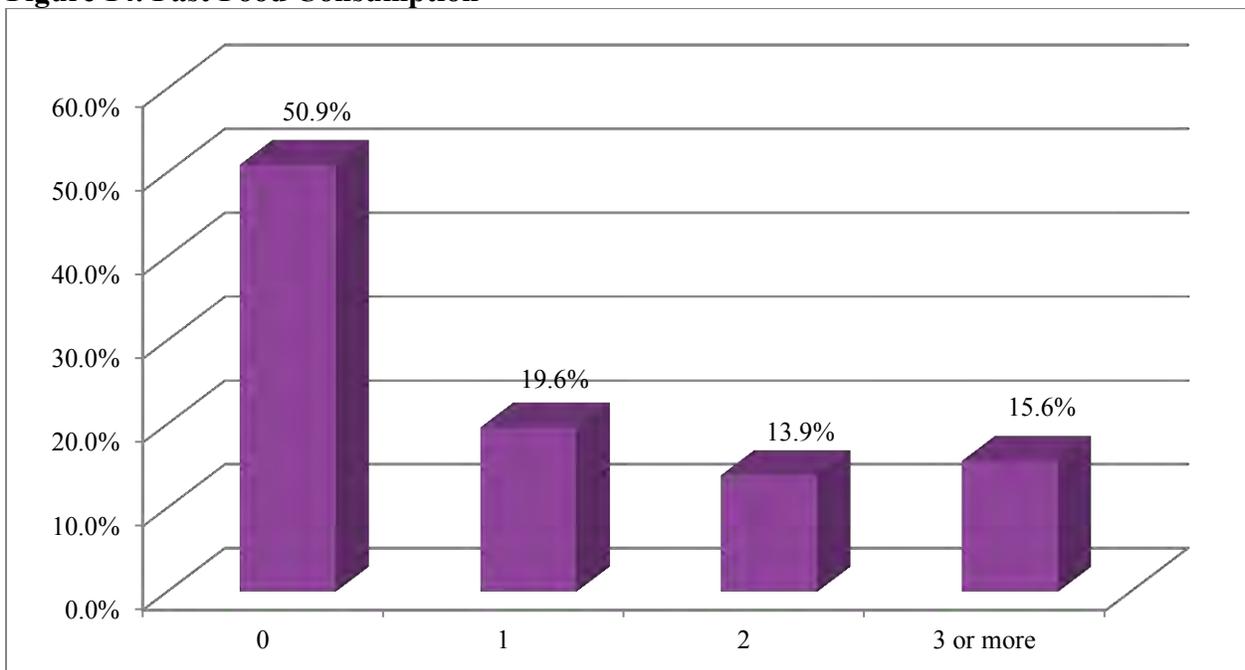
Fast Food Consumption

Studies show that individuals who eat meals prepared outside the home, especially at fast food restaurants, are at an increased risk of weight gain and obesity (U.S. Department of Agriculture & U.S. Department of Health and Human Services, 2010). This relationship is especially strong for those who consume one or more fast food meals per week.

To measure fast food consumption, participants were asked, “In the past 7 days, how many times did you eat fast food? Include fast food meals eaten at work, at home, or at fast-food restaurants, carryout, or drive-through (for example, McDonald's, Panda Express, Taco Bell, etc.).”

About half of participants (50.9%) indicated that they had not consumed any fast food in the past week, as illustrated in Figure 14.

Figure 14. Fast Food Consumption



Note. $n = 750$.

There was no statistically significant difference in fast food consumption by LGBT categories, $\chi^2(4) = .727, p > .05$. This indicates that rates of fast food consumption are relatively similar for each of the LGBT categories.

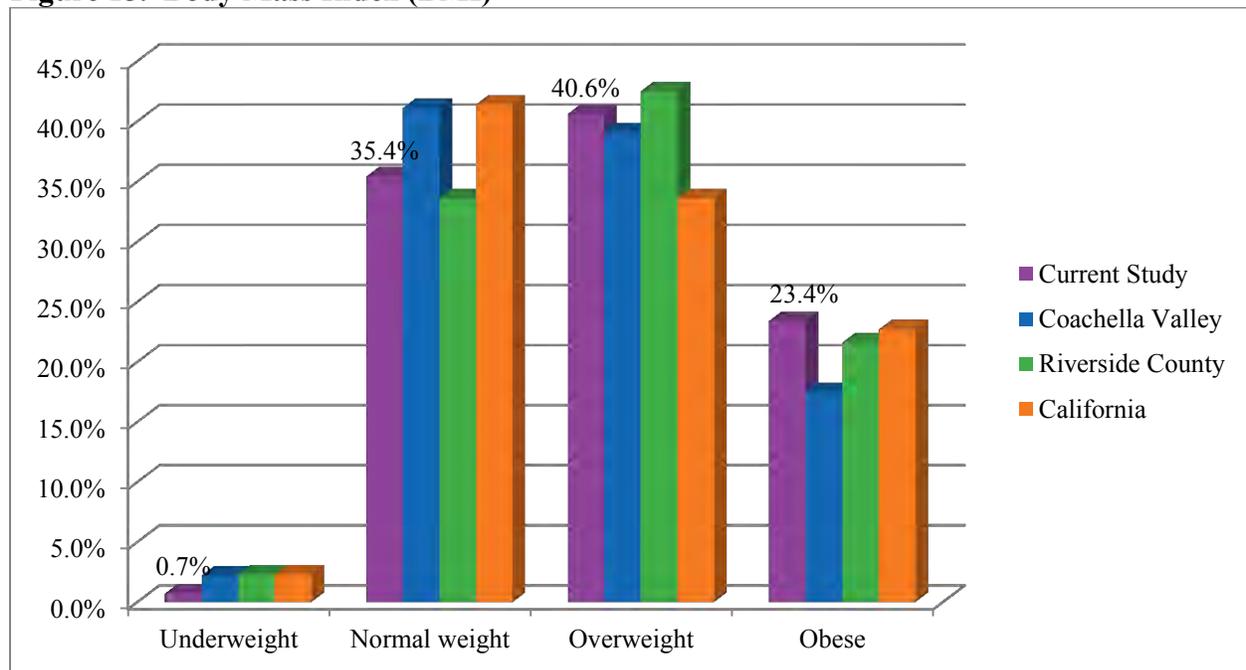
Body Mass Index (BMI)

Obesity puts people at risk for a wide range of disease and negative health conditions, including hypertension, diabetes, heart disease, stroke, and some cancers (National Heart, Lung, & Blood Institute, 1998). In fact, the CDC ranks obesity as the second leading cause of preventable death in the United States. Obesity causes an estimated 300,000 deaths each year (Surgeon General, 2013).

In this study, body mass index (BMI) is used as an indicator of obesity. BMI is a widely used indicator of body fatness with four standardized weight status categories: underweight, normal weight, overweight, and obese (CDC). In this study, participants were asked to self-report their height and weight. This information was then transformed into BMI using the formula provided by the CDC.

Results showed that approximately 64.0% of participants have a BMI in the “overweight” or “obese” category, as illustrated in Figure 15. While concerning, it is also apparent from Figure 15 that this trend mirrors that of the local region.

Figure 15. Body Mass Index (BMI)



Note. $n = 749$. The Coachella Valley data in this graph are from the HARC 2010 Community Health Monitor. The Riverside County and California data are from CHIS 2009.

There was a statistically significant difference in BMI category by LGBT category, $\chi^2(8) = 18.292, p < .05$ (note: these analyses excluded those few participants who are underweight). As illustrated in Table 11, gay and transgender participants are likely to be overweight, while bisexual and straight participants are likely to be normal weight. Lesbian participants are fairly evenly distributed across the three categories of normal, overweight, and obese.

Table 11. BMI by LBTS Category

LBTS Category	BMI Category				Total
	Underweight	Normal weight	Overweight	Obese	
Gay	0.2% (1)	33.6% (180)	44.8% (240)	21.5% (115)	71.6% (536)
Lesbian	2.7% (3)	36.4% (40)	27.3% (30)	33.6% (37)	14.7% (110)
Bisexual	0.0% (0)	43.3% (13)	30.0% (9)	26.7% (8)	4.0% (30)
Straight	0.0% (0)	47.2% (25)	32.1% (17)	20.8% (11)	7.1% (53)
Transgender	5.0% (1)	35.0% (7)	40.0% (8)	20.0% (4)	2.7% (20)
Total	0.7% (5)	35.4% (265)	40.6% (304)	23.4% (175)	100.0% (749)

Summary of Physical Fitness

On average, participants are physically active between four and five days per week, which indicates they are likely getting adequate amounts of physical exercise. However, exercise habits are fairly evenly distributed—while some participants do not exercise at all, others exercise every day.

Approximately half of participants eat fast food one or more days per week, which puts them at risk for obesity and the attendant co morbidities. Indeed, results indicate that over 2/3 of participants are overweight or obese at the present time. While concerning, these statistics are on par with local and national rates of obesity.

Substance Use, Misuse, and Abuse

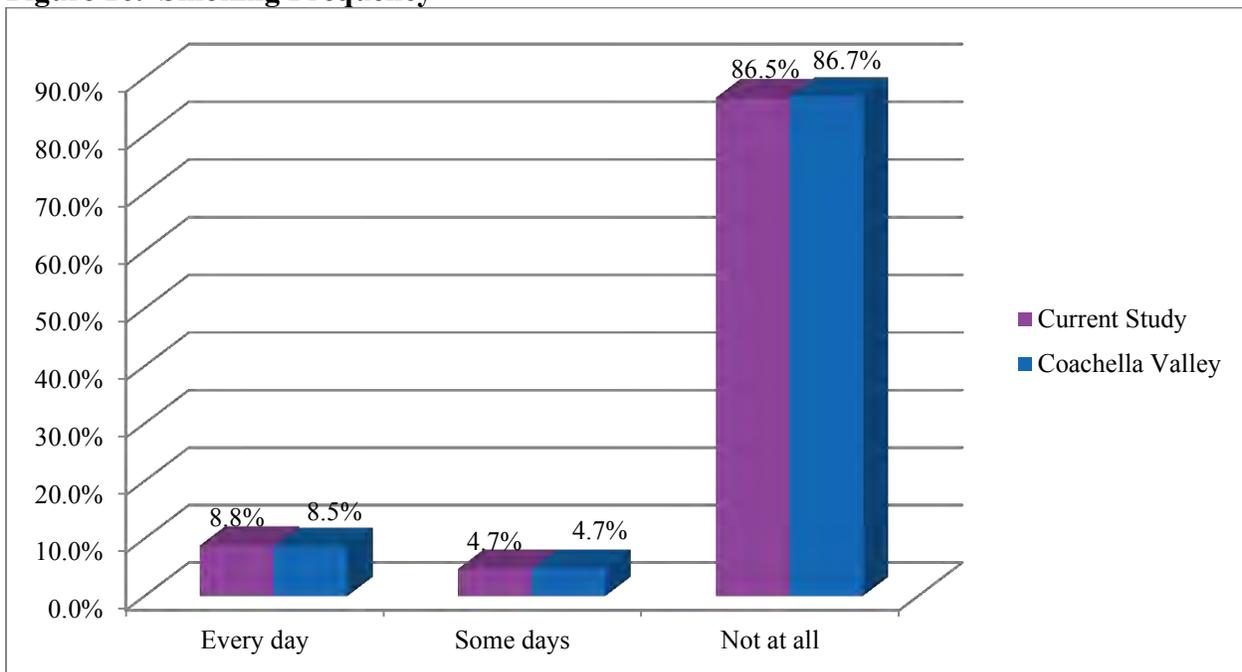
Smoking

Tobacco use has been linked to heart disease, bronchitis, and many different types of cancer, including cancer of the lungs, larynx, esophagus, pancreas, and kidney (U.S. Department of Health and Human Services, 2004).

According to the Centers for Disease Control and Prevention, 19.4% of American adults (43.8 million people) 18 years and older are current smokers. Tobacco use is still the leading preventable cause of death and is considered responsible for about 5 million deaths annually. 4 Cigarette smoking is the cause of about 20 percent of yearly deaths, and approximately 49,000 deaths are the result of secondhand smoke exposure per year (CDC, 2013).⁵

The majority (86.5%) of participants do not smoke, as illustrated in Figure 16. Smoking rates in the current study are virtually identical to rates across the Coachella Valley, according to HARC's Community Health Monitor data.

Figure 16. Smoking Frequency



Note. $n = 764$. The Coachella Valley data in this graph are from the HARC 2010 Community Health Monitor.

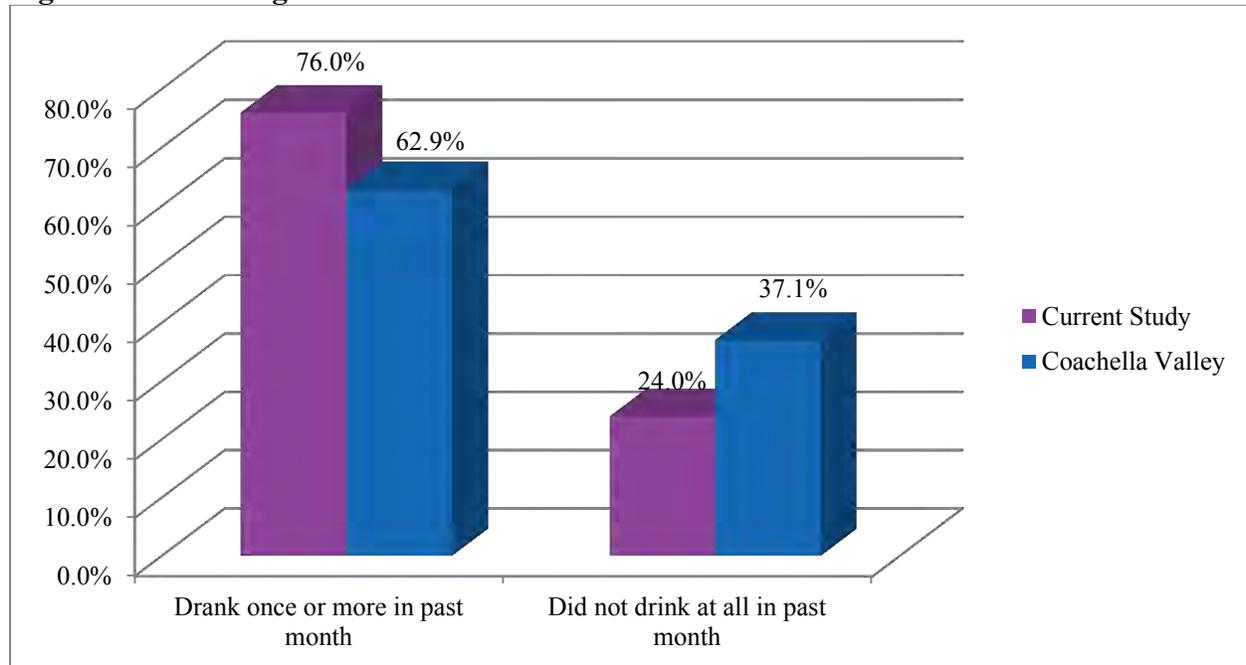
When dichotomized into “smokes” vs. “does not smoke”, there was no significant difference between LGBT categories, $\chi^2(4) = 2.940, p > .05$, indicating that the general trend of not smoking holds true for participants in all of the LGBT categories.

Drinking

Previous research has shown that moderate consumption of alcoholic beverages (defined as one drink per day for women and up to two drinks per day for men) may have certain health benefits, such as reduced risk of cardiovascular disease. However, excessive consumption can be a major health risk, damaging vital organs such as the brain and liver, and decreasing inhibitions that would normally prevent against other risky behavior.

In order to assess alcohol use and abuse, participants were asked a series of questions about consumption. First, participants were asked, “During the past 30 days, how many days per month did you have at least one drink of any alcoholic beverage?” A total of 183 participants (approximately 24.0% of the sample) had not consumed any alcoholic beverages in the past month. This is similar, but slightly less than the Coachella Valley as a whole, as illustrated in Figure 17.

Figure 17. Drinking in Past Month



Note. $n = 746$. The Coachella Valley data in this graph are from the HARC 2010 Community Health Monitor.

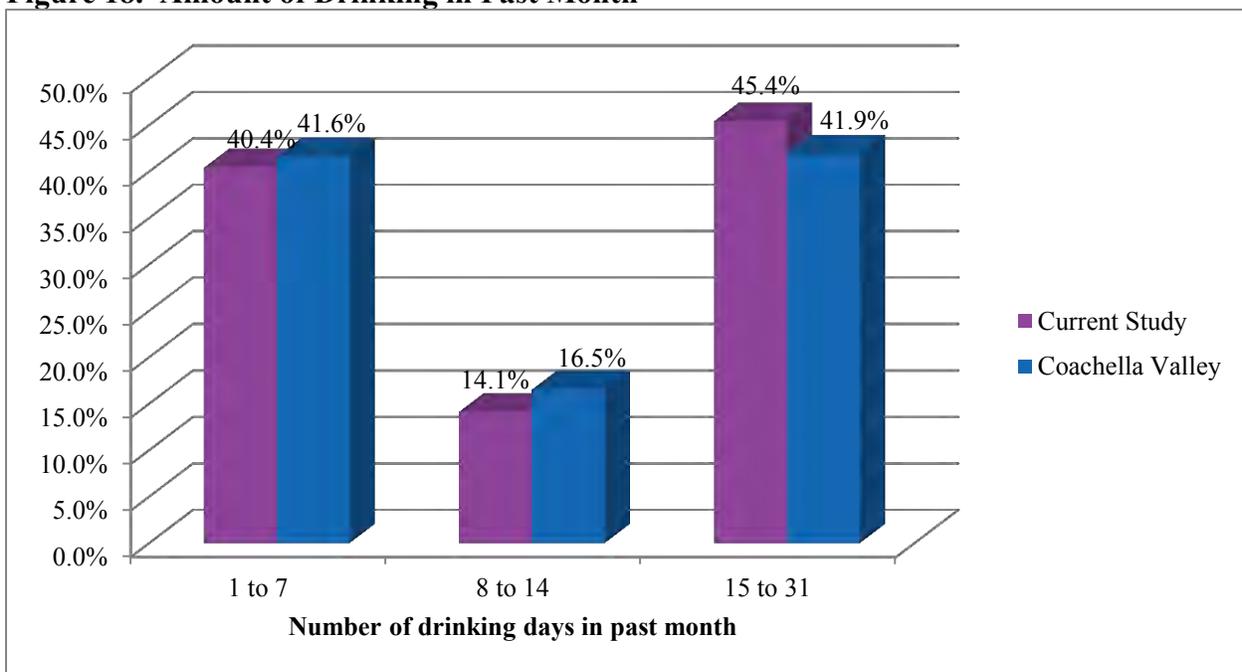
There is a significant difference in abstinence from drinking by LBGTBS category, $\chi^2(4) = 10.448, p < .05$. As illustrated in Table 12, lesbian participants are more likely to abstain from alcohol (35.3%) than the other participant groups, where abstinence rates range from 18.5% to 25.8%.

Table 12. Drinking in Past Month

LGBTQ Category	Drinking Behavior		Total
	Drank once or more in past month	Did not drink at all in past month	
Gay	78.1% (424)	21.9% (119)	71.1% (543)
Lesbian	64.7% (75)	35.3% (41)	15.2% (116)
Bisexual	74.2% (23)	25.8% (8)	4.1% (31)
Straight	81.5% (44)	18.5% (10)	7.1% (54)
Transgender	75.0% (15)	25.0% (5)	2.6% (20)
Total	76.0% (581)	24.0% (183)	100.0% (764)

Of the 581 participants that did drink at least one time in the past month, the number of days per month on which the participants drank ranged from 1 to 31. The average participant drank on approximately 14 days during the past month, or roughly every other day. As illustrated in Figure 18, the number of days per month on which participants drank closely mirrored the drinking frequency of the Coachella Valley as a whole.

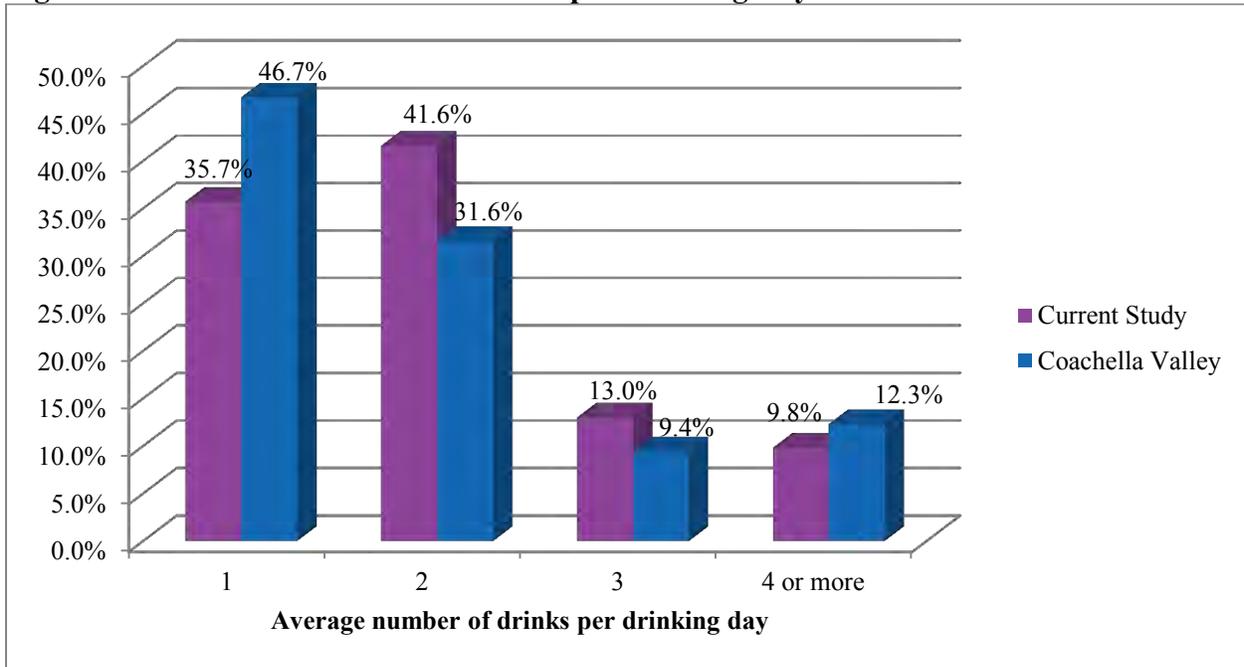
Figure 18. Amount of Drinking in Past Month



Note. n = 581. The Coachella Valley data in this graph are from the HARC 2010 Community Health Monitor.

Those participants who drank at least once in the past month were subsequently asked, “During the past 30 days, on the days when you drank, about how many drinks did you drink, on average?” Responses ranged between 1 and 15, with an average of about 2 drinks per drinking day. As illustrated in Figure 19, the vast majority of participants (90.3%) drank three or fewer drinks per drinking day.

Figure 19. Number of Drinks Consumed per Drinking Day



Note. $n = 575$. The Coachella Valley data in this graph are from the HARC 2010 Community Health Monitor.

Results of an ANOVA test indicated that there was no significant difference in the number of drinks consumed per drinking day by LGBTs category, $F(4) = 2.185$, $p > .05$, indicating that this pattern of amount of drinking is applicable to participants in all of the LGBTs categories.

One common form of alcohol abuse is “binge drinking”, typically defined as consumption of four or more drinks in one sitting for women, or five or more drinks in one sitting for men (National Institute of Alcohol Abuse and Alcoholism, 2004). As illustrated in Figure 19, less than 10% of participants report drinking four or more drinks on their average drinking day in the past month. This indicates that the majority of participants are *not* engaging in unhealthy binge drinking behaviors.

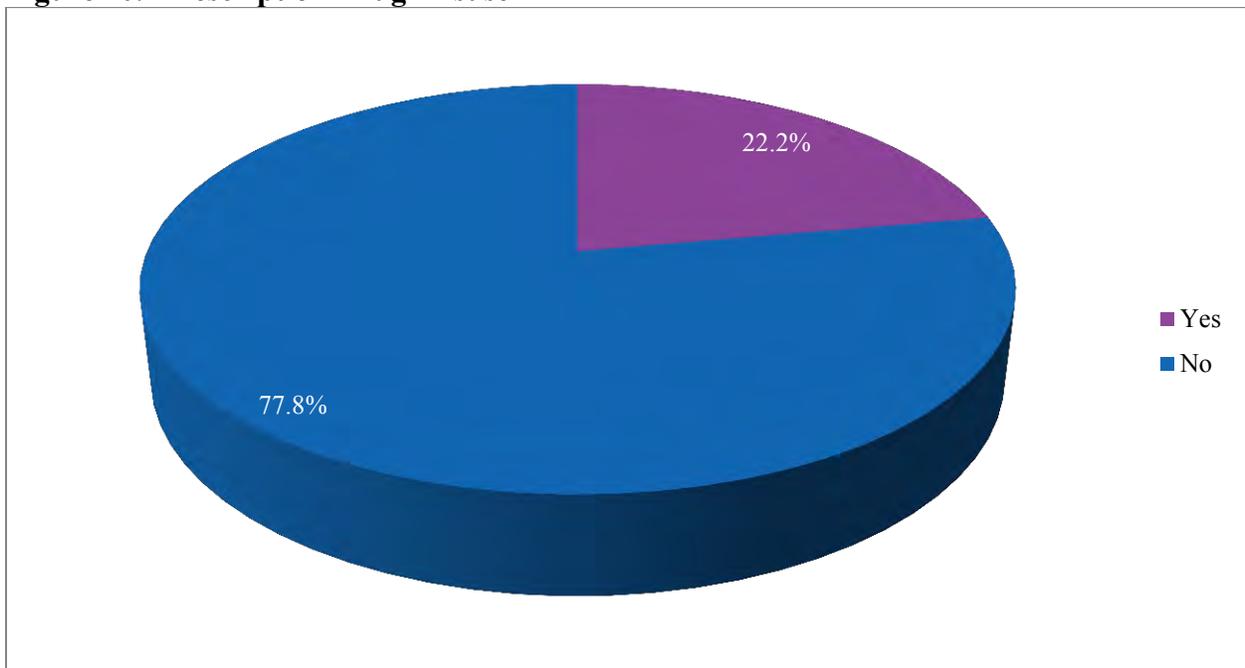
Prescription Drug Misuse

Prescription drug misuse refers to the use of a medication other than as directed by a healthcare provider. This can include behaviors such as taking too much or too little of a particular drug, taking it too often, or taking a drug that was prescribed to someone else.

Individuals who use prescription drugs that were prescribed to someone else are taking a great risk by consuming a controlled substance without the guidance of a physician. Without physician oversight, an individual may take the drug improperly, experience dangerous interactions with other drugs, food, or alcohol, or experience severe negative effects based on preexisting medical conditions that are contraindicated for use with this drug. Thus, using a prescription drug without the oversight of a physician can lead to serious health problems, worsening conditions, and even death (ASCP, 2012).

To assess prescription drug misuse, participants were asked, “Have you ever taken a prescription drug that was NOT prescribed to you (it was prescribed to someone else)?” As illustrated in Figure 20, results indicated that 22.2% had indeed taken a prescription drug that was prescribed to someone other than themselves.

Figure 20. Prescription Drug Misuse



Note. $n = 766$.

There was no significant difference in prescription drug misuse rates between LGBT categories, $\chi^2(4) = 1.763, p > .05$, indicating that this rate of prescription drug misuse is generally applicable to all LGBT categories.

Illicit Drug Use

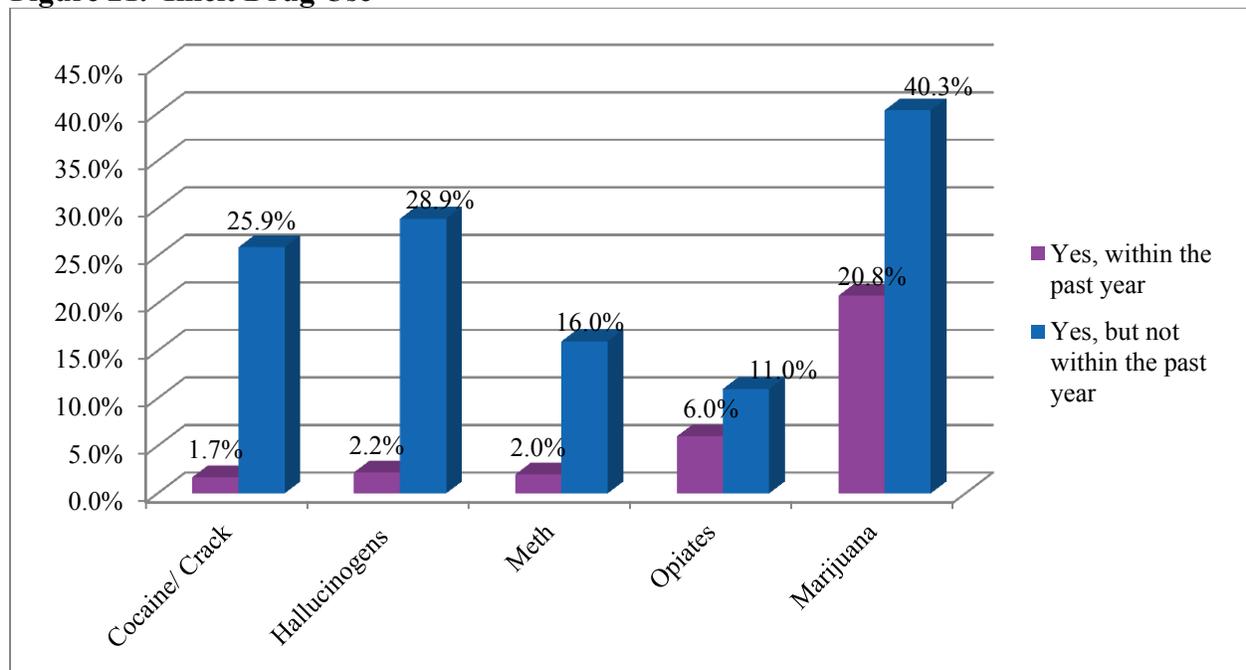
Illicit drug use is the use of illegal drugs, such as cocaine, LSD, and methamphetamines, or legal drugs without a prescription, such as marijuana or opiates. Illicit drug use can have negative health consequences, including addiction.

Two questions on the survey assessed illicit drug use. The first asked, “Have you ever used any of the following drugs? Cocaine or crack cocaine; methamphetamines; hallucinogens (such as LSD, acid, ecstasy, mushrooms).” Participants could select “yes, within the past year”, “yes, but not within the past year”, and “no never” as response options.

The second question was designed similarly, but addressed drugs that can sometimes be legally prescribed. In order to assess only illicit use of these drugs (not legal, physician-supervised use), the following question was posed: “Have you used any of the following drugs WITHOUT a prescription? Do not include any drugs you have taken on a doctor’s orders: Opiates (such as heroin, morphine, opium, Vicodin, Oxycodone); marijuana, hashish, or other cannabis.” Again, participants could select “yes, within the past year”, “yes, but not within the past year”, and “no never” as response options.

As illustrated in Figure 21, the most commonly used illicit drug was marijuana; over 20% of the population had used marijuana within the past year. Current use of other drugs was relatively low, although past use of cocaine/crack and hallucinogens was fairly high. This may be due to the age of the participants, indicating that they used these drugs at the height of their popularity (the 1970s for hallucinogens and the 1980s for cocaine) but have not used them recently.

Figure 21. Illicit Drug Use



Note. n ranges from 756 to 764.

Each of these drugs was then dichotomized into “used ever” and “never used”. Several chi-square analyses were conducted to assess whether certain drugs were more likely to have been used by the individual LGBT categories. Results demonstrated there was no statistically significant difference by LGBT categories in use of cocaine ($\chi^2(4) = 7.146, p > .05$), methamphetamines ($\chi^2(4) = 4.88, p > .05$), and opiates ($\chi^2(4) = 2.26, p > .05$). This indicates that all LGBT categories had relatively similar rates of use of cocaine, methamphetamines, and opiates.

There was a statistically significant difference in hallucinogen use by LGBT category, $\chi^2(4) = 19.21, p < .01$. As illustrated in Table 13, gay and bisexual participants exhibit relatively high rates of hallucinogen use (35.3% and 35.5%, respectively), while lesbian and transgender participants have a moderate rate of hallucinogen use (21.4% and 20%, respectively), and straight participants have a low rate of hallucinogen use (13%).

Table 13. Hallucinogen Use by LGBT Category

LGBT Category	Hallucinogen Use		Total
	Used	Never Used	
Gay	35.3% (190)	64.7% (349)	70.8% (539)
Lesbian	21.4% (25)	78.6% (92)	15.4% (117)
Bisexual	35.5% (11)	64.5% (20)	4.1% (31)
Straight	13.0% (7)	87.0% (47)	7.1% (54)
Transgender	20.0% (4)	80.0% (16)	2.6% (20)
Total	31.1% (237)	68.9% (524)	100.0% (761)

There was also a statistically significant difference in marijuana use by LGBT category, $\chi^2(4) = 19.06, p < .01$. As illustrated in Table 14, gay, lesbian, and transgender participants all have a rate of marijuana usage around the mean (between 55% and 63%). Bisexual participants have an especially high rate of marijuana usage (over 80%), while straight participants have an especially low rate of marijuana usage (37%).

Table 14. Marijuana Use by LBGBTS Category

LBGBTS Category	Marijuana Use		Total
	Used	Never Used	
Gay	62.7% (338)	37.3% (201)	70.9% (539)
Lesbian	60.3% (70)	39.7% (46)	15.3% (116)
Bisexual	80.6% (25)	19.4% (6)	4.1% (31)
Straight	37.0% (20)	63.0% (34)	7.1% (54)
Transgender	55.0% (11)	45.0% (9)	2.6% (20)
Total	61.1% (464)	38.9% (296)	100.0% (760)

While drug use can have long-term effects, recent drug use within the past year is a much greater health risk than drug use that occurred more than one year ago. Thus, in order to assess current drug use activity, a composite variable was created to assess whether an individual had recently used one or more drugs in the past year, as compared to those who had not used any drugs in the past year.

Results of a chi-square analysis demonstrated that recent drug use was significantly different based on LBGBTS category, $\chi^2(4) = 11.437, p < .05$. As is visible in Table 15, straight participants appear to be less likely to have used illegal drugs within the past year (7.4% compared to the average of 25.1% overall). In contrast, L, G, B, and T participants all had recent drug use rates between 22% and 30%.

Table 15. Recent Illicit Drug Use by LBGBTS Category

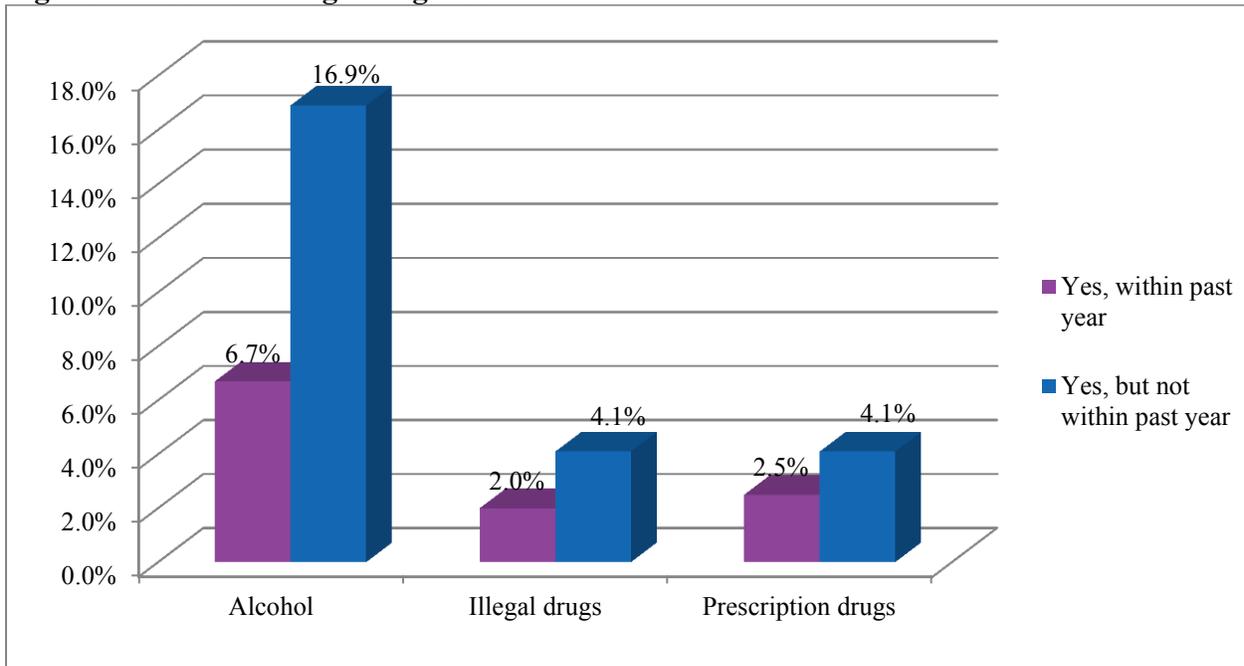
LBGBTS Category	Recent Illicit Drug Use		Total
	Has not used any drug within the past year	Has used one or more drugs within the past year	
Gay	72.6% (397)	27.4% (150)	71.1% (547)
Lesbian	77.8% (91)	22.2% (26)	15.2% (117)
Bisexual	77.4% (24)	22.6% (7)	4.0% (31)
Straight	92.6% (50)	7.4% (4)	7.0% (54)
Transgender	70.0% (14)	30.0% (6)	2.6% (20)
Total	74.9% (576)	25.1% (193)	100.0% (769)

Addiction

Addiction to alcohol or other psychotropic substances can be extremely detrimental for health. To assess potential addiction, participants were asked, “Have you or someone close to you (such as a friend, family member, or doctor) ever been worried that you may have a problem with or an addiction to any of the following substances?” Three types of substances were then listed: alcohol, illegal drugs, and prescription drugs.

Results indicate that alcohol abuse appears to be the most common of any form of substance abuse. Overall, much of the concern regarding substance abuse appears to have happened in the past, rather than within the past year, as illustrated in Figure 22.

Figure 22. Concern Regarding Addiction



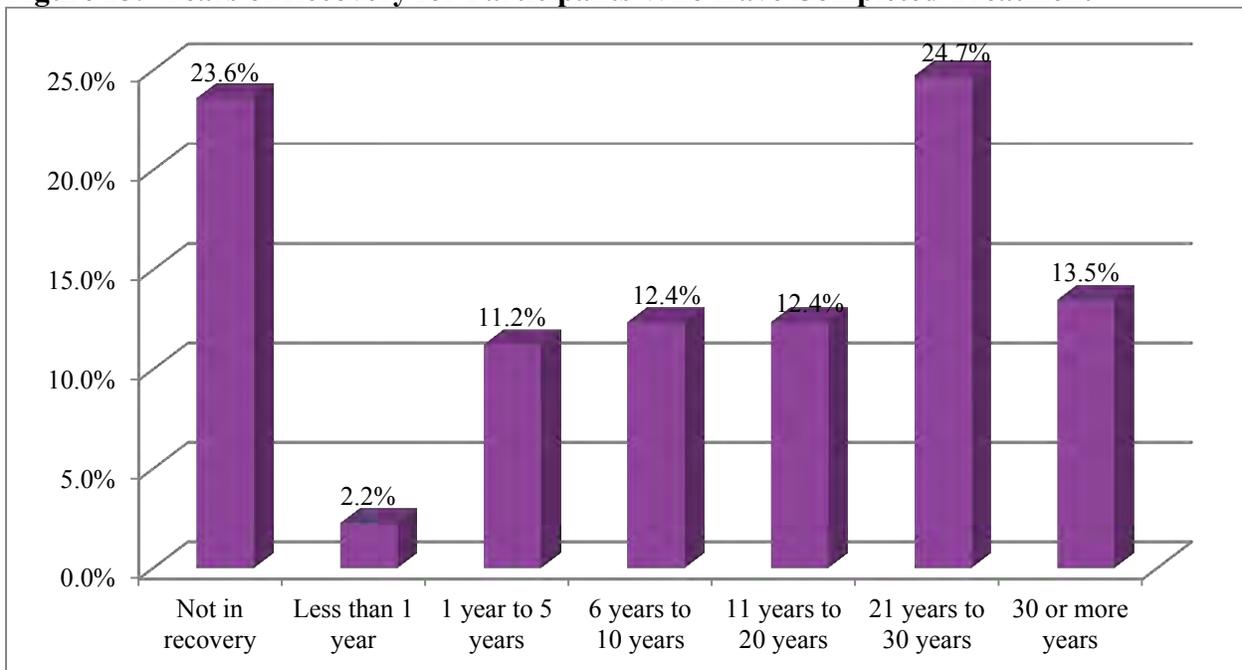
Note. *n* ranges from 756 to 765.

In order to further assess addiction, participants were also asked, “Have you ever completed treatment for drug or alcohol abuse?” Results showed that 11.3% of participants ($n = 89$) have completed some type of treatment for drug or alcohol abuse. This number did not statistically differ between LGBTs categories, $\chi^2(4) = 3.36, p > .05$.

Participants who indicated they had completed treatment were subsequently asked, “How many years have you been abstinent from your drug of choice (“in recovery”)?” Participants were instructed to enter “0” if they did not currently consider themselves to be in recovery.

As illustrated in Figure 23, results showed that 23.6% of these participants did not currently consider themselves to be in recovery. Of those who did consider themselves to be in recovery, length of recovery ranged from 4 months to 46 years. The average person who had completed treatment was currently abstinent for an average of about 14 years.

Figure 23. Years of Recovery for Participants Who Have Completed Treatment



Note. $n = 89$.

Results of an ANOVA showed that there was no significant difference in length of recovery by LGBT category, $F(4) = 1.84, p > .05$, indicating that average length of recovery did not significantly vary between the LGBT groups of participants.

Summary of Substance Use, Misuse, and Abuse

Less than 15% of participants smoke cigarettes, a rate that is similar to that in the Coachella Valley as a whole. Approximately $\frac{3}{4}$ of participants have consumed alcohol in the past month. However, in-depth analysis shows that the majority of participants are imbibing one to two drinks when they choose to drink, a level that is more likely to have health benefits than health damages. Indeed, very few participants have engaged in binge drinking in the past month, indicating that this is not a common risky behavior for this sample.

Approximately 22% of participants have used a prescription drug that was prescribed to someone other than themselves, which constitutes prescription drug misuse. However, it is worth noting that this does not assess prescription drug abuse or addiction.

In regards to illicit drug use, the majority of drug use has occurred more than a year ago, indicating that most participants are not current drug users. Approximately one quarter of participants used an illicit drug within the past year; the vast majority of these used marijuana.

Approximately 11% of participants have previously undergone treatment for substance abuse. A quarter of these participants do not consider themselves to currently be in recovery. Of those who are currently in recovery, most have been in recovery for over a decade.

Sexual Health

Sexually transmitted diseases (STDs) are a major health challenge in the United States: the CDC estimates that nearly 20 million new sexually transmitted infections occur each year.

Consequences of STDs can range from mildly bothersome symptoms to eventual death.

Additionally, STDs account for almost \$16 billion in healthcare costs each year. It is important to note that anyone can become infected with an STD, however, certain behaviors increase the risk of STD transmission, such as intravenous drug use, anal sex, and unprotected sex (CDC, 2013).

To assess risky behavior pertaining to sexual health, participants were asked a variety of questions assessing their sexual activity, the characteristics of their partners, and the steps that individuals with multiple partners took to prevent transmission of STDs.

First, participants were asked whether they had engaged in sexual intercourse of any type (including oral, anal, or vaginal) within the past year. Results showed that the majority of participants (71.2%, $n = 544$) had been sexually active in the past year. There was a statistically significant difference in sexual activity by LGBT category, $\chi^2(4) = 14.704, p < .01$. As illustrated in Table 16, it appears that gay participants have a higher rate of sexual activity than other participants (75% versus rates around 60%).

Table 16. Sexual Activity by LGBT Category

LGBT Category	Sexual Activity		Total
	Sexually Active in Past Year	Not Sexually Active in Past Year	
Gay	75.0% (409)	25.0% (135)	71.3% (545)
Lesbian	59.5% (69)	40.5% (47)	15.2% (116)
Bisexual	64.5% (20)	35.5% (11)	4.1% (31)
Straight	66.0% (35)	34.0% (18)	6.9% (53)
Transgender	57.9% (11)	42.1% (8)	2.5% (19)
Total	71.2% (544)	28.8% (220)	100.0% (764)

However, monogamous sexual activity is relatively low-risk in terms of health. Thus, participants who indicated they were sexually active were then asked to identify whether or not they had had sexual intercourse with more than one partner within the past year. Responses indicated a roughly even split: 51.8% of sexually active participants reported having sexual intercourse with more than one partner, while 48.2% reported having sexual intercourse with just one partner.

There was a statistically significant difference in sexual activity with multiple partners by LGBT category, $\chi^2(4) = 85.310, p < .001$. As illustrated in Table 17, lesbian and straight participants tend to have sex with only one person (monogamy rates of 85.7% and 91.4%, respectively). This is also true, to a lesser degree, for transgender participants (monogamy rate of 63.6%). In contrast, bisexual participants are evenly split between monogamy and multiple partners, and gay participants have relatively low rates of monogamy (37.5%).

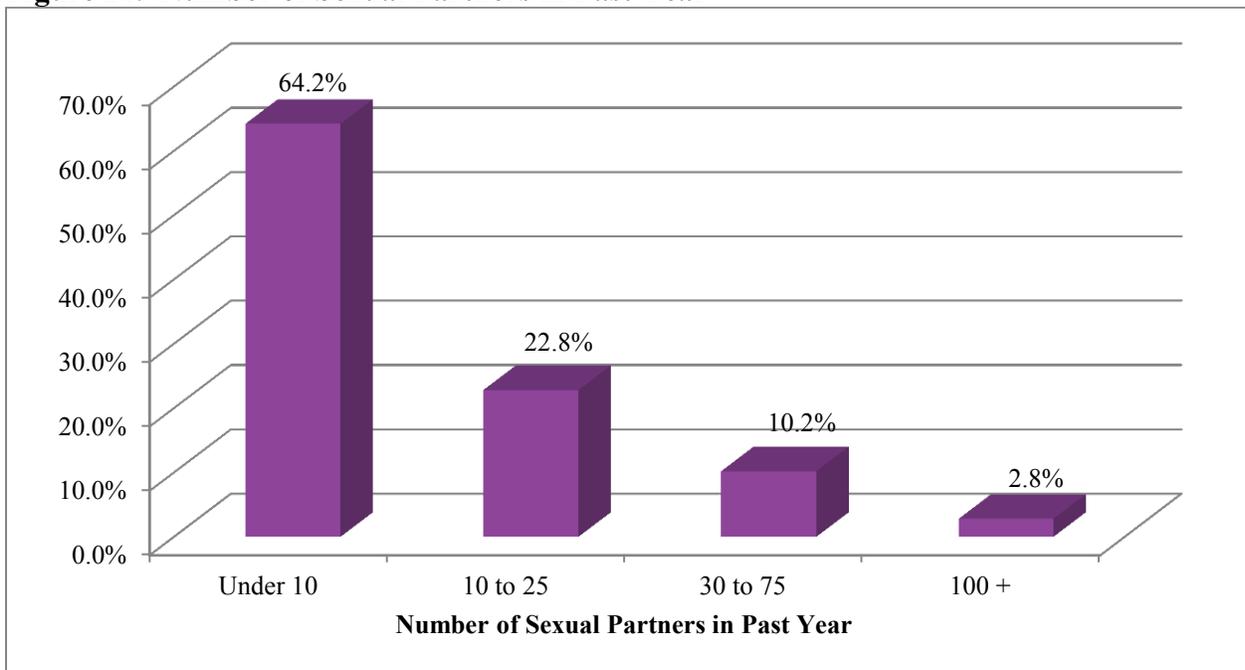
Table 17. Type of Sexual Activity by LGBT Category

LGBT Category	Type of Sexual Activity		Total
	Multiple Partners	Monogamous	
Gay	62.5% (252)	37.5% (151)	74.8% (403)
Lesbian	14.3% (10)	85.7% (60)	13.0% (70)
Bisexual	50.0% (10)	50.0% (10)	3.7% (20)
Straight	8.6% (3)	91.4% (32)	6.5% (35)
Transgender	36.4% (4)	63.6% (7)	2.0% (11)
Total	51.8% (279)	48.2% (260)	100.0% (539)

Individuals who had had sexual intercourse with multiple partners within the past year were subsequently asked several questions about their encounters. It is worth noting that this subset of the population (those who are currently sexually active with multiple partners) is almost exclusively gay (over 90%), and thus, it is not possible to analyze this subset further by LGBT categories, due to the very low numbers of L, B, T, and S participants.

Individuals who indicated that they had had sexual intercourse with multiple partners in the past year were then asked to indicate how many partners they had had intercourse with. Twelve of the participants who had previously indicated that they had had sex with more than one partner in the past year on the yes-no question now indicated that they had only had sexual intercourse with one partner. These 12 participants were removed from this analysis. The number of sexual partners within the past year ranged from 2 to 250. On average, participants who had had multiple sexual partners within the past year had had sex with approximately 14 partners. However, this average is heavily influenced by the extreme outliers, and thus, in this case, the median (5 partners) is a more representative indicator. As illustrated in Figure 24, the majority of participants had less than 10 sexual partners in the past year.

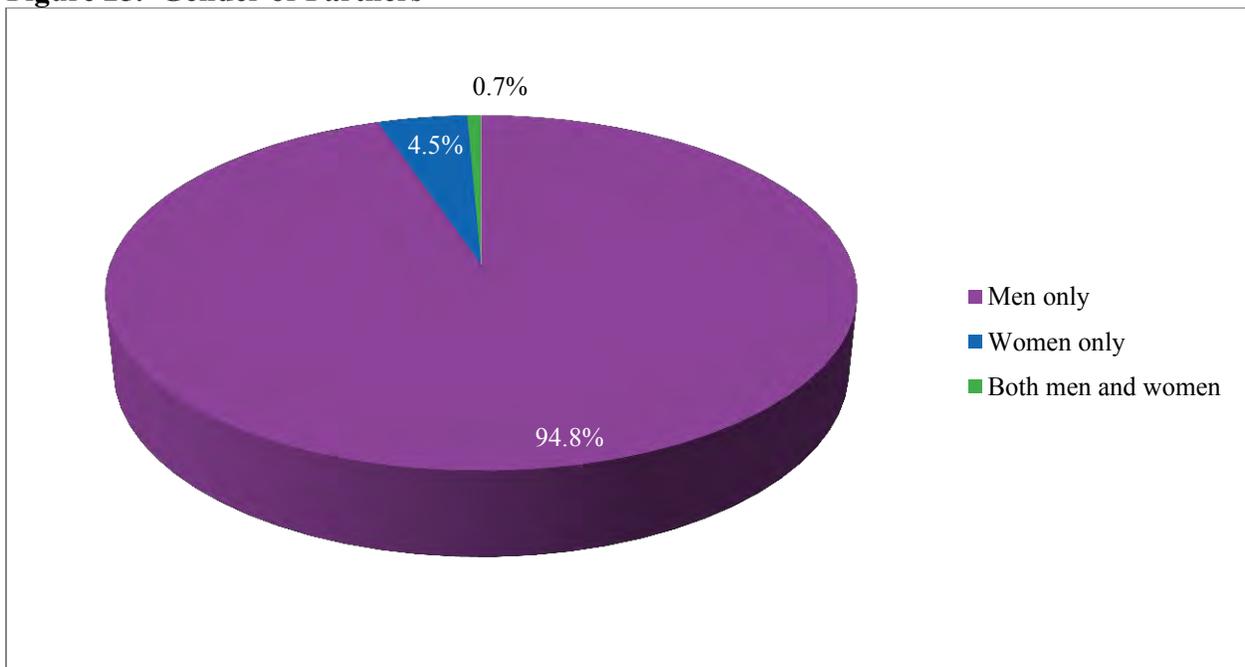
Figure 24. Number of Sexual Partners in Past Year



Note. $n = 254$. Only includes data from individuals who have been sexually active with more than one partner in the past year.

Participants who had had sex with multiple partners in the past year were also asked the gender of those partners. As illustrated in Figure 25, most of these sexual partners were men.

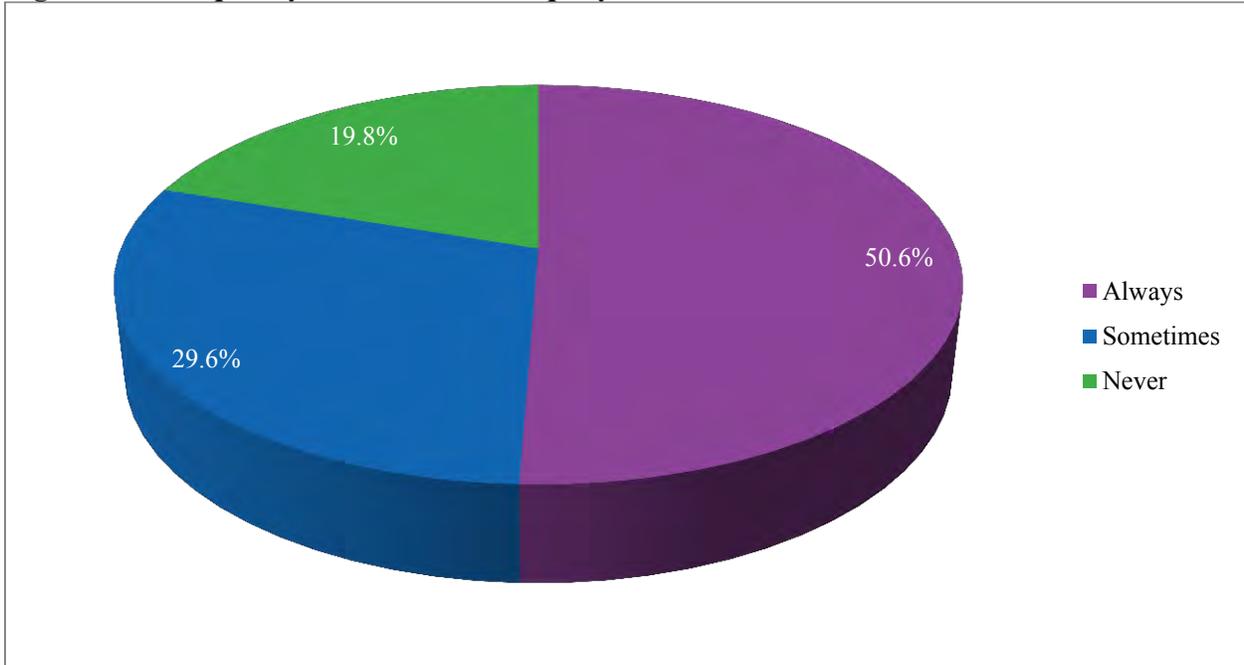
Figure 25. Gender of Partners



Note. $n = 254$. Only includes data from individuals who have been sexually active with more than one partner in the past year.

These participants were also asked, “Do you ask your sexual partners about their HIV or STD status?” As illustrated in Figure 26, about half of participants reported always asking their partners about their HIV/STD status prior to engaging in sexual intercourse. This indicates that the other half of the population is likely putting themselves at risk for transmission of STDs by not knowing their partners’ infection status prior to intercourse.

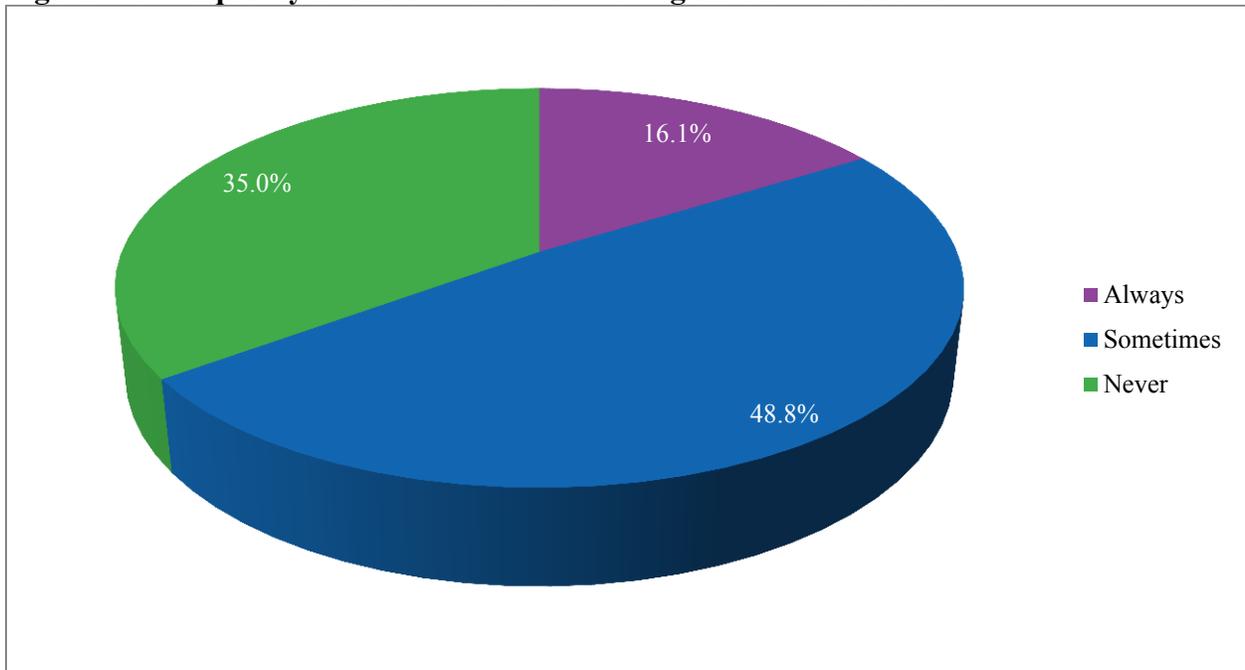
Figure 26. Frequency of STD Status Inquiry



Note. $n = 253$. Only includes data from individuals who have been sexually active with more than one partner in the past year.

Participants who were sexually active with multiple partners were also asked to rate how often they used protection in the past year. Results indicated that, as illustrated in Figure 27, very few of these participants used protection every time they had sexual intercourse. This potentially indicates a serious health risk, as the risk of STD transmission is high for individuals who engage in unprotected sex with multiple partners, especially men having sex with men.

Figure 27. Frequency of Use of Protection During Sexual Intercourse



Note. $n = 254$. Only includes data from individuals who have been sexually active with more than one partner in the past year.

Open-ended responses elaborated that sexual health is a major topic of concern to some members of the community. For example:

- “I’m not sure how much of the gay male population really care or practice safe sex regularly (condoms, divulging information,...)”
- “The Coachella Valley, with its clothing optional resorts, it's frequent “party” weekends (White Party, Fist Fest, Gay Pride, etc.) and often high rates of Syphilis and other STI's including HIV -- is a place where the phenomenon of sex addiction and/or internet addiction should be on the table for discussion. Certainly not everyone who attends a party or stays in a clothing optional resort is a sex addict. But for those that are, there is absolutely no place to go to even get support or help. In contrast, not everyone who has a drink in a bar is an alcoholic. But for those that are there is extensive help available.”
- “Local gay community is very sexually active and has contact with others from all over the world-- STD's are a special and serious problem here (reference White Party). Guys don't want to go to the county government or private docs for testing due to privacy/insurance concerns.”

Summary of Sexual Health

On average, over 70% of participants have been sexually active within the past year. Gay participants are more likely than other participants to be sexually active. Gay participants are also more likely to be sexually active with more than one partner, as are bisexual participants (to a lesser degree). Lesbian, straight, and transgender participants are more likely to be sexually active with just one person.

In order to further explore risky sexual behavior, the remaining questions were only directed at participants who had engaged in sexual activity with multiple partners in the past year (almost exclusively gay or bisexual men). Generally, these participants had sex with males only, and had had less than 10 partners in the past year.

About half of these participants regularly inquired about a partner's STD/HIV status prior to engaging in sexual relations with them, indicating that the other half may or may not be having sex with multiple partners without know whether they are "clean". Additionally, the percentage of participants who are sexually active with multiple partners that always use condoms is less than 20%, indicating that over 80% of these participants have had sex within the past year with multiple partners without a condom. Thus, it is clear that many gay participants are engaging in extremely risky sexual behavior: unprotected sex with multiple partners without inquiring about STD status prior to intercourse. This behavior is a serious sexual health risk.

Violence

The World Health Organization has declared violence to be a major public health issue. The consequences of violence reach far beyond simple injury and/or death—victims of violence have an increased risk of depression, alcohol abuse, anxiety, and suicidal behavior (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002).

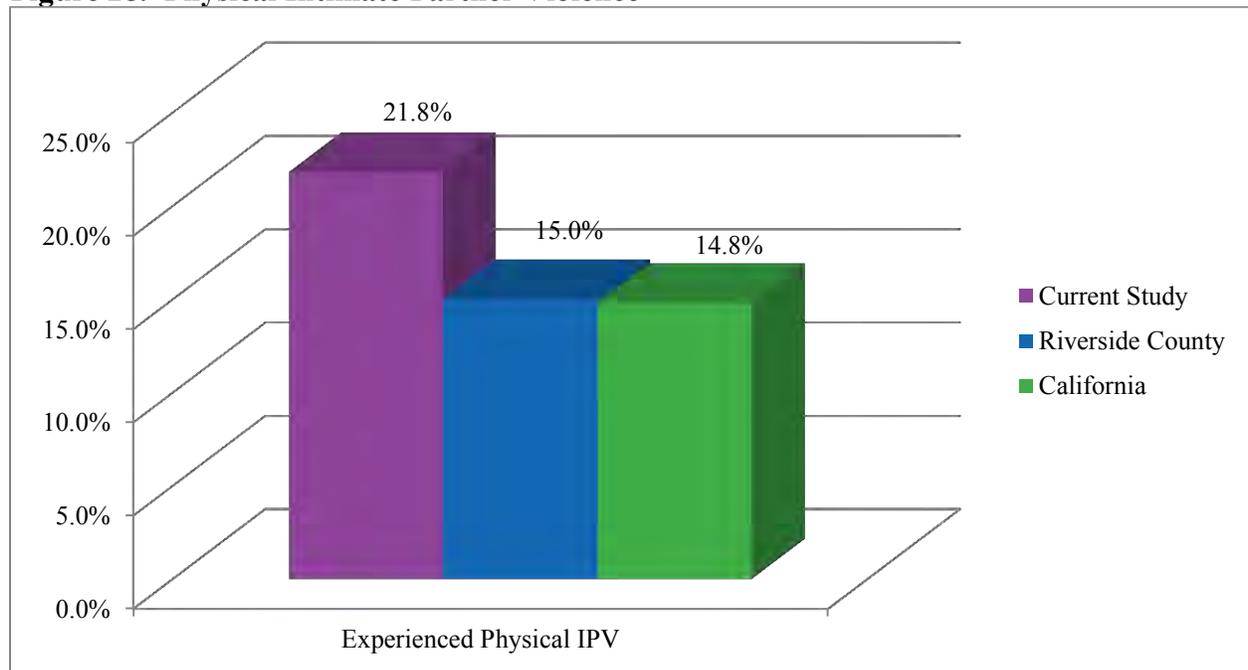
In particular, much research has focused on intimate partner violence (IPV), violence that stems from a significant other or spouse. Previous research has shown that both physical and psychological IPV are strongly related to negative physical and mental health outcomes for both men and women. Negative health outcomes stemming from IPV include increased depressive symptoms, substance use, chronic disease development, mental illness development, and injury (Coker, Davis, Arias, Desai, Sanderson, Brandt, & Smith, 2002).

To assess violence, the current study utilized two questions that are standard for use on the CHIS survey: one assessing IPV in terms of physical violence, and the other assessing IPV in terms of sexual violence. In order to also assess violence stemming from individuals other than an intimate partner, two parallel items were created: one to assess physical violence from someone other than an intimate partner, and another to assess sexual violence from someone other than an intimate partner.

Physical Violence

Results showed that 21.8% of participants had been physically abused by an intimate partner. As illustrated in Figure 28, this is quite a bit higher than local rates of physical IPV.

Figure 28. Physical Intimate Partner Violence



Note. $n = 765$. Riverside County and California data in this graph are from CHIS 2009.

There was a statistically significant difference in rates of physical IPV by LGBTTS category, $\chi^2(4) = 16.168, p < .01$. As illustrated in Table 18, gay participants have the lowest rates of physical abuse by an intimate partner (18.3%), while lesbians have the highest rate (33.9%).

Table 18. Physical Intimate Partner Violence by LGBTTS Category

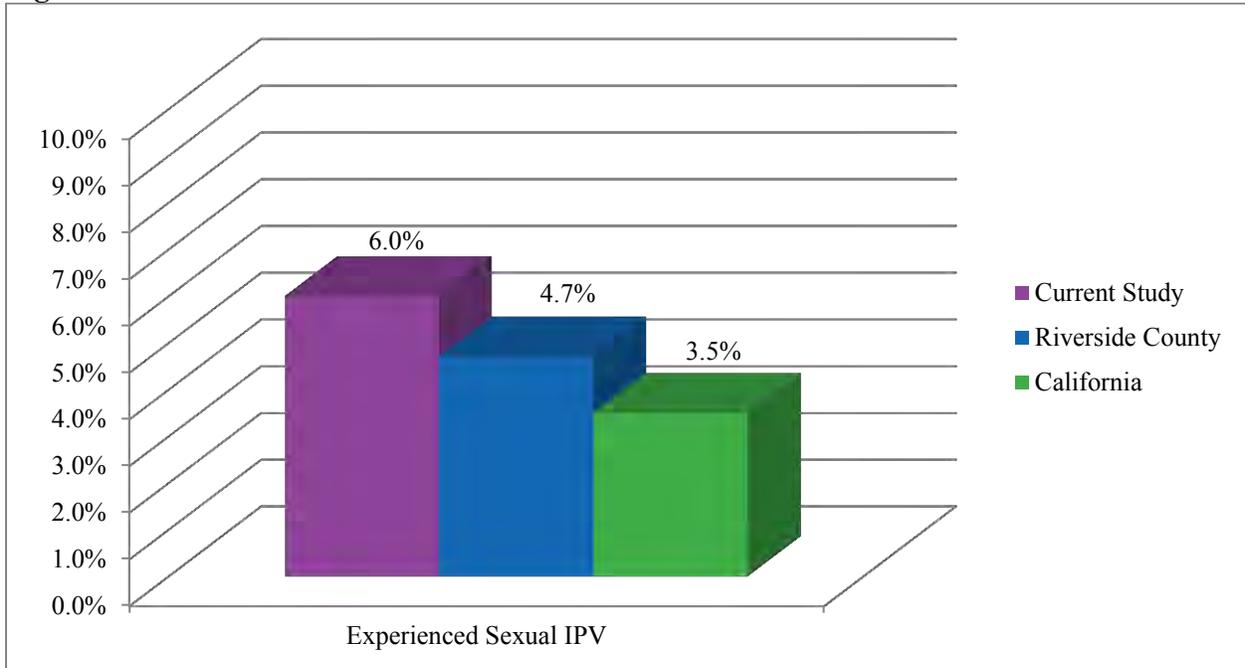
LGBTTS Category	Physical IPV		Total
	Experienced Physical IPV	Never Experienced Physical IPV	
Gay	18.3% (100)	81.7% (446)	71.4% (546)
Lesbian	33.9% (39)	66.1% (76)	15.0% (115)
Bisexual	26.7% (8)	73.3% (22)	3.9% (30)
Straight	29.6% (16)	70.4% (38)	7.1% (54)
Transgender	20.0% (4)	80.0% (16)	2.6% (20)
Total	21.8% (167)	78.2% (598)	100.0% (765)

Results showed that 20.8% of participants ($n = 158$) had experienced physical violence from someone other than an intimate partner. There was no significant difference between LGBTTS categories in the rates of physical violence that stem from someone other than an intimate partner, $\chi^2(4) = 3.608, p > .05$, indicating that this rate of physical violence is relatively consistent across LGBTTS categories.

Sexual Violence

Results showed that 6.0% ($n = 46$) had experienced sexual violence from an intimate partner. As visible in Figure 29, this is somewhat higher than rates of sexual IPV in the county as a whole and the state as a whole.

Figure 29. Sexual Intimate Partner Violence



Note. $n = 766$. Riverside County and California data in this graph are from CHIS 2009. Note that Riverside County estimates for this topic are potentially statistically unstable.

Cell sizes were too low to cross-section sexual IPV by LGBTTS category with any level of certainty.

Results showed that 11.4% of participants ($n = 87$) had experienced sexual violence from someone other than an intimate partner. Cell sizes were too low to cross-section sexual violence from non-partners by LGBTTS category with any level of certainty.

Treatment for Victims of Violence

Any participants who reported experiencing either physical or sexual violence, from either an intimate partner or someone else, were subsequently asked if they had talked with a mental health professional about the incident. Approximately 41.4% of these victims of violence reported that they had talked to a mental health professional about the incident. Cell sizes were too low to assess whether there were significant differences in help-seeking behavior by LGBT categories.

Victims of violence who did not talk to a mental health professional about the incident were subsequently asked to identify the barriers that prevented them from seeking help. As illustrated in Table 19, the majority of the responses fell in the “other” category, indicating that the barrier they experienced was not on the list. Of the barriers on the list, it is clear that the most common barrier to seeking help was that victims were embarrassed and wanted to forget about the incident.

Table 19. Barriers to Seeking Treatment for Violence

Barrier	Number of participants
Embarrassed, wanted to forget about it	56
Didn't know where to go	23
Lack of LGBT services	18
Lack of insurance	17
Fear of negative consequences	16
Too expensive	12
<i>Other</i>	67

A total of 67 participants indicated an “other” barrier kept them from seeking mental help in regards to the violent issue. Qualitative analysis resulted in eight main themes, represented here in descending order of frequency:

- No need:
 - “Did not feel I needed counseling”
 - “I didn’t find it necessary”
 - “Not that traumatic”
- Ended relationship:
 - “I ended the relationship”
 - “Kicked the bugger out!”
 - “Altercation with a former helper which terminated it”
- Youth:
 - “I was a kid”
 - “Too young to understand”
 - “I was a minor and the offenders were my parents”
- Dealt with it:
 - “I took care of it myself”
 - “Read books and dealt with it myself with positive outcome”
 - “Talked to supportive nonprofessional friends”
- Isolated incident:
 - “It was just a single slap in the face”

- “Isolated issue”
- “It happened only once”
- Not applicable:
 - “NA”
 - “Not applicable”
 - “Does not relate to me”
- Work-related:
 - “I was a police officer, part of the job”
 - “In serviced and brushed off”
 - “Work related”
- Other:
 - “Was in active addiction”
 - “The other party had friends willing to give false witness”
 - “Called police but no help”

Summary of Violence

About 22% of participants had experienced physical violence from an intimate partner. This rate is distinctly higher than comparable rates in the county and state as a whole. Lesbians have experienced especially high rates of physical intimate partner violence (nearly 35%).

Approximately 21% of participants experienced physical violence from someone other than an intimate partner.

Approximately 6% of participants have experienced sexual violence from an intimate partner. This rate is slightly higher than county and state levels, but not drastically so. Rates of sexual violence from someone other than an intimate partner are approximately 11% across all participants.

Of those who experienced violence, approximately 41% talked to a mental health professional about what happened. Reasons for not speaking to a mental health professional about the violent incident included embarrassment and a lack of knowledge about where to go for services.

Additionally, several participants stated that they did not seek out a mental health professional because they did not feel the need, or because the solution had been resolved by ending the relationship (in reference to intimate partner violence, usually).

Chronic Illness

Chronic illness is the leading cause of death and disability in the United States today, responsible for 7 out of every 10 deaths. Approximately 133 million Americans are living with at least one chronic illness. These conditions negatively impact quality of life, and often result in extremely high healthcare costs.

According to the National Vital Statistics report, chronic disease was the leading cause of death in the United States in 2010. Specifically, heart disease was the number 1 killer in the U.S., followed by cancer and lower respiratory diseases (Murphy, Xu, & Kochanek, 2013).

To assess the burden of chronic disease in this study, participants were asked to report whether or not they had ever been diagnosed with a series of chronic illnesses. As illustrated in Table 20, high blood cholesterol was the most prevalent disease, affecting nearly half of the participants. Note that AIDS and HIV were separated, as AIDS tends to require far greater medical treatment than HIV and imply far more serious health problems.

Table 20. Chronic Illness Diagnoses

Disease	Number of Participants	Percent of Sample
High blood cholesterol	373	48.5%
Arthritis	239	31.5%
Hepatitis	164	21.8%
HIV	148	19.5%
Asthma or other respiratory disease	147	19.4%
Cancer	147	19.4%
High blood pressure/ hypertension	147	19.4%
Heart disease/ heart attack	91	12.0%
Diabetes	82	10.9%
AIDS	72	9.6%

Results of a series of chi-square analyses showed that there was a significant difference in disease diagnoses for eight of the 10 major diseases examined in this study. There were no significant differences between LGBTs groups for arthritis ($\chi^2(4) = 8.210, p > .05$) or asthma/other respiratory diseases ($\chi^2(4) = .489, p > .05$).

High Blood Cholesterol

Prevalence of high blood cholesterol varied significantly by LGBTTS category, $\chi^2(4) = 37.311, p < .05$. As illustrated in Table 21, gay and bisexual participants have very high prevalence rates (both over 50%), while lesbian, straight, and transgender participants have much lower prevalence rates.

Table 21. High Blood Cholesterol by LGBTTS Category

LGBTTS Category	High blood cholesterol		Total
	Yes	No	
Gay	54.8% (296)	45.2% (244)	71.0% (540)
Lesbian	38.8% (45)	61.2% (71)	15.2% (116)
Bisexual	54.8% (17)	45.2% (14)	4.1% (31)
Straight	22.2% (12)	77.8% (42)	7.1% (54)
Transgender	15.0% (3)	85.0% (17)	2.6% (20)
Total	49.0% (373)	51.0% (388)	100.0% (761)

Hepatitis

Prevalence of hepatitis varied significantly by LGBTTS category, $\chi^2(4) = 52.958, p < .001$. As illustrated in Table 22, gay participants have significantly higher rates of hepatitis than other participants. For lesbian, straight, and transgender participants, rates of hepatitis are especially low.

Table 22. Hepatitis by LGBTTS Category

LGBTTS Category	Hepatitis A, B, or C		Total
	Yes	No	
Gay	28.5% (153)	71.5% (383)	71.1% (536)
Lesbian	2.6% (3)	97.4% (111)	15.1% (114)
Bisexual	16.1% (5)	83.9% (26)	4.1% (31)
Straight	3.8% (2)	96.2% (51)	7.0% (53)
Transgender	5.0% (1)	95.0% (19)	2.7% (20)
Total	21.8% (164)	78.2% (590)	100.0% (754)

HIV

Prevalence of HIV varied significantly by LGBTTS category, $\chi^2(4) = 65.733, p < .001$. As illustrated in Table 23, only gay and bisexual participants reported a diagnosis of HIV. Of these, gay participants had a HIV prevalence rate that was more than double that of bisexual participants (26.9% vs. 9.7%).

Table 23. HIV by LGBTTS Category

LGBTTS Category	HIV		Total
	Yes	No	
Gay	26.9% (145)	73.1% (395)	71.2% (540)
Lesbian	0.0% (0)	100.0% (114)	15.0% (114)
Bisexual	9.7% (3)	90.3% (28)	4.1% (31)
Straight	0.0% (0)	100.0% (53)	7.0% (53)
Transgender	0.0% (0)	100.0% (20)	2.6% (20)
Total	19.5% (148)	80.5% (610)	100.0% (758)

Cancer

Prevalence of cancer varied significantly by LGBTTS category, $\chi^2(4) = 10.163, p < .05$. As illustrated in Table 24, over 20% of lesbian and gay participants, respectively, had been diagnosed with cancer, while bisexual, straight, and transgender participants all reported prevalence rates below 10%.

Table 24. Cancer by LGBTTS Category

LGBTTS Category	Cancer		Total
	Yes	No	
Gay	20.4% (110)	79.6% (430)	71.2% (540)
Lesbian	24.6% (28)	75.4% (86)	15.0% (114)
Bisexual	9.7% (3)	90.3% (28)	4.1% (31)
Straight	9.4% (5)	90.6% (48)	7.0% (53)
Transgender	5.0% (1)	95.0% (19)	2.6% (20)
Total	19.4% (147)	80.6% (611)	100.0% (758)

High Blood Pressure/Hypertension

Prevalence of high blood pressure and hypertension varied significantly by LGBTTS category, $\chi^2(4) = 36.184, p < .001$. As illustrated in Table 25, gay participants had a high rate of diagnosis of high blood pressure (53.0%) when compared to the other participants, whose rates ranged between 25% and 35%.

Table 25. High Blood Pressure/Hypertension by LGBTTS Category

LGBTTS Category	High blood pressure/ Hypertension		Total
	Yes	No	
Gay	53.0% (288)	47.0% (255)	71.1% (543)
Lesbian	30.2% (35)	69.8% (81)	15.2% (116)
Bisexual	35.5% (11)	64.5% (20)	4.1% (31)
Straight	25.9% (14)	74.1% (40)	7.1% (54)
Transgender	25.0% (5)	75.0% (15)	2.6% (20)
Total	46.2% (353)	53.8% (411)	100.0% (764)

Heart Disease/Heart Attack

Prevalence rates of heart disease/heart attack varied significantly by LGBTTS category, $\chi^2(4) = 14.021, p < .01$. As illustrated in Table 26, gay and bisexual participants have prevalence rates in the mid-teens (14.3% and 16.1%, respectively), while prevalence rates in other participant groups are much lower.

Table 26. Heart Disease/Heart Attack by LGBTTS Category

LGBTTS Category	Heart disease/ Heart attack		Total
	Yes	No	
Gay	14.3% (77)	85.7% (461)	71.2% (538)
Lesbian	7.0% (8)	93.0% (106)	15.1% (114)
Bisexual	16.1% (5)	83.9% (26)	4.1% (31)
Straight	0.0% (0)	100.0% (53)	7.0% (53)
Transgender	5.0% (1)	95.0% (19)	2.6% (20)
Total	12.0% (91)	88.0% (665)	100.0% (756)

Diabetes

Prevalence rates of diabetes varied significantly by LGBTTS category, $\chi^2(4) = 9.801, p < .05$. As illustrated in Table 27, gay and bisexual participants appear to have higher rates of diabetes than lesbian, straight, or transgender participants.

Table 27. Diabetes by LGBTTS Category

LGBTTS Category	Diabetes (Type 1 or Type 2)		Total
	Yes	No	
Gay	12.7% (68)	87.3% (466)	71.1% (534)
Lesbian	4.4% (5)	95.6% (108)	15.0% (113)
Bisexual	16.1% (5)	83.9% (26)	4.1% (31)
Straight	5.7% (3)	94.3% (50)	7.1% (53)
Transgender	5.0% (1)	95.0% (19)	2.7% (20)
Total	10.9% (82)	89.1% (669)	100.0% (751)

AIDS

Prevalence of AIDS varied significantly by LGBTTS category, $\chi^2(4) = 27.893, p < .001$. As illustrated in Table 28, only gay and bisexual participants reported having been diagnosed with AIDS. Within that, gay participants had a prevalence rate that was approximately double that of bisexual participants.

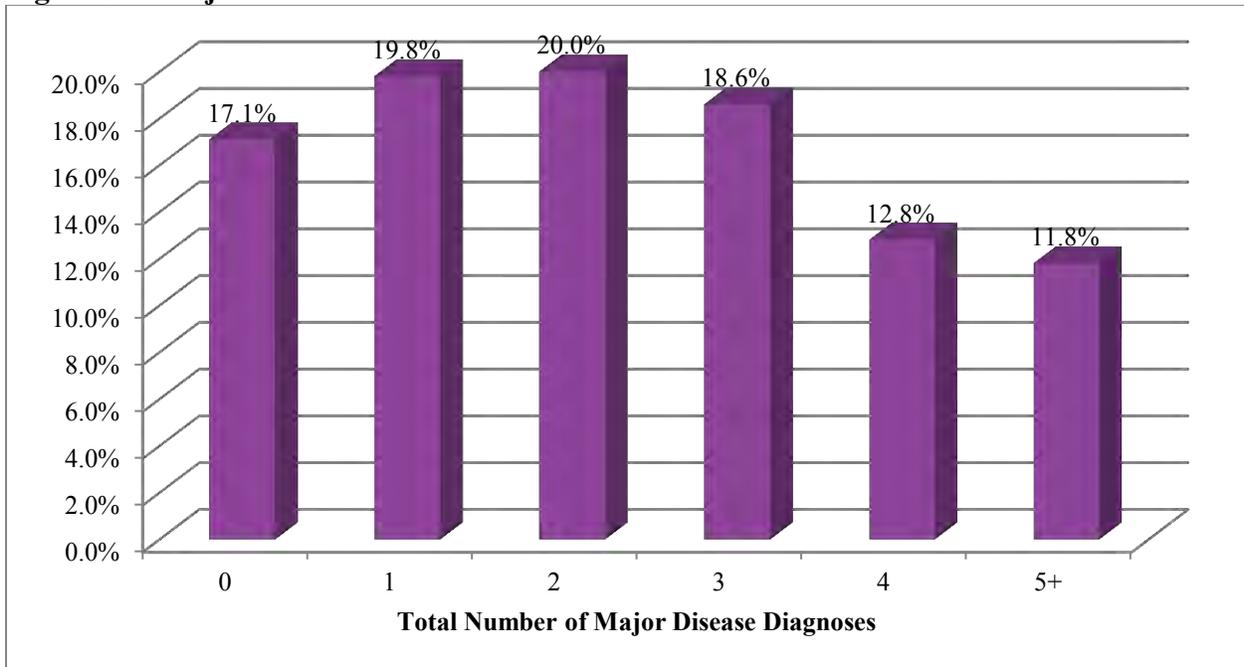
Table 28. AIDS by LGBTTS Category

LGBTTS Category	AIDS		Total
	Yes	No	
Gay	13.2% (70)	86.8% (461)	71.0% (531)
Lesbian	0.0% (0)	100.0% (113)	15.1% (113)
Bisexual	6.5% (2)	93.5% (29)	4.1% (31)
Straight	0.0% (0)	100.0% (53)	7.1% (53)
Transgender	0.0% (0)	100.0% (20)	2.7% (20)
Total	9.6% (72)	90.4% (676)	100.0% (748)

Many major illnesses are related. For example, an individual with HIV may also have high cholesterol as a result of the HIV medication. Similarly, individuals with high blood pressure are at risk for heart attack. Therefore, it is useful to consider all of these diseases together, in addition to the individual consideration described above. To assess the overall disease burden on participants, major disease diagnoses were summed. Participants could potentially have no major disease diagnoses (free from all of the 10 diseases listed) or all 10.

As illustrated in Figure 30, only 17% of participants had no major disease diagnoses. Approximately 20% of participants have been diagnosed with one major disease, and over half of participants have two or more of the listed diseases. In fact, four participants report having been diagnosed with eight of the 10 major diseases listed above, indicating that they need a great deal of medical care that is extremely complex.

Figure 30. Major Disease – Total Disease Burden



Note. $n = 721$.

Results of an ANOVA demonstrated a significant difference in total number of major disease by LGBT category, $F(4) = 21.03, p < .001$. As illustrated in Table 29, gay and bisexual participants had significantly more chronic illnesses than other participants.

Table 29. Average Number of Major Disease Diagnoses by LGBTs

LGBTs Category	Average number of major disease diagnoses	Total n
Gay	2.67	507
Lesbian	1.61	110
Bisexual	2.29	31
Straight	1.09	53
Transgender	0.95	20
Total	2.32	721

Summary of Major Disease

The most common major diseases are high cholesterol, arthritis, and hepatitis. Less than 20% of participants have no chronic illness diagnoses. In fact, the majority of participants have been diagnosed with more than one chronic illness.

In this sample, only gay and bisexual participants have been diagnosed with HIV and AIDS. Overall, gay and bisexual participants have more chronic illness than their lesbian, straight, or transgender counterparts.

Mental Health

According to the World Health Organization, mental health is defined as “a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.” (WHO, 2011). This includes both the presence of positive states (such as high self-esteem or social support) and the absence of negative states (such as mental illness or loneliness).

Mental Health Disorders

To assess formal diagnoses of mental health disorders, participants were asked, “Have you ever been told by a doctor or other healthcare professional that you have any of the following mental health issues?”

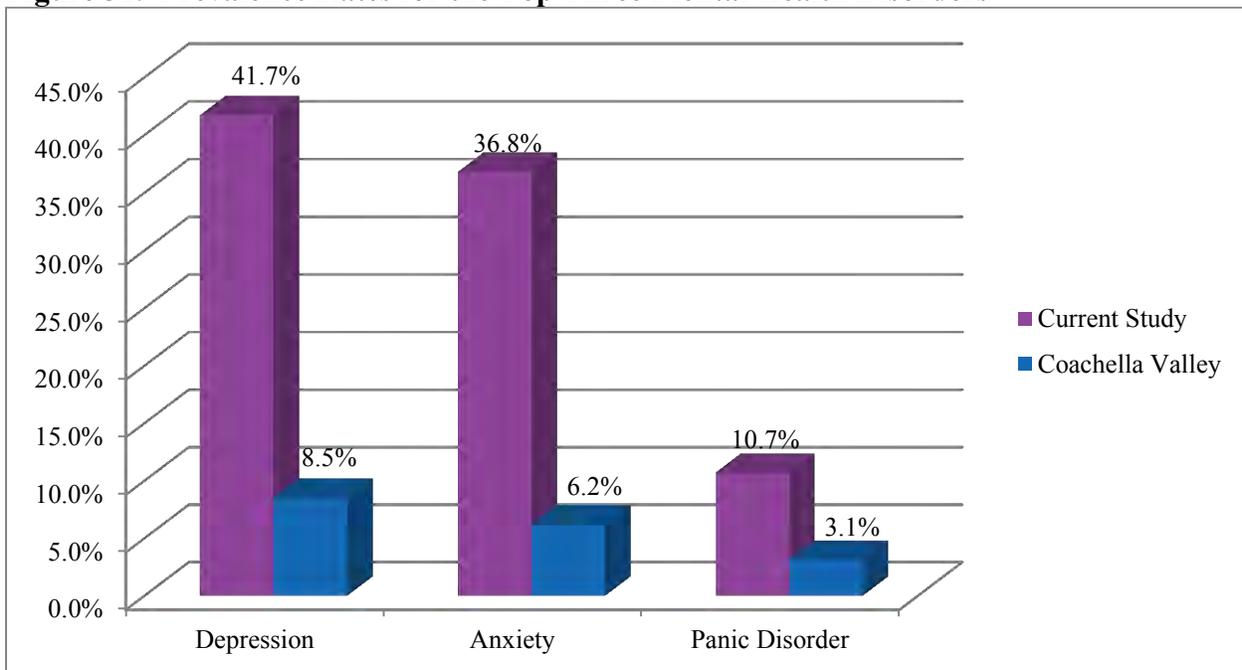
As illustrated in Table 30, the most common mental health diagnosis in the sample is depression; over 40% of participants have been diagnosed with depression. Anxiety is also a very common diagnosis; over a third of participants have been previously diagnosed with anxiety.

Table 30. Mental Health Disorder Diagnoses

Mental Health Diagnoses	Number of Participants	Percent of Population
Depression	319	41.7%
Anxiety	281	36.8%
Panic disorder	81	10.7%
PTSD	78	10.4%
Substance abuse/alcoholism	59	7.9%
ADD/ADHD	37	5.0%
Bipolar disorder	28	3.8%
Eating disorder	17	2.3%
<i>Other</i>	32	4.3%

HARC’s 2010 Community Health Monitor asked a very similar question (although there were slight differences in terminology, such as “depressive disorder” instead of “depression”, and some mental health disorders exist in one study but not the other). While it is not directly comparable, due to slightly different wording and response options, it is informative that the top three mental health disorders in Coachella Valley are the same as the top three in this study: depression, anxiety, and panic disorder. The prevalence rates for these three mental health disorders in both studies are presented in Figure 31. It is worth noting that these prevalence rates cannot be directly contrasted, given the slightly different wording, but interpreted rather as general trends. Even with this caveat, it is clear that mental health disorders are more common in the current study than in the adult population of the Coachella Valley as a whole.

Figure 31. Prevalence Rates for the Top Three Mental Health Disorders



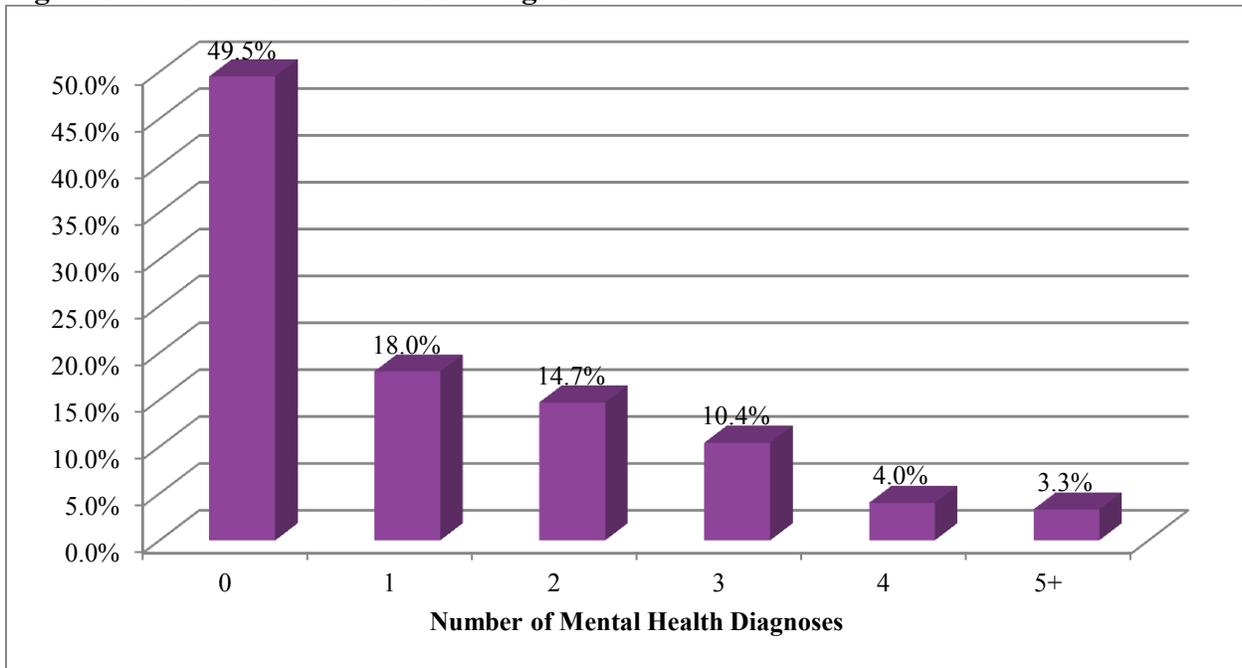
Note. n's ranged from. The Coachella Valley data in this graph are from the HARC 2010 Community Health Monitor. HARC used the term "depressive disorder" instead of "depression", and the term "generalized anxiety disorder" instead of "anxiety", so these prevalence rates should be used for general information, not for direct comparison of prevalence.

There was no significant difference in either depression diagnoses ($\chi^2(4) = 6.086, p > .05$) or anxiety diagnoses by LBGT category ($\chi^2(4) = 6.096, p > .05$). The incidence rates for the other mental health diagnoses were too low to assess significant differences between LBGT categories.

Mental health disorders often co-occur. That is, a person who has been diagnosed with depression is more likely to also be diagnosed with anxiety, in comparison to someone who has no mental health disorders. To assess this phenomenon, all mental health disorders were summed. An individual could have none (indicating they have never been diagnosed with any of the nine possible mental health disorders listed) or all nine.

As illustrated in Figure 32, about half of participants have never been diagnosed with any of the major mental disorders listed. Approximately 18% have been diagnosed with a single mental health disorder, while the remaining 30% of participants have been diagnosed with more than one mental health disorder.

Figure 32. Total Mental Disorder Diagnoses



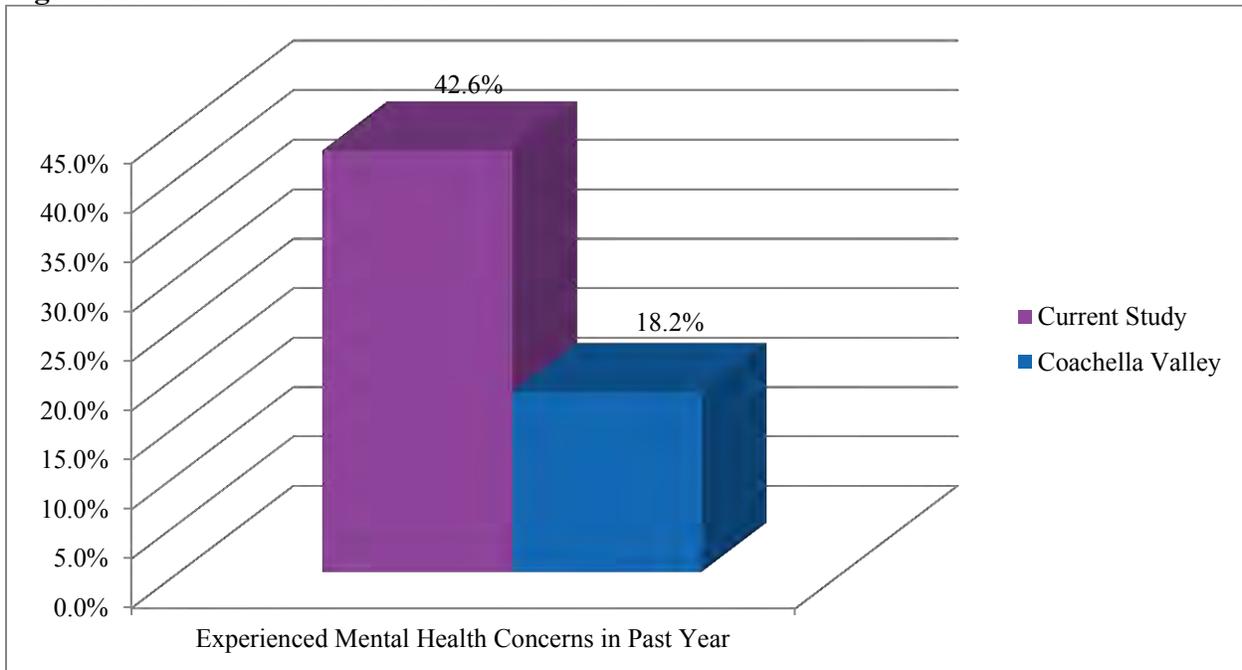
Note. $n = 721$.

Results of a chi-square analysis showed that there was no significant difference between participants with no mental health diagnoses and those with one or more mental health diagnoses, $\chi^2(4) = 3.97, p > .05$. That is, no one LGBT category experienced more or less mental health diagnoses than the others.

Other Mental Health Concerns

While diagnoses of mental disorders is important, there are many instances where mental health problems may not be diagnosed by a healthcare provider, but still are detrimental to well-being overall. In order to assess this, participants were asked, “Have you had any emotional, mental, or behavioral problems, such as stress, anxiety, or depression that concerns you during the past 12 months?”. Results showed that 42.6% of participants had experienced such problems in the past year, while 57.4% had not. As illustrated in Figure 33, this rate is more than double the rate for mental health concerns in the adult population of the Coachella Valley as a whole.

Figure 33. Mental Health Concerns in Past Year



Note. $n = 768$. The Coachella Valley data in this graph are from the HARC 2010 Community Health Monitor.

There was no statistically significant difference in these mental health problems by LGBTs category, $\chi^2(4) = 5.383, p > .05$, indicating that all participant groups experienced mental health concerns with roughly equal frequency.

Participants who reported experiencing a recent mental, behavioral, or emotional problem were then asked if they sought professional help for this problem. Approximately 58.6% of those who had experienced such a problem reported also seeking professional help, while the remaining 41.4% reported that they had not sought out professional help in response to this problem. There were no statistically significant differences in help-seeking behavior by LGBTs category, $\chi^2(4) = 2.366, p > .05$.

The 138 participants who reported experiencing an emotional, mental, or behavioral problem that concerned them but did not seek out professional help were subsequently asked to identify barriers that prevented them from seeking professional help. Participants were encouraged to check all barriers that applied. Results, as illustrated in Table 31, indicated that the most common barrier to receiving treatment was actually not on the list—48 people checked “other” on the list of barriers. Of the barriers on the list, it appears that socioeconomic barriers are the most common: “too expensive” and “lack of insurance” were top of the list.

Table 31. Barriers to Seeking Treatment for Mental Health Concerns

Barrier	Number of Participants	Percent of Population
Too expensive	45	5.9%
Lack of insurance	36	4.7%
Didn't know where to go	27	3.5%
Lack of LGBT culturally competent services	17	2.2%
Distrust of counseling (I don't believe it helps)	15	2.0%
Fear of negative repercussions or mental health stigma	13	1.7%
<i>Other</i>	48	6.2%

Qualitative analysis of the open-ended responses attached to the “other” option showed that responses fell into three major categories:

1. Chose not to seek treatment
2. Sought other treatment
3. Prevented from seeking treatment

Chose Not To Seek Treatment: About two-thirds of responses fell into the “chose not to seek treatment” category. These participants were not prevented from seeking treatment for their mental health problem, but rather, consciously chose not to seek treatment. This category is further broken down into three major sub-categories: “lack of severity”, “problems are transitory”, and “handled it on my own”.

Responses in the “lack of severity” group indicated that participants did not think the problem was severe enough to seek treatment. For example:

- “Didn't seem serious enough for help”
- “Not severe enough to seek help”
- “Problem was not serious enough—minor worry only”

Responses in the “problems are transitory” group indicated that participants did not seek help because they recognized that their particular problem was short-term or transitory and would resolve itself with time. For example:

- “Was for 8 weeks and passed”
- “Grieving—figured it would pass with time”
- “Knowledge that it was transitory”

Responses in the “handled it on my own” group indicated that the participants did not seek treatment because they “handled it” or “worked through it” by themselves. For example:

- “I felt I could resolve my stress”
- “Dealt with feelings on my own”
- “Worked it out myself”

Sought Other Treatment: Only about 5 participants indicated that they had sought out other treatment. This included seeking treatment lay-people and obtaining medications from primary physicians. For example:

- “12 step meetings”

- “I spoke to my friends”
- “Physician prescribed anti-depressant”

Prevented from Seeking Treatment: About one quarter of the responses indicated that the participant did indeed wish to seek treatment, but that they were prevented from seeking it by some barrier. These barriers are broken out into four main sub-categories: “previous lack of success”, “lack of anonymity”, “lack of time”, and “lack of providers”.

Responses in the “Previous Lack of Success” group indicated that participants did not seek treatment because of a previous lack of success:

- “Previous use of anti-depressants didn’t help”
- “Previous unsuccessful and poor MSW”

Responses in the “Lack of Anonymity” group indicated that the insular community in Coachella Valley provides a displeasing lack of anonymity that prevents participants from seeking help:

- “Lack of confidential treatment in valley”
- “Small community, want anonymity”

Responses in the “Lack of Time” group indicated a lack time prevented participants from seeking help:

- “No time”
- “Didn’t make time”
- “Lack of time to go to counselor”

Responses in the “Lack of Providers” group indicated that a lack of providers (or competent providers) was a barrier to their help-seeking behavior:

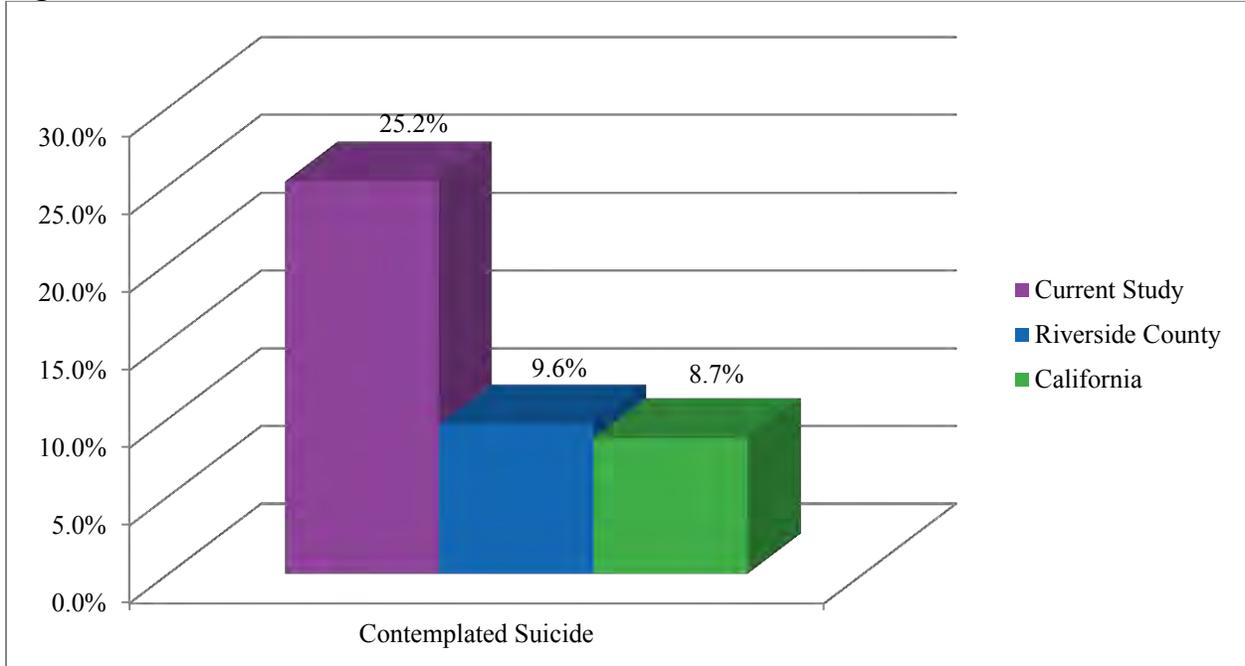
- “Lack of competent providers who accept Medicare”
- “Counseling not adequately covered by Medicare”
- “PPO limits choices and don’t qualify to use DAP”

Suicide

According to the National Vital Statistics report, suicide was the 10th leading cause of death in the United States, accounting for more than 38,000 deaths in 2010 alone (Murphy et al., 2013).

Participants were asked to report whether they had ever seriously thought about committing suicide. Approximately one quarter of participants reported having seriously thought about committing suicide. As illustrated in Figure 34, this is more than double the rate of suicidal ideation in the county and state as a whole.

Figure 34. Suicidal Ideation



Note. $n = 758$. Riverside County and California data in this graph are from CHIS 2009.

There was no significant difference in suicidal ideation by LGBT categories, $\chi^2(4) = 6.140, p > .05$.

Those individuals who reported contemplating suicide were then asked whether they had contemplated suicide within the past year. Results showed that 61 participants (30.7% of those who had considered committing suicide) had contemplated it within the past year. At this level, there are too few participants to accurately assess differences in recent suicidal ideation by LGBT category.

Individuals who reported suicidal ideation were also asked whether they had ever attempted suicide. Results showed that 70 participants (35.4% of those who had considered committing suicide) had attempted suicide.

Individuals who reported attempting suicide were subsequently asked whether they had made any suicide attempts within the past year. Results showed that 3 participants (4.3% of those who had attempted suicide) had made an attempt within the past year, as illustrated in Figure 35.

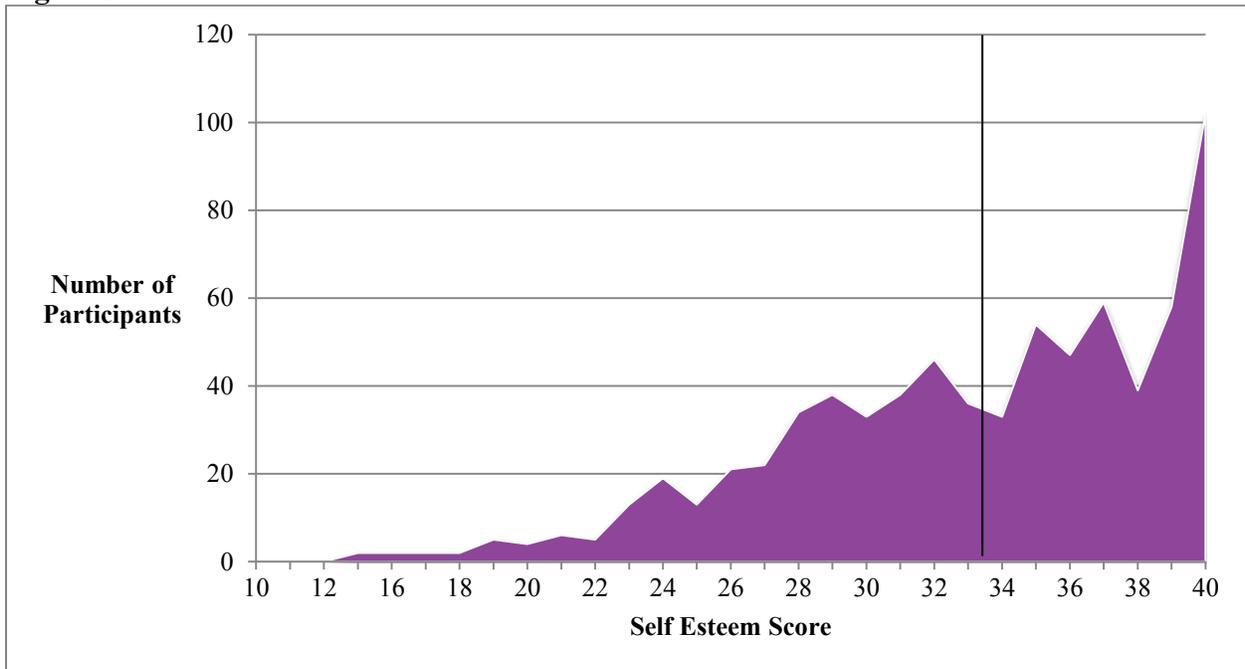
Figure 35. Suicide Attempts



Self-Esteem

Self-esteem in this study was measured using the Rosenberg Self-Esteem Scale (Rosenberg, 1979). Theoretically, scores on the Rosenberg Self-Esteem scale can range from 10 (very low self-esteem) to 40 (very high self-esteem). In the current study, the participants exhibited nearly the maximum range, with scores ranging from 13 to 40. The average self-esteem score was 33.22. As illustrated in Figure 36, many participants have very high self-esteem—over 100 participants scored the maximum number on the self-esteem scale. In fact, over half of participants scored in the top 25% of possible self-esteem scores, indicating that this sample as a whole has very high self-esteem.

Figure 36. Self Esteem



Note. $n = 733$.

Results showed no significant difference in self-esteem scores by LGTBTS category, $F(4) = 1.149, p > .05$. This indicates that gay, lesbian, bisexual, straight, and transgender participants all have relatively similar self-esteem levels, which are close to the mean of the overall sample.

Summary of Mental Health

Approximately half of participants have been diagnosed with one or more mental health disorders. The top three most commonly diagnosed disorders include depression, anxiety, and panic. These are the same three most common for the general population in the Coachella Valley, however, prevalence rates in this study seem to be much higher than in the general population (HARC, 2010).

About 40% of participants have experienced some emotional, mental, or behavioral problems that concerned them within the past year. This is more than twice the prevalence rate for such problems in the general adult population in the Coachella Valley (HARC, 2010). About 60% of these individuals sought professional help for the problem. Barriers to seeking help included the expense associated with seeking help, a lack of insurance, a lack of knowledge about where to go, and a choice to not seek treatment.

Over one quarter of participants seriously considered suicide. This rate is more than double the rate of suicidal ideation in the County and State. About one third of participants who had considered suicide had also attempted suicide.

In contrast, overall self-esteem scores were relatively high. Over half of participants had self-esteem scores in the top quartile of possible scores, and over 100 participants scored the absolute highest possible score on the self-esteem scale. Overall, this indicates that while participants tend to have high levels of self-esteem, they also have high levels of mental health disorders, serious concerns, and suicidal ideation.

Isolation, Loneliness, and Social Support

Isolation, loneliness, and a lack of adequate social support are conditions that are major risk factors for both mental and physical health. Isolation is defined by physical separation from other people, such as living alone. In contrast, loneliness is the feeling of being alone which occurs when there is a mismatch between the amount of contact desired and the amount actually experienced. Social support is the counterpart to isolation and loneliness. Social support can be instrumental (such as financial assistance or physical assistance) or emotional (such as feeling cared for or a sense of belonging), and it can stem from nearly anyone—a spouse, a friend, a coworker, or a pet (Tomaka, Thompason, & Palacios, 2006).

Previous research has shown that isolation, loneliness, and lack of social support can lead to increased levels of morbidity and mortality from all sources, including diabetes, hypertension, liver disease, arthritis, and emphysema (Tomaka et al., 2006). Isolation, loneliness, and a lack of social support have also been linked to increased rates of infection, depression, and cognitive decline (Cornwell & Waite, 2009).

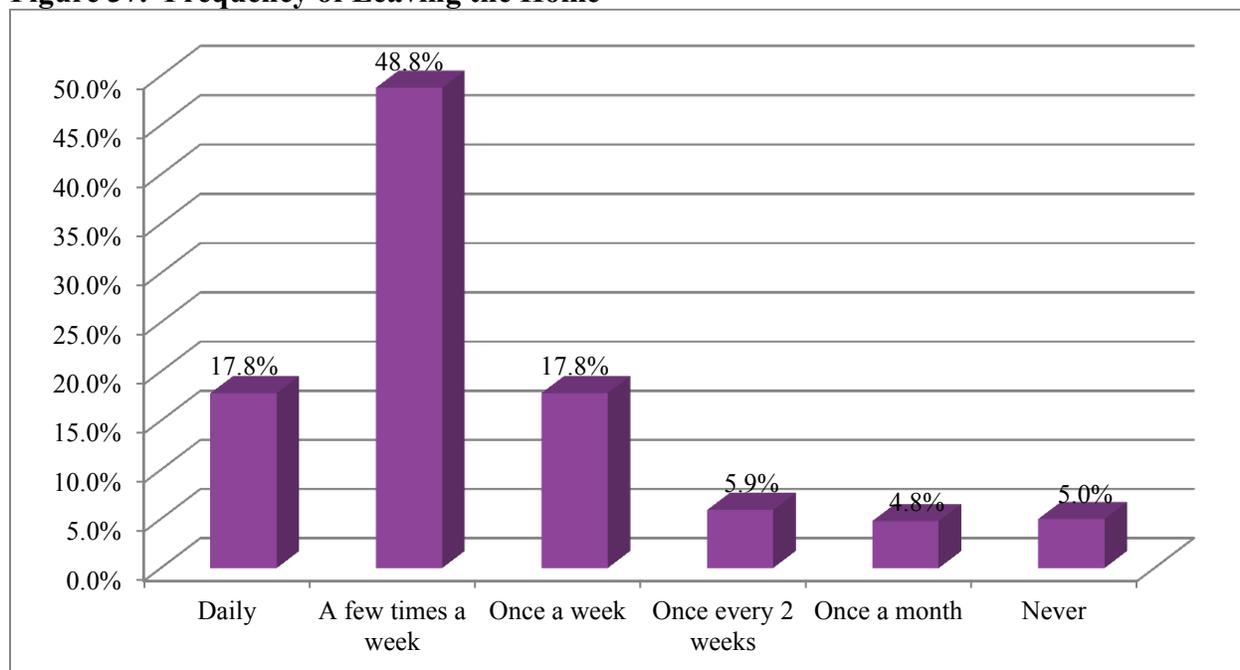
Isolation

To assess isolation, participants were asked to identify whether they currently lived with others, or whether they lived alone. About two-thirds of participants (63.9%) live with other people, while the remaining one third live alone. There was no significant difference in living alone by LGBTS category, $\chi^2(4) = 5.465, p > .05$. That is, no one group was more or less likely to live alone than the other groups.

One participant eloquently described how isolation can make receiving healthcare difficult: “The lack of understanding in the medical community, from receptionists to doctors, of what it is like to be completely alone. The simple act of arranging transportation for a medical procedure can be stressful. Prior to a couple of surgeries when I asked about transportation and aftercare, it was just assumed that I had someone available 24/7 who could drop everything to look after me. No one could direct me to any services to assist me. I have always prided myself on my independence and ability to cope with any situation, and it is very demeaning to have to beg for help!”

Some individuals may live alone, but be quite active outside of the home, thus reducing their isolation. To assess this, participants were asked to report how often they left their home to visit a family member or friend within the past month. As illustrated in Figure 37, results showed that most participants left the home frequently, visiting family or friends multiple times per week. There was no significant difference in frequency of leaving the home by LGBTS category, $\chi^2(8) = 5.209, p > .05$.

Figure 37. Frequency of Leaving the Home



Note. $n = 766$.

Isolation may be exacerbated by lack of transportation means, or by issues with existing transportation. To assess this, participants were asked, “In the past month, have you been able to get somewhere due to transportation problems?” Results showed that 4.2% of participants ($n = 32$) had indeed experienced such difficulty. This rate is too low to examine potential differences by LGBTs groups.

Participants who indicated experiencing a transportation problem were then asked to report what caused the problem. As illustrated in Table 32, car problems and cost were the biggest barriers to transportation.

Table 32. Transportation Barriers

Barrier	Frequency
Car problems	10
Cost	9
Inability to drive	7
Inadequate public transportation	7
Physical barriers	3
<i>Other</i>	8

One participant described how a lack of transportation can be detrimental to health: “Transportation has become so expensive I can no longer afford a vehicle for Doctor visits so I am struggling to find new ways as there is no Public transport where I live. The nearest bus stop is 9 miles from my door. I have investigated moving closer to services but the options are limited. Transportation has become yet another barrier to obtain services.”

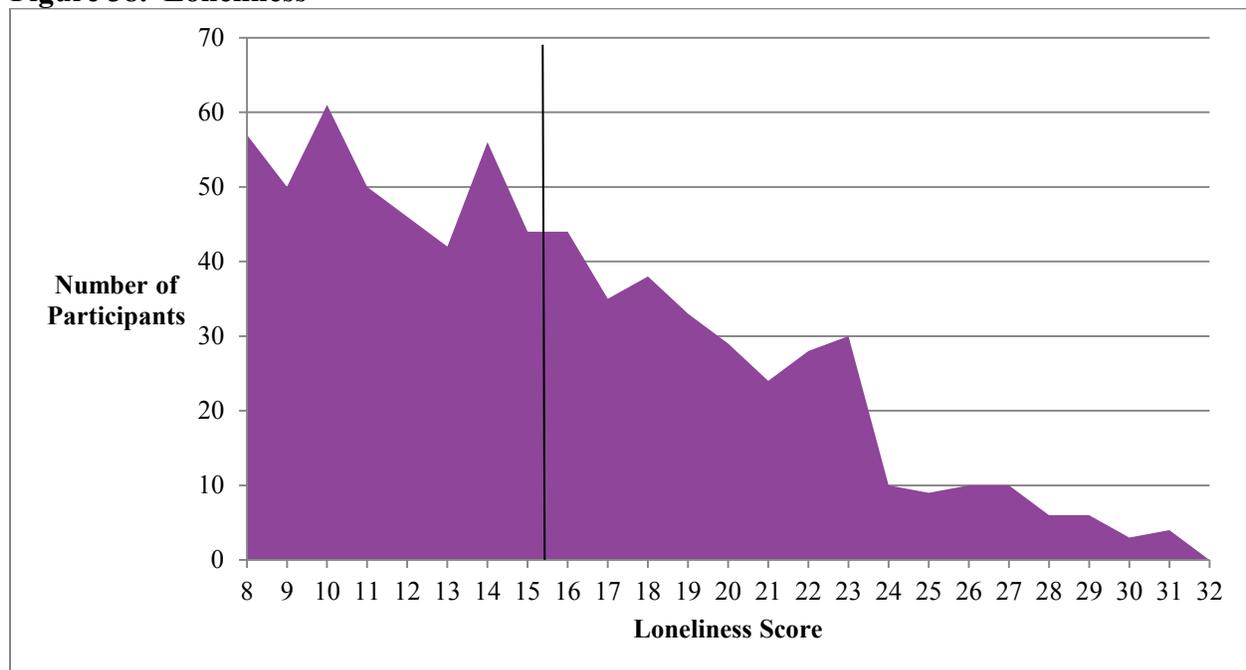
Loneliness

It is worth noting that isolation is different from loneliness, although the two often co-occur. Some people who are isolated may be perfectly content to have relatively little contact with others. In contrast, individuals who are lonely feel that they are cut off from individuals, and that this is undesirable. Loneliness exists when there is a gap between the amount of social contact that is desired and the amount of social contact that is actually experienced (Hays & DiMatteo, 1987). Additionally, an individual may appear to be relatively social, but still have feelings of loneliness.

In the current study, loneliness was measured using the UCLA Loneliness Scale Short Form (ULS-8), a widely utilized measure of loneliness (Hays & DiMatteo, 1987). Using the ULS-8, loneliness scores could theoretically range from 8 (never lonely) to 32 (always lonely). Participants in the current study exhibited nearly the full range, with loneliness scores ranging from 8 to 31, as illustrated in Figure 38. The average loneliness score was 15.39. Over half of participants have loneliness scores in the “least lonely” quartile. In contrast, only 4% of participants have scores that fall into the “most lonely” quartile. Overall, this sample does not appear to suffer from extreme loneliness.

This level of loneliness is slightly lower, but overall comparable to the average loneliness scores achieved in other studies (for example, 16.65 for female adults and 16.80 for male adults in Wilson, Cutts, Lees, Mapungwana, & Maungandize, 1992).

Figure 38. Loneliness

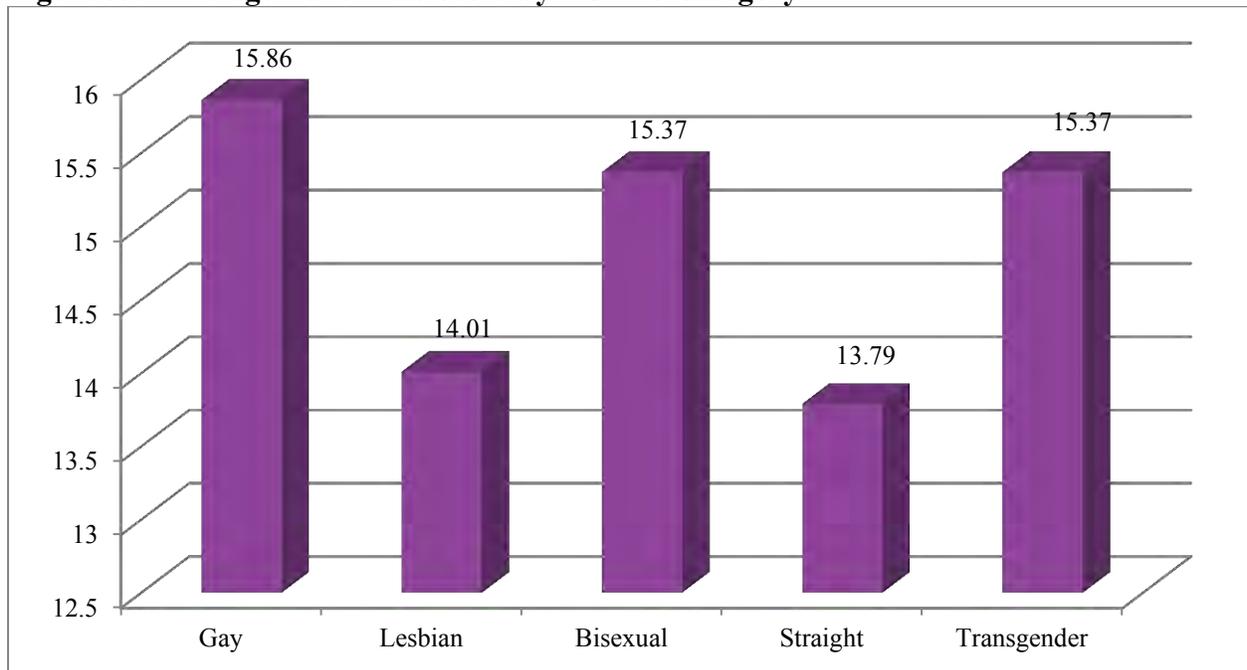


Note. $n = 725$.

Results show that there is a significant difference in loneliness by LGTBTS category, $F(4) = 3.880, p < .05$. As illustrated in Figure 39, gay, bisexual, and transgender participants all had

relatively similar levels of loneliness (around 15), while lesbian and straight participants had a significantly lower level of loneliness (around 14).

Figure 39. Average Loneliness Score by LGBTs Category



Note. $n = 725$.

Social Support

Social relationships are an important part of overall wellness. Previous research has demonstrated that social support can buffer the negative effects of many stressors, including unemployment, bereavement, and threats of death. Social support can also reduce the amount of medication needed to treat illness, accelerate recovery during hospitalization, and encourage greater compliance with physician recommendations (Cobb, 1976). Additionally, previous research has shown that those who are highly socially connected have lower rates of mortality due to a number of causes, including suicide, cardiovascular disease, and cancer (Berkman, Glass, Brissette, & Seeman, 2000).

Primary Source of Social Support

Participants were asked to indicate their main sources of social support from a set list. As illustrated in Table 33, friends provided the majority of social support for many participants, as did spouses/significant others.

Table 33. Primary Sources of Social Support

Source of Social Support	Number of Participants
Friends	561
Spouse or significant other	444
Pets	247
Extended family	178
Siblings	124
Coworkers	98
Children	83
Parents	79
Religious community	73
Community-based organization	69
Support groups	45
Healthcare provider	39
<i>Other</i>	42

A total of 42 participants indicated that the majority of their social support came from an “other” source. Qualitative analyses of these “other” responses provided six general categories of support sources:

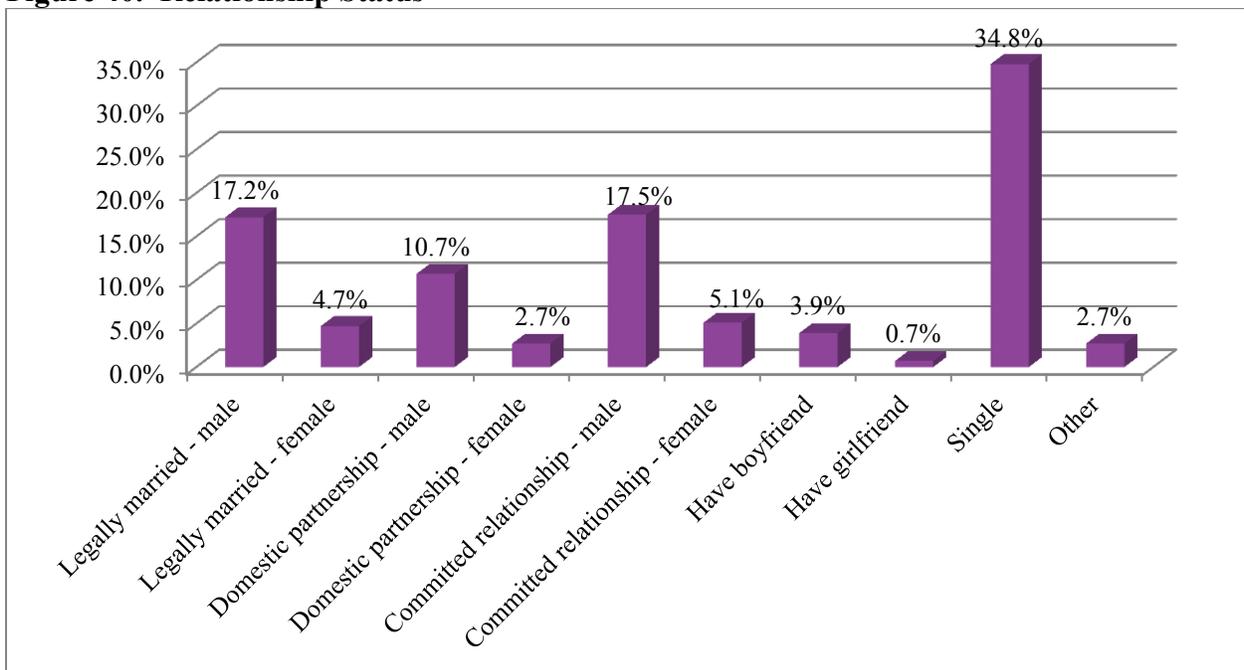
- Social groups that stem from various hobbies or interests (e.g., “card club”, “golfing”, “church”, “volunteering”)
- People close to the individual (e.g., “roommate”, “neighbors”)
- Online relationships (e.g., “Facebook”, “internet chat rooms”)
- Substance abuse groups (e.g., “AA”, “AA and NA”)
- No main source of social support (e.g., “I get almost no support”, “nowhere, don’t have any”)
- Other (e.g., “fans”, “anonymous sexual encounters”)

Spouse/Significant Other

As illustrated in Table 33, spouses/significant others are a major source of support for many people. Thus, in order to assess how many participants may have this source of social support available to them, participants were asked, “Which of the following BEST describes your CURRENT primary relationship status?” Options included “single”, “legally married to a male”, “legally married to a female”, “in a legally recognized registered domestic partnership with a male”, “in a legally recognized registered domestic partnership with a female”, “in a committed relationship with a male”, “in a committed relationship with a female”, “have boyfriend”, “have girlfriend”, and “something else (please specify)”.

The majority of the sample (64.2%) report being in some type of relationship at the present time. As illustrated in Figure 40, about one third of the participants identify as single.

Figure 40. Relationship Status



Note. $n = 767$.

Twenty-one participants indicated a relationship status that did not fall within the nine categories listed. About one third of these “other” responses described a widowed relationship status. The remaining responses were varied. For example,

- “In a committed three-way relationship with two other males”
- “Committed with male but open”
- “Great roommate”

Results showed no significant difference in relationship status (in any type of relationship vs. single) by LGBTs group, $\chi^2(4) = 6.944, p > .05$. However, when relationship data was separated by legal status, there was a significant difference between the LGBTs categories, $\chi^2(8) = 23.021, p < .01$. Overall, the sample was fairly evenly split between the three categories: single individuals, individuals in a legally recognized relationship (married or in a legally

recognized registered domestic partnership), and individuals in a relationship that was not legally recognized (a committed relationship or a boyfriend/girlfriend relationship). As is visible in Table 34, it appears that straight participants have a significantly higher rate of legally recognized relationships than the LGBT groups (63.0% as versus the 36.3% average).

Table 34. Relationship Status by LGBTs Category

LGBTs Category	Relationship Status			Total
	Single	In a legally recognized relationship	In a relationship that is not legally recognized	
Gay	36.8% (195)	34.5% (183)	28.7% (152)	71.0% (530)
Lesbian	31.9% (36)	35.4% (40)	32.7% (37)	15.1% (113)
Bisexual	48.4% (15)	32.3% (10)	19.4% (6)	4.2% (31)
Straight	24.1% (13)	63.0% (34)	13.0% (7)	7.2% (54)
Transgender	44.4% (8)	22.2% (4)	33.3% (6)	2.4% (18)
Total	35.8% (267)	36.3% (271)	27.9% (208)	100.0% (746)

Pet Ownership

Pets were the third most frequently listed main source of social support in Table 33. One participant elaborated, “having a pet can be a very comforting, supportive and positive experience for most individuals with a health condition, especially those with HIV/AIDS, Cancers and other chronic diseases.”

To assess pet ownership, participants were asked whether or not they currently lived with pets. Results showed that the majority of participants (63.9%) live with pets. There was a significant difference in pet ownership by LGBTs category, $\chi^2(4) = 10.828, p < .05$. As illustrated in Table 35, while all groups are more likely to live with pets than to not live with pets, it appears that lesbian participants have the highest rate of pet ownership (76.9%).

Table 35. Pet Status

LGBTs Category	Pet Status		Total
	Living with pets	Not living with pets	
Gay	61.9% (337)	38.1% (207)	71.1% (544)
Lesbian	76.9% (90)	23.1% (27)	15.3% (117)
Bisexual	61.3% (19)	38.7% (12)	4.1% (31)
Straight	56.5% (30)	43.4% (23)	6.9% (53)
Transgender	65.0% (13)	35.0% (7)	2.6% (20)
Total	63.9% (489)	36.1% (276)	100.0% (765)

Relationship to Family of Origin

A healthy relationship with one’s family of origin can be a major source of social support and positive experiences in an individual’s life. To assess participants’ relationship to their family of origin, participants were asked, “Generally speaking, how would you characterize your current relationship with your family?”

As illustrated in Table 36, parents and children were not relevant to the majority of participants. This indicates that many people in the sample do not have children, and that, likely due to the relatively advanced age of the participants, have deceased parents.

Table 36. Relationship to Family of Origin

Individual/ group	Type of Relationship					Total n
	No connection at all	Strained or difficult relationship	Neutral relationship	Close and supportive relationship	Deceased or not applicable	
Mother	2.7% (21)	4.2% (32)	5.9% (45)	23.2% (178)	64.1% (492)	768
Father	3.0% (23)	2.9% (22)	5.2% (40)	12.8% (98)	76.1% (584)	767
Siblings	6.8% (52)	9.9% (75)	23.5% (179)	43.8% (333)	16.0% (122)	761
Children	3.0% (22)	0.8% (6)	2.7% (20)	20.5% (151)	73.0% (537)	736
Extended family	17.9% (136)	2.4% (18)	34.3% (260)	24.4% (185)	21.1% (160)	759

If the “deceased or not applicable” responses are removed, the majority of participants have close and supportive relationships with all types of family, with the exception of extended family, as illustrated in Table 37.

Table 37. Relationship to Family of Origin – NA Removed

Individual/group	Type of Relationship				Total n
	No connection at all	Strained or difficult relationship	Neutral relationship	Close and supportive relationship	
Mother	7.6% (21)	11.6% (32)	16.3% (45)	64.5% (178)	276
Father	12.6% (23)	12.0% (22)	21.9% (40)	53.6% (98)	183
Siblings	8.1% (52)	11.7% (75)	28.0% (179)	52.1% (333)	639
Children	11.1% (22)	3.0% (6)	10.1% (20)	75.9% (151)	199
Extended family	22.7% (136)	3.0% (18)	43.4% (260)	30.9% (185)	599

Religion

Religion is a major source of social support for some people. To capture this, participants were asked, “Would you consider yourself to be religious or spiritual?” Results showed that approximately 56.3% considered themselves to be religious and/or spiritual.

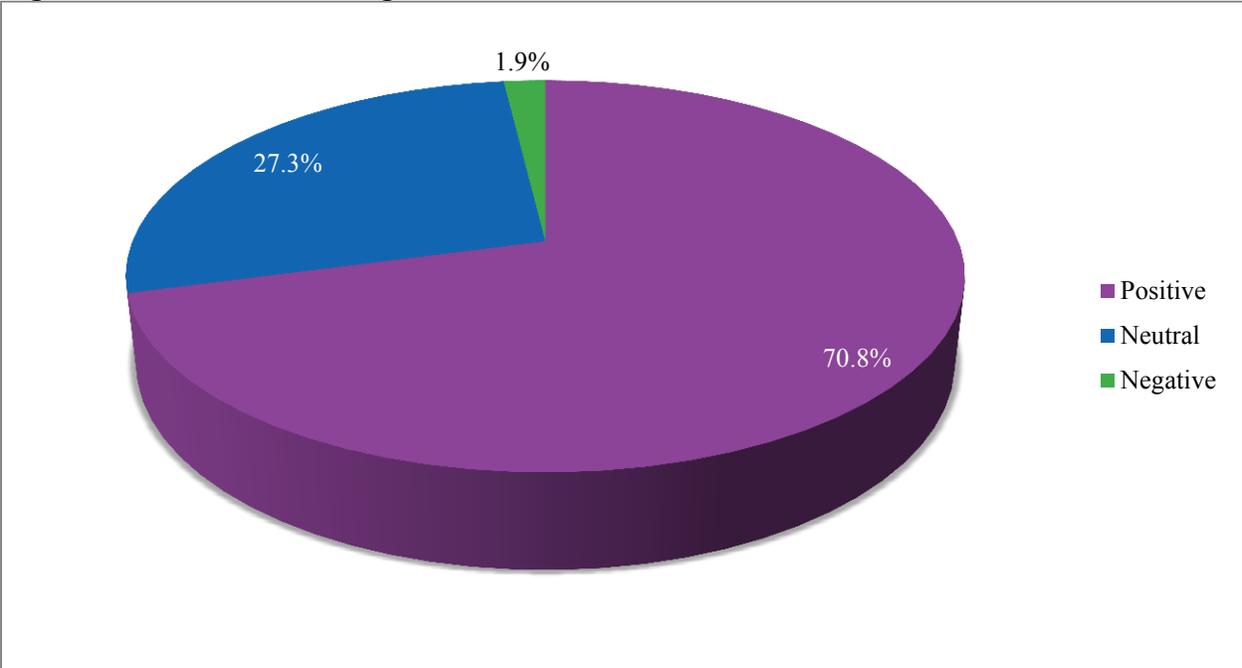
There was a significant difference in religious identification by LGTBS category, $\chi^2(4) = 19.654, p < .01$. As illustrated in Table 38, straight participants have the highest rates of religious identification (75.9%). Gay and transgender participants have the lowest levels of religious identification (51.7% and 50%, respectively).

Table 38. Religion by LGTBS Category

LGBTBS Category	Religion		Total
	Religious or spiritual	Not religious or spiritual	
Gay	51.7% (281)	48.3% (263)	71.2% (544)
Lesbian	66.1% (76)	33.9% (39)	15.1% (115)
Bisexual	67.7% (21)	32.3% (10)	4.1% (31)
Straight	75.9% (41)	24.1% (13)	7.1% (54)
Transgender	50.0% (10)	50.0% (10)	2.6% (20)
Total	56.2% (429)	43.8% (335)	100.0% (764)

Participants who identified themselves as religious or spiritual were subsequently asked whether those beliefs were a positive, neutral, or negative influence in their lives. As illustrated in Figure 41, very few participants found that their religious or spiritual beliefs had a negative influence on their lives. This number was too low to examine potential differences by LGTBS category.

Figure 41. Influence of Religion



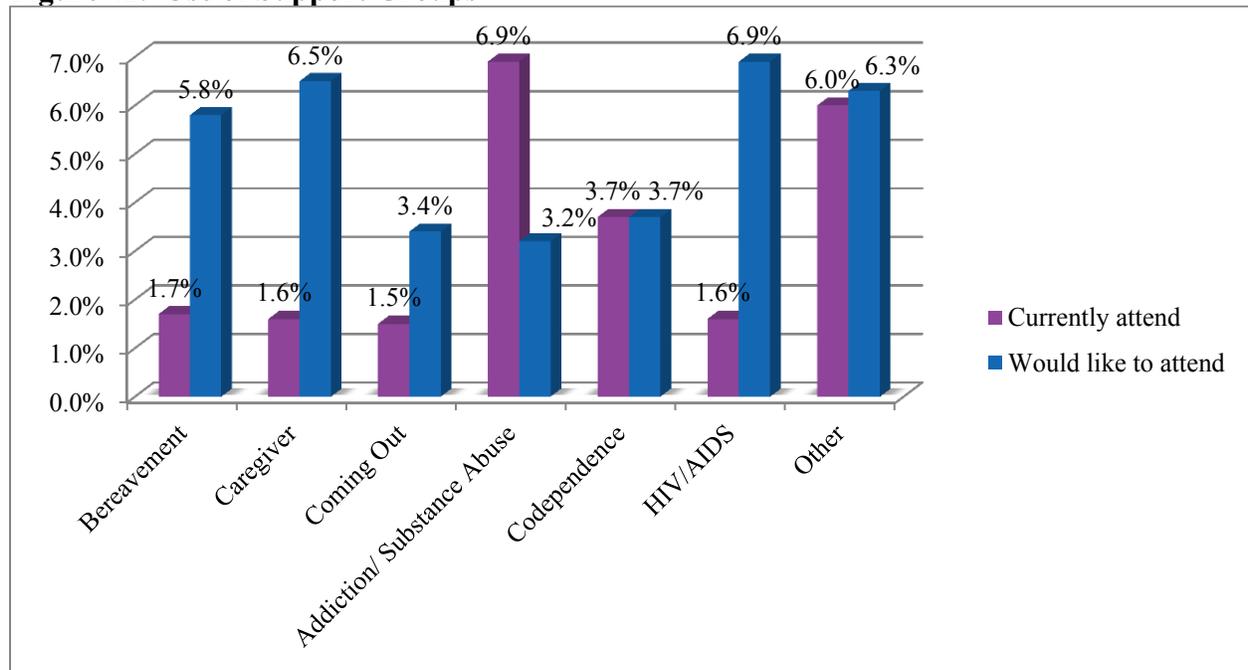
Note. n = 432.

Support Groups

Some people obtain their social support from formalized support groups designed to bring people with similar needs together. To assess this, participants were asked, “How would you describe your current use of support groups? Please rate each type of group listed below: coming out support groups, addiction/substance abuse support groups (such as AA, NA, CMA), bereavement support groups, caregiver support groups, support groups for family & friends of substance abusers (such as Al-Anon, ACOA), HIV/AIDS support groups, other support groups (please specify).” Participants were able to indicate three different use of these support groups: “I do not want/need this type of support group”, “I do not attend, but I would like to”, and “I attend this type of support group”.

Results indicated that the majority of participants (over 85%) do not want or need the specified support groups. As illustrated in Figure 42, rates of current attendance and rates of desired attendance for any one type of group were below 7% of the total sample.

Figure 42. Use of Support Groups



Note. n ranged from 754 to 757.

Currently Used Support Groups

As illustrated in Figure 42, the most common support group for participants to attend is addiction and substance abuse group, such as AA or NA. As covered in the “Substance Use, Misuse, and Abuse” section of this report, about 11% of participants report attending a substance abuse treatment program, and about three-quarters of these participants consider themselves to currently be in recovery. These participants are likely to be those who are currently attending the addiction and substance abuse support groups.

The next most commonly attended support group is the “other” category. These “other” responses were qualitatively analyzed. Six main themes emerged from this analysis:

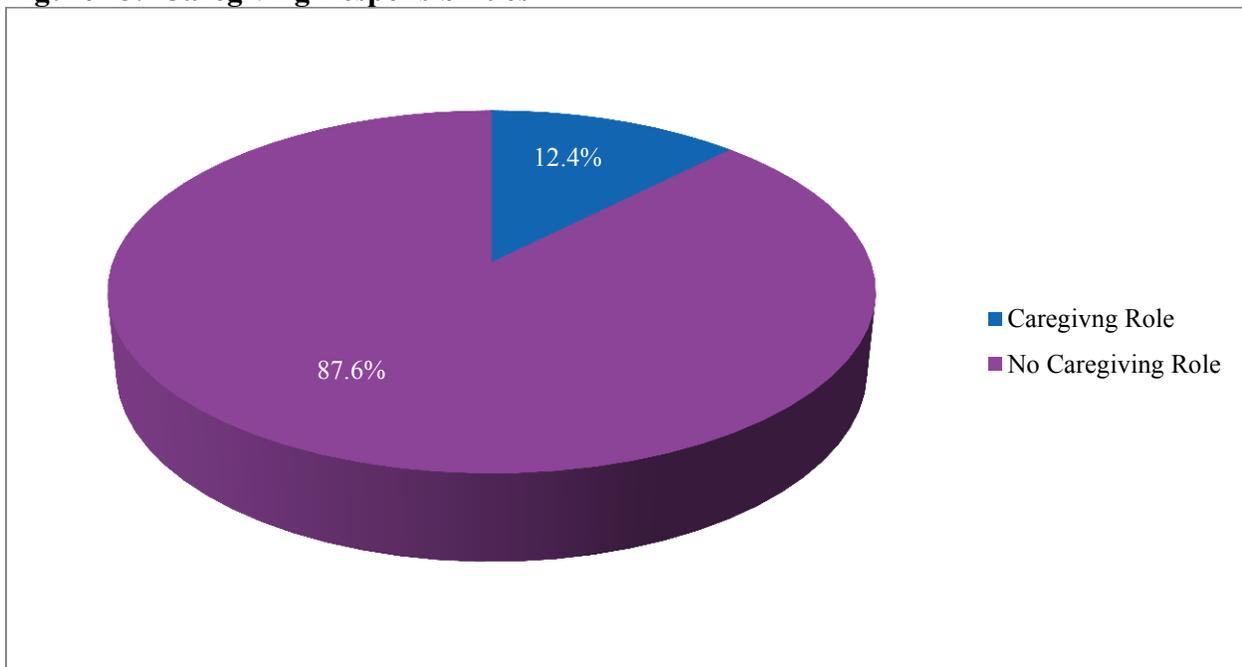
- LGBT-specific support groups (e.g., “PFLAG”, “trans group”, “gay men’s discussion group”)
- Chronic illness/disease-related support groups (e.g., “cancer support group”, “fibromyalgia support group”, “multiple sclerosis support group”)
- Mental health-related support group (e.g., “NAMI”, “mental health”)
- Social groups (e.g., “Casual lunch or lite dinner social get together”, “A small group of men for coffee and sharing once a week”, “Social groups for woman”)
- Other (e.g., “Weight watchers”, “CVC”, “Center for Spiritual Living”)

Desired Support Groups

As illustrated in Figure 42, the most commonly desired support groups are HIV/AIDS support groups, caregiver support groups, bereavement support groups, and “other” support groups. As covered in the “Chronic Illness” section of this report, 19.5% of participants report being diagnosed with HIV, and 9.6% report being diagnosed with AIDS. This relatively high prevalence rate indicates there is a large potential audience for HIV/AIDS support groups.

To assess the potential prevalence of caregiving, participants were asked, “Do you currently play a major caregiving role for another adult?” As illustrated in Figure 43, about 12.4% of participants currently play a caregiving role for another adult, indicating a large potential audience for a caregiver support group.

Figure 43. Caregiving Responsibilities



Note. $n = 769$.

There was no significant difference in caregiving roles by LGBTs category, $\chi^2(4) = 3.827, p > .05$. This indicates that all participant groups have roughly equal caregiving responsibilities.

One participant described the struggle of being a caregiver: “As the primary care giver for an 84 year old mother I am appalled on an almost weekly basis at how hard we have to fight to get her the tiniest crumbs of healthcare. It is exhausting time consuming and depressing.”

The third most commonly desired support group was the “other” category. These “other” responses were qualitatively analyzed. Six main themes emerged from this analysis:

- LGBT-specific support groups (e.g., “Partners/spouses of TG”, “Gay parents w small children”, “Lesbian caregivers”)
- Depression and/or anxiety related support groups (e.g., “Anxiety support group”, “Family members of depressed individuals”)
- Socialization-related support groups (e.g., “Adjusting to living alone”, “Social groups”, “Support in becoming social”)
- Aging and/or senior-specific support groups: (e.g., “Aging women’s support group”, “Adjusting to aging”, “Senior oriented”)
- HIV combined with other health concerns: (e.g., “Aging with HIV”, “An HIV and cancer support group”, “HIV/AIDS long term survivors”)
- Other (e.g., “Weight loss”, “Sexual abuse”, “Education success”)

Summary of Isolation, Loneliness, and Social Support

About one-third of participants currently live alone, indicating that they may be relatively isolated. However, over 80% of participants leave the home to visit friends and family once a week or more. This indicates a probable high level of social connectedness, and lower level of isolation. Only about 4% of participants experience transportation problems that keep them from getting to their destinations. This means that most people who want to be social are able to reach their desired destinations.

Loneliness levels were similar to those in other communities, indicating a “normal” amount of loneliness. About half of the participants had loneliness scores that fell into the “least lonely” quartile of possible scores. About 4% of participants fell into the “most lonely” quartile of possible scores, indicating a potential health risk for these individuals. Lesbian and straight participants had particularly low levels of loneliness scores, indicating that they are satisfied with the amount of social contacts they have.

Most participants receive their social support from friends, spouses/significant others, and pets. However, not all participants have access to all of these potential sources of support. About one third of participants currently identify as “single” and do not have a spouse or significant other. Similarly, about one third of participants do not currently live with a pet. Lesbian participants had very high levels of pet ownership, less than a quarter of lesbian participants did not have a pet.

Most participants have a close and supportive relationships with the relevant family members in their lives, including parents, siblings, and children (when applicable). The exception to this was extended family members; a neutral relationship with these family members was more common.

A little over half of participants identified as religious or spiritual. For most of these people, religion was a positive or neutral influence in their lives, indicating it was probably a source of social support. However, for about 2% of those who identified as religious or spiritual, religion was a negative influence in their lives.

Most participants do not currently attend formalized support groups. The most commonly attended support groups are those related to addiction, such as AA or NA. Several participants expressed a desire to attend HIV/AIDS support groups and caregiver support groups. Over 12% of participants report holding a major caregiving role for another adult, indicating that caregiving support groups would have a relatively large potential audience.

LGBT-Specific

The participants that identified as L, G, B, or T (that is, not straight non-transgender) were asked some additional questions specific to their experiences as an LGBT person.

Outness

The extent to which non-normative sexual or gender orientation is disclosed to others is known as “outness level”. Individuals may have different levels of outness in different situations, such as an individual who is out to friends and family but closeted (or “not out”) at work (Balsam & Mohr, 2007). Being out to a healthcare provider has been associated with increased comfort, better communication, and a greater frequency of healthcare use. Lack of outness with a healthcare provider can result in delay of care (Steele, Tinmouth, & Lu, 2006).

This study measured outness by using an adapted version of the Mohr and Fassinger Outness Inventory (2000). Participants were asked to indicate whether they were out or not out to 12 different people or groups of people in their lives. As illustrated in Table 39, due to the relatively advanced age of this sample, there were many participants whose parents fell into the “not applicable” category (presumably because they are deceased).

Table 39. Out or Not Out

Individual/ Group of people	Outness		
	Out	Not Out	Not Applicable
Mother	51.5% (365)	3.7% (26)	44.9% (318)
Father	39.6% (279)	3.4% (24)	57.0% (402)
Siblings	82.3% (582)	5.4% (38)	12.3% (87)
Extended family	78.2% (554)	13.8% (98)	7.9% (56)
Work peers	66.5% (470)	5.0% (35)	28.6% (202)
Work supervisors	59.1% (417)	4.7% (33)	36.3% (256)
Old straight friends	82.6% (583)	11.9% (84)	5.5% (39)
New straight friends	90.0% (638)	4.9% (35)	5.1% (36)
Acquaintances	91.6% (646)	6.2% (44)	2.1% (15)
Members of religious community	37.4% (263)	4.1% (29)	58.5% (411)
Leaders of religious community	37.0% (260)	3.3% (23)	59.7% (419)
Healthcare providers	92.1% (650)	4.4% (31)	3.5% (25)

When the “not applicable” responses are removed, it is clear that the majority of participants are out to each of the listed people or groups of people in their lives, as illustrated in Table 40. This may be due to the high numbers of LGBT people in the Coachella Valley. As one participant stated, “I think Palm Springs is the gayest friendly city I have ever lived. I feel very comfortable about my homosexuality and don't even think of it living in this community.”

Excluding the “not applicable” responses, the lowest level of outness is for extended family and relatives, with approximately 85.0% of participants indicating that they are out to this group. The highest rate of outness is with physicians—excluding “not applicable” responses, over 95% of participants are out to their healthcare providers. This is encouraging, for, as one participant stated, “I think every LGBT needs to be honest and up front with health care providers so that they can receive the very best care possible.”

Table 40. Out or Not Out – NA Removed

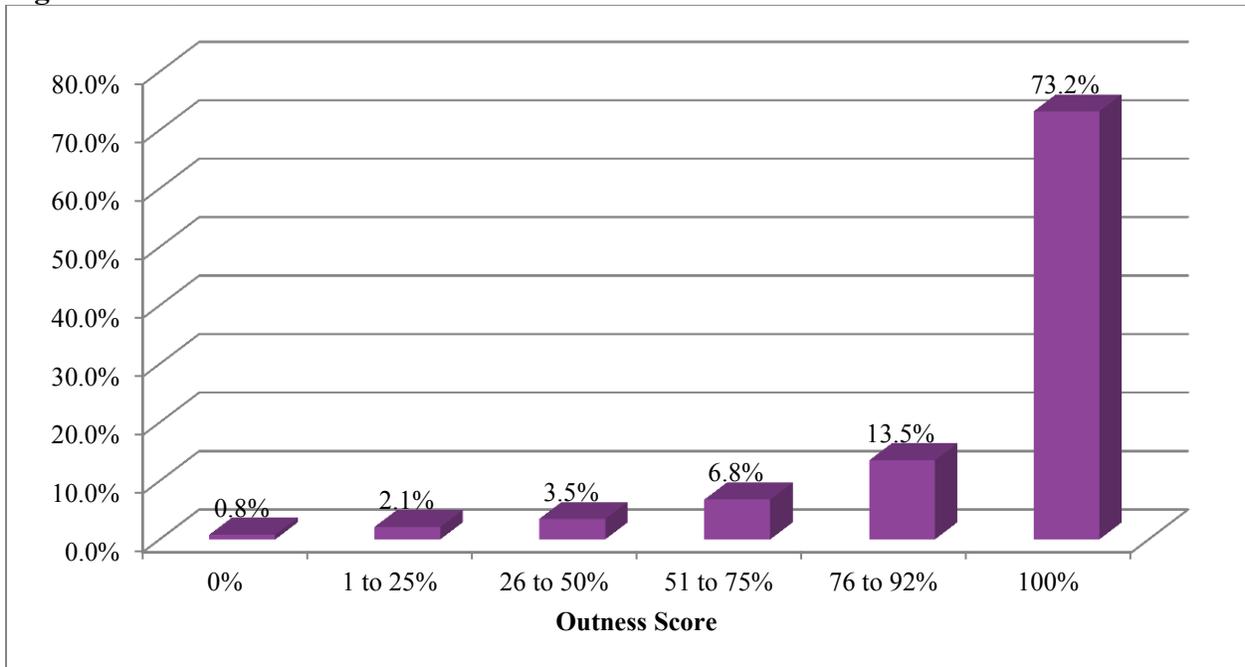
Individual/Group of People	Outness		Total n
	Out	Not Out	
Mother	93.4% (365)	6.6% (26)	391
Father	92.1% (279)	7.9% (24)	303
Siblings	93.9% (582)	6.1% (38)	620
Extended family	85.0% (554)	15.0% (98)	652
Work peers	93.1% (470)	6.9% (35)	505
Work supervisors	92.7% (417)	7.3% (33)	450
Old straight friends	87.4% (583)	12.6% (84)	667
New straight friends	94.8% (638)	5.2% (35)	673
Acquaintances	93.6% (646)	6.4% (44)	690
Members of religious community	90.1% (263)	9.9% (29)	292
Leaders of religious community	91.9% (260)	8.1% (23)	283
Healthcare providers	95.4% (650)	4.6% (31)	681

The number of participants that are not out to any one person or group of people are too low to cross-section this subject by LGBT categories.

The data from these questions was combined to create an “outness score”. This score ranged from 0.0 (not out to any of the applicable people in their lives) to 1.0 (out to all relevant people in their lives). These scores were transformed into percentages for ease of interpretation. A participant with an outness score of 100% is out to all of the applicable people in his or her life. A participant with an outness score of 50% is out to half of the applicable people in his or her life. A participant with an outness score of 0% is out to none of the applicable people in his or her life.

As illustrated in Figure 44, the majority of participants are out to all applicable people in their lives. However, it is worth noting that six participants had an outness score of 0—they were not out to any of the applicable people in their lives. A total of 35 participants were out to less than half of the applicable people in their lives.

Figure 44. Outness Score



Note. $n = 709$.

When dichotomized, there was a significant difference in outness by LGBT category, $\chi^2(3) = 11.314, p < .05$. As illustrated in Table 41, gay participants are the most likely group to be fully out to all applicable people/groups of people in their lives.

Table 41. Outness by LGBTs Category

LGBTs Category	Outness		Total
	Less than 100% out	Fully out	
Gay	23.9% (130)	76.1% (415)	76.9% (545)
Lesbian	34.5% (40)	65.5% (76)	16.4% (116)
Bisexual	41.4% (12)	58.6% (17)	4.1% (29)
Transgender	42.1% (8)	57.9% (11)	2.7% (19)
Total	26.8% (190)	73.2% (519)	100.0% (709)

Availability of Culturally Appropriate Health Services

One of the goals of this study was to identify the current availability of culturally-competent health services.

To assess this, participants were first given the following definition: “‘LGBT-welcoming’ or ‘gay-friendly’ services are those where your service provider, such as a doctor, police officer, or a counselor, is respectful and knowledgeable of LGBT-specific needs, and you feel comfortable being open with your sexuality or gender.”

Then participants were asked, “Do you feel that any of the following health services in Coachella Valley need to be more ‘LGBT-welcoming’?” and provided with a list of nine commonly accessed health-related services.

As illustrated in Table 42, many participants selected the “not applicable” option especially for domestic violence treatment services, in-home caregivers, and crisis intervention services. In order to get a clearer picture of only the “applicable” responses, the “not applicable” responses were removed for analysis, as illustrated in Table 43.

Table 42. LGBT Welcoming Services

Service	Needs to be more welcoming	Does not need to be more welcoming	Not applicable
Healthcare providers	41.5% (288)	48.3% (335)	10.2% (71)
Mental health services	36.0% (250)	32.9% (228)	31.1% (216)
Senior-specific	50.4% (349)	20.7% (143)	28.9% (200)
Police services	62.1% (431)	20.0% (139)	17.9% (124)
Crisis intervention services	40.4% (278)	20.8% (143)	38.8% (267)
Domestic violence treatment services	41.0% (284)	14.0% (97)	45.0% (312)
In-home caregivers	40.3% (278)	17.5% (121)	42.2% (291)
Pharmacists	35.8% (247)	43.2% (298)	21.0% (145)
Social services	42.9% (297)	21.4% (148)	35.7% (247)

As illustrated in Table 43, healthcare providers and pharmacists are the only two services where the majority of participants felt there was no need to be more LGBT-welcoming. For all other services listed (mental health services, senior-specific services, police services, crisis intervention services, domestic violence treatment services, in-home caregivers, and social services), the majority of contributing participants report the services need to be more LGBT-welcoming.

Table 43. LGBT Welcoming Services – NA Removed

Service	Needs to be more LGBT welcoming	No need to be more LGBT welcoming
Healthcare providers	46.2% (288)	53.8% (335)
Mental health services	52.3% (250)	47.7% (228)
Senior-specific services	70.9% (349)	29.1% (143)
Police	75.6% (431)	24.4% (139)
Crisis intervention services	66.0% (278)	34.0% (143)
Domestic violence treatment services	74.5% (284)	25.5% (97)
In-home caregivers	69.7% (278)	30.3% (121)
Pharmacists	45.3% (247)	54.7% (298)
Social services	66.7% (297)	33.3% (148)

There was no significant difference in the perceived need for more LGBT-welcoming mental health services ($\chi^2(3) = 7.196, p > .05$), senior-specific services ($\chi^2(3) = 4.904, p > .05$), and police services, ($\chi^2(3) = 4.643, p > .05$).

The cell sizes are too small to ascertain a statistically significant difference with confidence in domestic violence services and in-home caregivers, so these analyses are not described here, due to their unreliability.

The perceived need for more LGBT-welcoming healthcare providers varied significantly by LGBT category, $\chi^2(3) = 17.225, p < .01$. As is visible in Table 44, gay, lesbian, and bisexual participants are relatively evenly split on the subject of the need for more LGBT-welcoming healthcare providers. In contrast, nearly all transgender participants feel that healthcare providers need to be more LGBT-welcoming.

Table 44. Welcoming Healthcare Providers by LGBT Category

LGBT Category	Need for healthcare providers to be more LGBT-welcoming?		Total
	Needed	No need	
Gay	42.7% (206)	57.3% (276)	77.4% (482)
Lesbian	56.1% (55)	43.9% (43)	15.7% (98)
Bisexual	48.1% (13)	51.9% (14)	4.3% (27)
Transgender	87.5% (14)	12.5% (2)	2.6% (16)
Total	46.2% (288)	53.8% (335)	100.0% (623)

The perceived need for crisis service providers (such as homeless shelters or food pantries) to be more LGBT-welcoming differed significantly by LGBT categories, $\chi^2(3) = 10.677, p < .05$. As illustrated in Table 45, almost all transgender participants perceive there to be a need for more LGBT-welcoming crisis intervention services, a much larger rate than that for other participant groups.

Table 45. Welcoming Crisis Intervention Services by LGBT Category

LGBT Category	Need for crisis intervention services to be more LGBT-welcoming?		Total
	Needed	No need	
Gay	62.2% (201)	37.8% (122)	76.7% (323)
Lesbian	75.8% (50)	24.2% (16)	15.7% (66)
Bisexual	76.5% (13)	23.5% (4)	4.0% (17)
Transgender	93.3% (14)	6.7% (1)	3.6% (15)
Total	66.0% (278)	34.0% (143)	100.0% (421)

The perceived need for more pharmacy services to be more LGBT-welcoming differed significantly by LGBT category, $\chi^2(3) = 8.340, p < .05$. As is illustrated in Table 46, a large proportion of transgender participants see a need for more LGBT-welcoming pharmacists, while other participant groups have lower rates in this category.

Table 46. Welcoming Pharmacy Services by LGBT Category

LGBTB Category	Need for pharmacy services to be more LGBT-welcoming?		Total
	Needed	No need	
Gay	43.0% (184)	57.0% (244)	78.5% (428)
Lesbian	52.5% (42)	47.5% (38)	14.7% (80)
Bisexual	42.9% (9)	57.1% (12)	3.9% (21)
Transgender	75.0% (12)	25.0% (4)	2.9% (16)
Total	45.3% (247)	54.7% (298)	100.0% (545)

There is a significant difference in the perceived need for social services that are LGBT-welcoming, $\chi^2(3) = 9.803, p < .05$. As illustrated in Table 47, transgender participants believe that social services need to be more LGBT-welcoming at higher rates than gay, lesbian, or bisexual participants.

Table 47. Welcoming Social Services by LGBT Category

LGBT Category	Need for social services to be more LGBT-welcoming?		Total
	Needed	No need	
Gay	63.4% (218)	36.6% (126)	77.3% (344)
Lesbian	76.8% (53)	23.3% (16)	15.5% (69)
Bisexual	70.6% (12)	29.4% (5)	3.8% (17)
Transgender	93.3% (14)	6.75% (1)	3.4% (15)
Total	66.7% (297)	33.3% (148)	100.0% (445)

When interpreting these results, it is important to note that several participants struggled with the format of the question. For example, one participant stated, “In a previous question asking if I felt there needed to be better awareness of ‘LGBT’ issues within several categories, I said NO, simply because I feel that most people in those fields are already very helpful with LGBT issues. However, there is always some room for improvement. In comparison to other places Health Care for LGBT people, particularly older LGBT people is very good.”

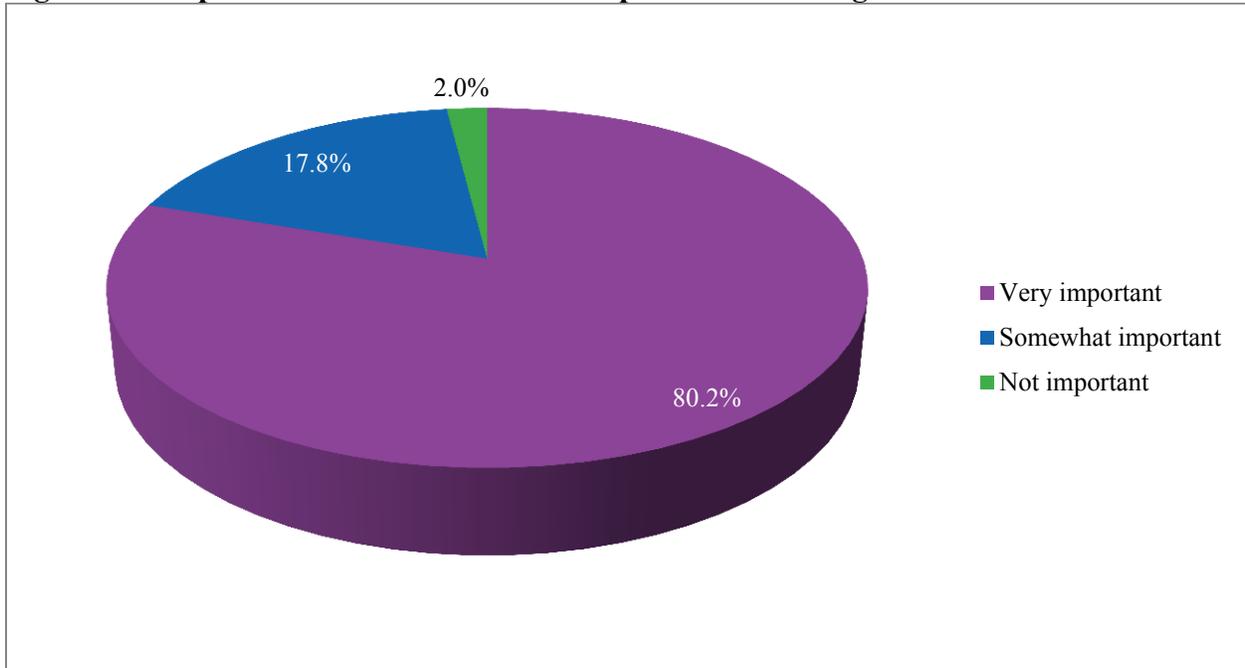
Similarly, another stated, “Question 59 was difficult to answer.....if you think your doctor is welcoming, you should put “NO”? Everything could be ‘more’ welcoming.”

Based on this confusion, it may have been more strategic to ask participants whether or not they currently have an LGBT-welcoming provider of each type, rather than whether there is a need for services of this type to be “more” welcoming. These participants’ comments should be considered when interpreting the need for “more welcoming” services described here. Future research should rephrase this question to reduce confusion and increase clarity.

Most Needed Health Services

Participants were asked, “How important is it to the Coachella Valley to have low-cost counseling services specifically for the LGBT community?” As illustrated in Figure 45, the majority of participants believe that this is very important.

Figure 45. Importance of Low-Cost LGBT-Specific Counseling Services in CV



Note. $n = 706$.

Cell sizes were too low to examine potential differences in importance rating by LGBT category.

Several open-ended responses elaborated on the importance of low-cost counseling. One participant stated, “I was in a very severe depression and had very bad anxiety and PTSD and suicidal thoughts from an auto accident that left me with physical limitations. I had no money at the time or health insurance. Through the LGBT center I was able to receive low-cost mental healthcare. I am now working again and productively moving forward with life. I truly believe if that service at low cost was not available to me I would have been a suicide statistic. I am grateful for the help I received and learning how to manage my physical pain and thought process to be happy and productive again.”

Another participant said, “Mental Health Care is a most important aspect to Basic Medical Care. It is difficult to find Low-Cost Mental Health Care for many of us. Many Doctors just want to write a prescription for a pill. We need workshops and Trained Therapists and Support especially in the HIV community. There is some help at DAP however it is difficult for a number of reasons. If you are low-income there are too few choices for Mental Health care let alone Basic medical care.”

In order to assess where gaps exist in services for the LGBT community, participants were presented with a list of health-related services and prompted, “Please rank, in order of importance, the TOP THREE services you believe are the MOST NEEDED for the LGBT community in the Coachella Valley.” Participants were further instructed that “1” indicated “most important”.

The results of this question were weighted, such a rating of “1” carried more weight than a rating of “2”, which carried more weight than a rating of “3”. Thus, these weighted results were combined to create a single score to indicate the importance level of the most needed services. As illustrated in Table 48, primary care services were rated as the most needed services for the LGBT community in the Coachella Valley, followed by mental health services and counseling and then specialty care services.

Table 48. Most Needed Health Services for the LGBT Community

Service	Weighted Score
Primary care services	1079
Mental health services and counseling	833
Specialty care services	593
Social support services	472
Low cost housing	438
Substance Abuse treatment	400
Transportation	152
Domestic violence services	87
<i>Other</i>	<i>61</i>

Several open-ended responses also confirmed that primary care was a large need in the local LGBT community. For example:

- “Not enough choice of primary care services provided by gay/lesbian physicians in Coachella Valley”
- “‘Trans’ specific Primary/Endo care is SORELY lacking. I have an established Dr/Patient relationship for almost 8 years now, but I could only get it (at the time) by traveling to Los Angeles. Also, It took MANY years before any therapists in the CV even understood what Trans is... Better now, but I think there are not enough choices. I have not seen a “regular” Dr. since I came out 8 years ago - SOLELY because of the lack of understanding I have been met with so often, I just refuse to put myself through that kind of agony. So the times I was in dire need of professional health care, I always go to the E.R. when most of the cases could have been handled by an ‘office’ type physician.”
- “Need more doctors in the valley, I call doctor for an appointment when I need care and the first opening is always 2 months out, The city needs to recruit more good doctors”

There was no significant difference by LGBT category in the perceived need for social services ($\chi^2(3) = 7.53, p > .05$), housing services ($\chi^2(3) = .410, p > .05$), or substance abuse services ($\chi^2(3) = 5.71, p > .05$). Cell sizes were too small to assess potential differences in the perceived need for transportation services and violence prevention services. However, there were statistically significant differences in the perceived need for the top three services, primary care, mental health care, and specialty care.

There was a statistically significant difference in the perceived need for primary care by LGBT category, $\chi^2(3) = 10.64, p < .05$. As illustrated in Table 49, lesbian participants were less likely than gay, bisexual, or transgender participants to rank primary care as one of the top three most needed health services.

Table 49. Need for Primary Care by LGBT Category

LGBT Category	Top Three Most Needed Health Services: Primary Care		Total
	Not in the Top Three	Ranked in the Top Three	
Gay	36.9% (202)	63.1% (345)	76.5% (547)
Lesbian	53.0% (62)	47.0% (55)	16.4% (117)
Bisexual	41.9% (13)	58.1% (18)	4.3% (31)
Transgender	35.0% (7)	65.0% (13)	2.8% (20)
Total	39.7% (284)	60.3% (431)	100.0% (715)

There was a statistically significant difference in the perceived need for mental health services, $\chi^2(3) = 12.95, p < .01$. As illustrated in Table 50, transgender participants are much more likely to have ranked mental health services in the top three most needed services than gay, lesbian, or bisexual participants.

Table 50. Need for Mental Health Services by LGBT Category

LGBT Category	Top Three Most Needed Health Services: Mental Health Services		Total
	Not in the Top Three	Ranked in the Top Three	
Gay	46.4% (254)	53.6% (293)	76.5% (547)
Lesbian	32.5% (38)	67.5% (79)	16.4% (117)
Bisexual	35.5% (11)	64.5% (20)	4.3% (31)
Transgender	20.0% (4)	80.0% (16)	2.8% (20)
Total	42.9% (307)	57.1% (408)	100.0% (715)

There was a statistically significant difference in the perceived need for specialty care services, $\chi^2(3) = 11.71, p < .01$. As illustrated in Table 51, gay and bisexual participants rank specialty care services much higher than lesbian or transgender participants. This may be because HIV/AIDS care is a specialty care service, and only gay and bisexual participants in this sample have been diagnosed with HIV/AIDS.

Table 51. Need for Specialty Care by LGBT Category

LGBT Category	Top Three Most Needed Health Services: Specialty Care		Total
	Not in the Top Three	Ranked in the Top Three	
Gay	59.0% (323)	41.0% (224)	76.5% (547)
Lesbian	72.6% (85)	27.4% (32)	16.4% (117)
Bisexual	51.6% (16)	48.4% (15)	4.3% (31)
Transgender	80.0% (16)	20.0% (4)	2.8% (20)
Total	61.5% (440)	38.5% (275)	100.0% (715)

Positive Aspects of Being LGBT

Participants were asked, “Which, if any, of the following do you as positive things about being an LGBT person?” Participants were encouraged to check as many positive aspects as applied to them. As illustrated in Table 52, authentic self and honesty, increased empathy and compassion for others, and belonging to a community were the top ranked positive aspects of being LGBT. Overall, the L, G, B, and T sub-groups ranked the positive aspects relatively similarly. “Authentic self and honesty” and “increased empathy and compassion” are in the top three for each individual group.

Table 52. Positive Aspects of Being LGBT

Positives	Number of Participants
Authentic self and honesty	552
Increased empathy and compassion for others	533
Belonging to a community	502
Personal insight	475
Creating families of choice	427
Social justice and activism	426
Understanding privilege and oppression	418
Having strong connections with others	392
Freedom from gender-specific roles	362
Exploring sexuality and relationships	361
Equalitarian relationships	356
A sense of self-congruence	310
I can't think of anything positive about being LGBT	12

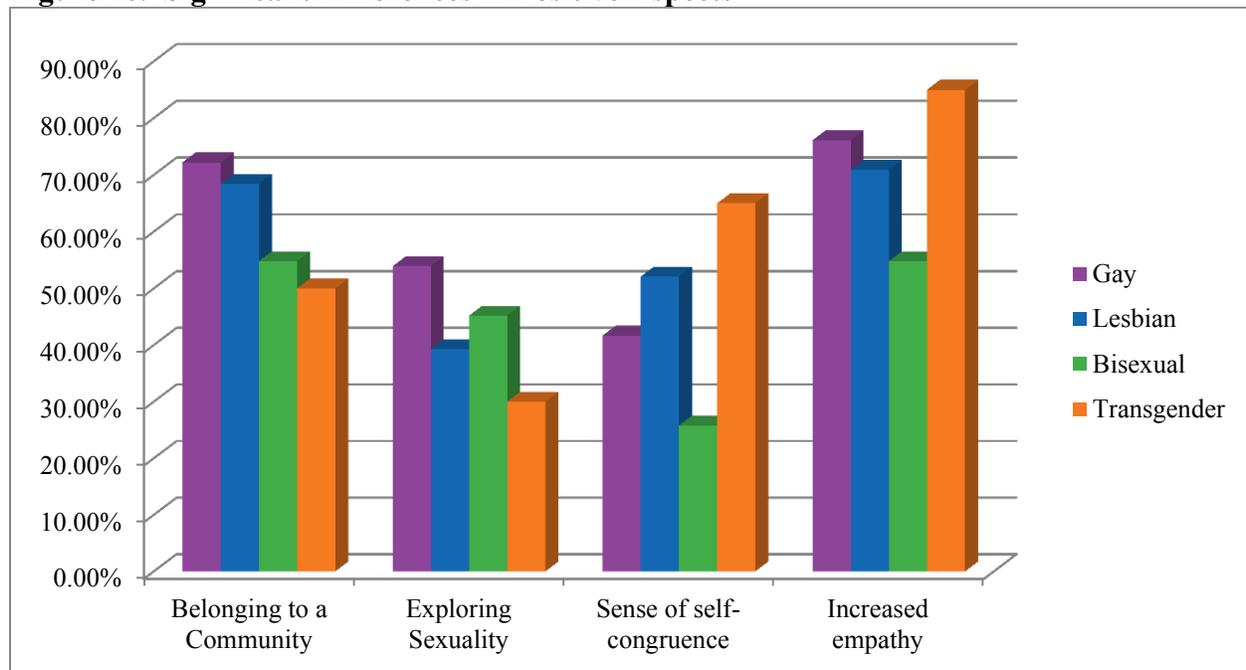
There were statistically significant differences by LGBT category in four of the positive aspects: increased empathy and compassion for others ($\chi^2(3) = 8.95, p < .05$), belonging to a community ($\chi^2(3) = 8.64, p < .05$), exploring sexuality and relationships ($\chi^2(3) = 12.15, p < .01$), and sense of self-congruence ($\chi^2(3) = 12.00, p < .01$).

As illustrated in Figure 46, gay participants were most likely to list “belonging to a community” as a positive aspect of being LGBT, while only about half of transgender participants listed this as a positive aspect of being LGBT.

Gay and bisexual participants are more likely than lesbian or transgender participants to list “exploring sexuality and relationships” as a positive aspect of being LGBT.

Bisexual participants were less likely than other participants to list “increased empathy and compassion for others” or “sense of self-congruence” as positive aspects to being a member of the LGBT community.

Figure 46. Significant Differences in Positive Aspects



Note. *n*'s ranged from 310 to 533.

Most participants who identified with one positive aspect also identified with other positive aspects. On average, most participants identified with about eight positive aspects. This number did not significantly differ by LGBT group, $F(3) = 1.36, p > .05$.

Some of the open-ended responses described these positive aspects in more depth. For example:

- “As a community, we tend to ‘stick together.’ This is a natural reaction to past prejudices and resentments from persons and institutions. This ‘sticking together’ can be cause resentments by the population at large...‘those people’ etc..I think it is important to keep encouraging people of all ages to come out...we really do change the world one family member, one work associate, one fellow club member at a time.”
- “I think Palm Springs is the gayest friendly city I have ever lived. I feel very comfortable about my homosexuality and don't even think of it living in this community.”
- “Having a positive attitude supported by the GLT agencies is helpful and gives me the push I need to keep abreast of what is going on and how it impacts me and my “family of choice”.”

It is unfortunate that 12 participants indicated that they could not think of anything positive about being LGBT. This was illustrated in some of the open-ended comments. For example, one participant stated, “I don't go to ‘pride’ events because I am certainly not proud of being gay. Being gay gave me AIDS (I was diagnosed before there was a test), surrounded me with a bunch of selfish, hedonistic, vain men primarily interested in just anonymous sex. Palm Springs has the highest rate of syphilis in the country, that says it all. I don't even want to touch anyone for fear of getting infected yet once again.”

Summary of LGBT-Specific

Overall, the majority of participants are 100% out to the people in their lives. Gay participants in particular have high levels of outness. Participants are most likely to be out to their healthcare provider. This is a good indication that these participants are likely receiving care tailored specifically to their needs as a part of the LGBT community. However, it is worth noting that several participants were not out to any of the relevant people in their lives, which may be putting them at risk for receiving poor health care (not to mention the strain of being closeted).

Opinions were generally mixed as to the current availability of LGBT-welcoming health services. This may be due in part to participant confusion regarding how to answer the question regarding current availability of culturally competent services. As one participant noted, “Everything could be ‘more’ welcoming”. However, overall the transgender participants felt that services needed to be more welcoming at a higher rate than other participants. This may potentially indicate that local healthcare services are welcoming to non-normative sexual orientations, but not to non-normative gender orientations.

The three most needed health services for the LGBT community included primary care services, mental health care services, and specialty services. Lesbian participants were less likely than other participants to perceive primary care as one of the most-needed services for the LGBT community in the Coachella Valley. Transgender participants were more likely than other participants to perceive mental health care as one of the most-needed services for the LGBT community in the Coachella Valley. Gay and bisexual participants were more likely than lesbian and transgender participants to perceive specialty care as one of the most-needed services for the LGBT community in the Coachella Valley (this may be due to the fact that HIV and AIDS diagnoses are primarily restricted to these same two groups). The majority of participants felt that having low-cost mental health services available for the LGBT community was extremely important in the Coachella Valley.

The list of positive aspects of being LGBT resonated with many participants. Overall, “authentic self and honesty” and “increased empathy and compassion for others” were consistently listed by all groups as a positive aspect of being LGBT. While the majority of participants identified with several positive aspects of being LGBT, it is worth noting that 12 participants selected “I cannot think of anything positive about being LGBT”.

Transgender-Specific

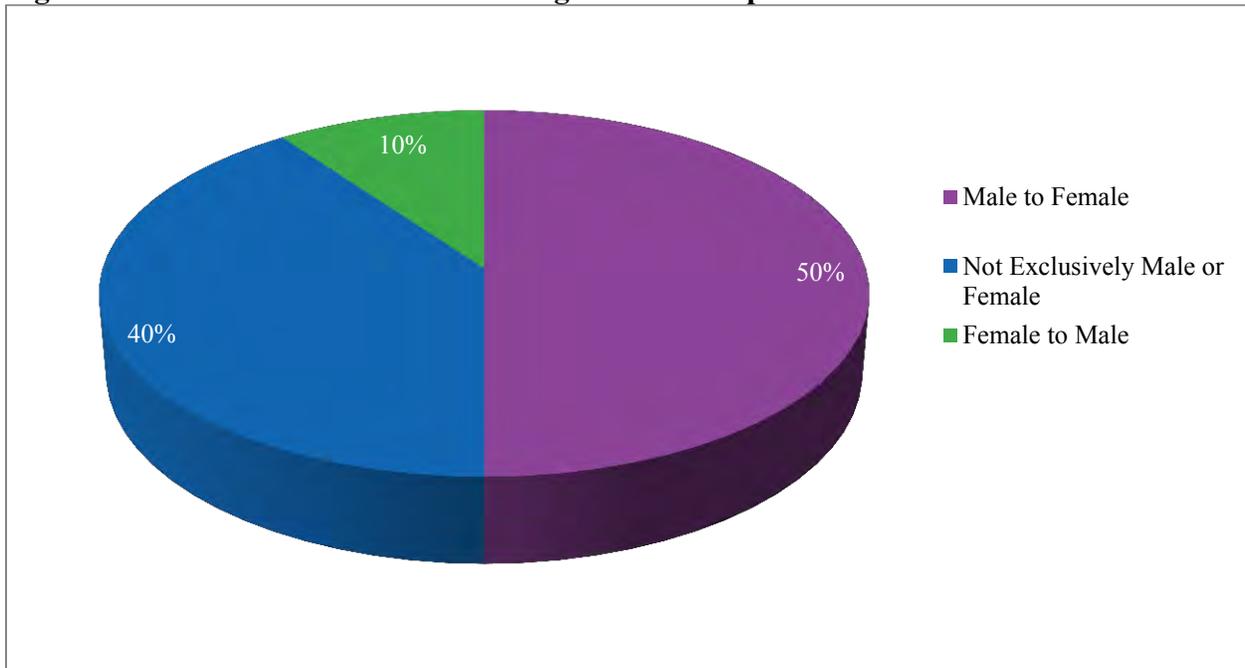
Transgender participants experience unique health issues and needs that merit individual attention. Thus, individuals who identified as transgender were asked a sub-set of questions designed expressly for the transgender population.

Demographics

While the majority of relevant demographics have already been described in the “Demographics” portion of this report, it is worth elaborating on a few key demographics for the transgender participants. These include gender orientation, gender identification, and sexual orientation.

The majority of transgender participants identified as male-to-female, as illustrated in Figure 47. However, it is important to note that individuals from all three gender orientations are included in this study.

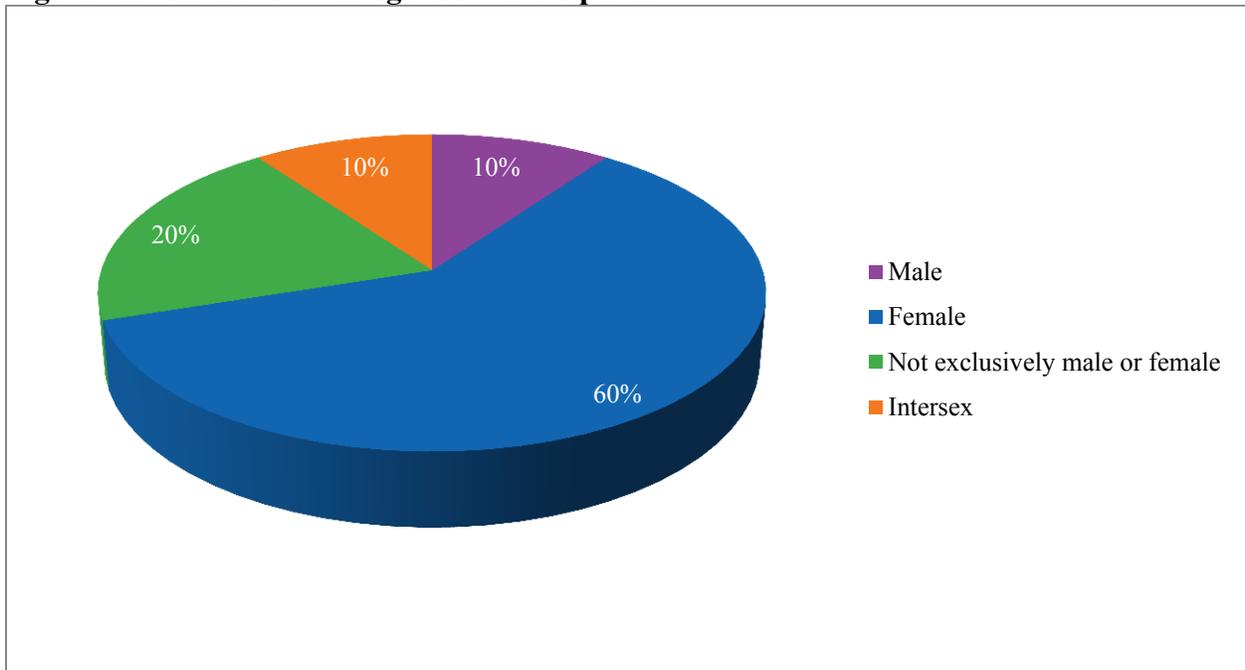
Figure 47. Gender Orientation of Transgender Participants



Note. n = 20.

The majority of transgender participants identified their gender as female. However, as illustrated in Figure 48, gender is distinctly diverse for transgender participants.

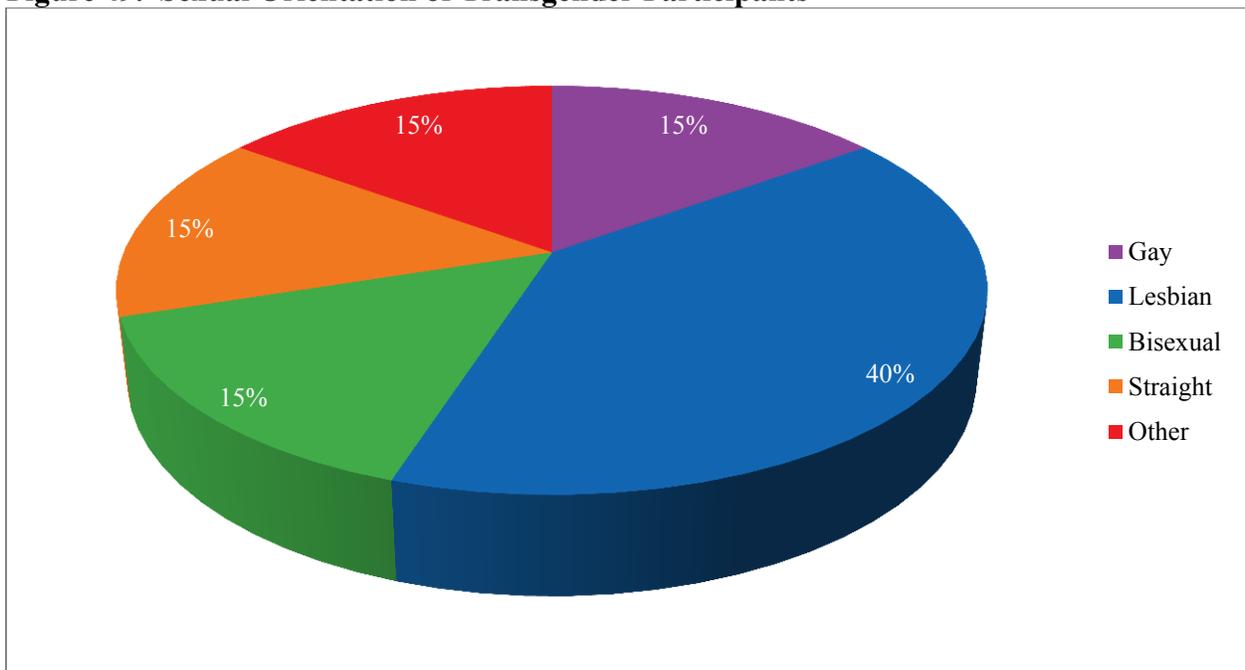
Figure 48. Gender of Transgender Participants



Note. n = 20.

Transgender participants are also extremely diverse in their sexual orientation, as illustrated in Figure 49. Transgender participants include representatives from each sexual orientation included in this survey.

Figure 49. Sexual Orientation of Transgender Participants

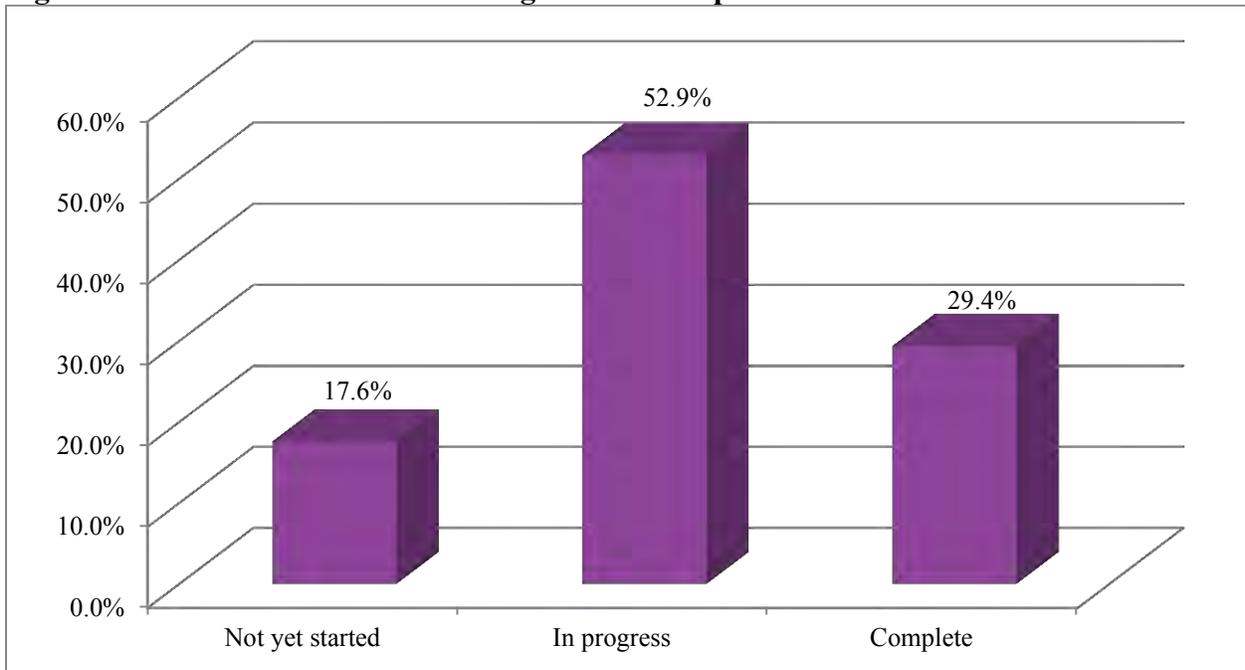


Note. n = 20.

Transition

Many transgender people make a transition from one gender to another. To assess this transition, participants were asked, “How would you characterize your transition?” As illustrated in Figure 50, about half of participants characterized their transition as “in progress”.

Figure 50. Transition Status of Transgender Participants



Note. $n = 17$.

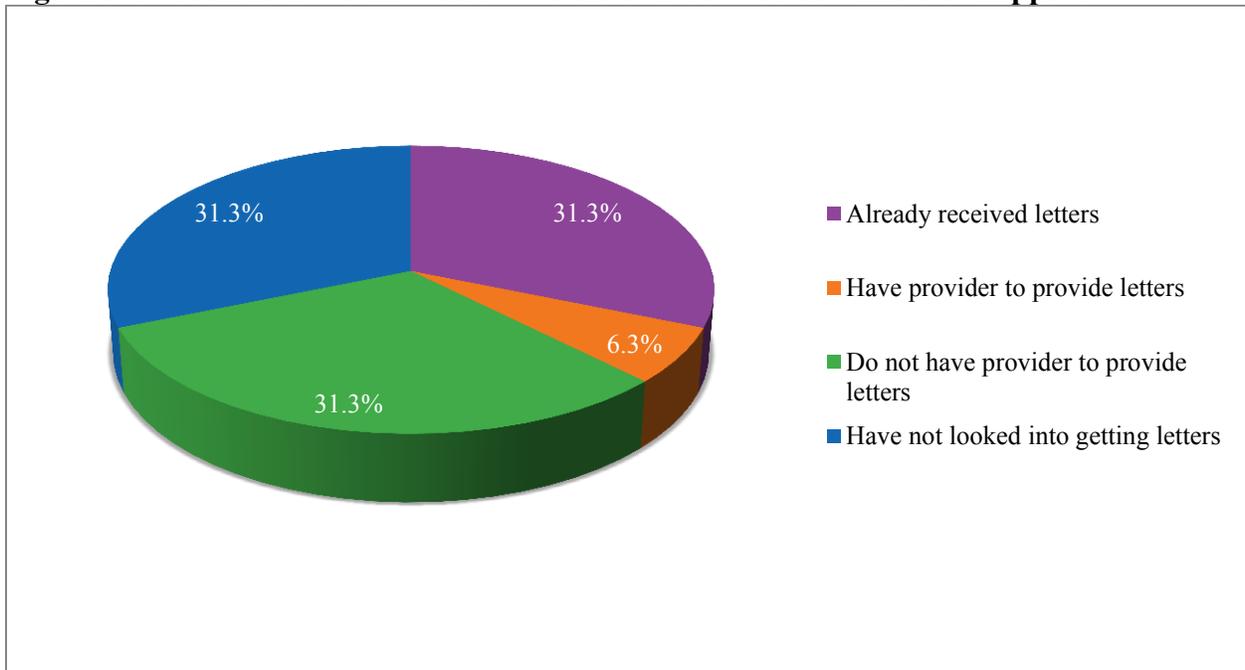
Letters of Support

In order to obtain many health services related to the transition process (such as surgery or hormone replacement therapy), transgender participants need to provide a letter of support from a mental health professional. However, not all mental health professionals are qualified, certified, and/or willing to provide these letters. Thus, some transgender people may not be able to obtain the letters, and this becomes a barrier to completing their transition.

In order to assess this, participants were asked, “Do you have access to a mental health professional that can provide you with the letters of support you need for your transition (such as letters that will allow you to start hormone replacement therapy or qualify for surgery)?” Response options included “yes, I have already received the letters I need”, “yes, I have a provider who will provide me with a letter at a later date”, “no I do not have a provider who will provide me with the letters”, and “I have not looked into getting any letters of support at this time”.

As illustrated in Figure 51, responses were varied. While some participants already received the needed letters or had a mental healthcare provider lined up to provide the letters, other do not.

Figure 51. Access to a Mental Health Professional to Provide Letters of Support



Note. $n = 16$.

Surgery

Surgery is a part of many transgender people’s transition from one gender to another. In order to assess surgery rates, participants were asked, “Have you ever had any form of gender reassignment surgery, such as genital reconstruction, mastectomy, breast augmentation, or masculinization/feminization of facial features?” Results show that 35.0% of transgender participants ($n = 7$) have had some form of gender reassignment surgery in the past.

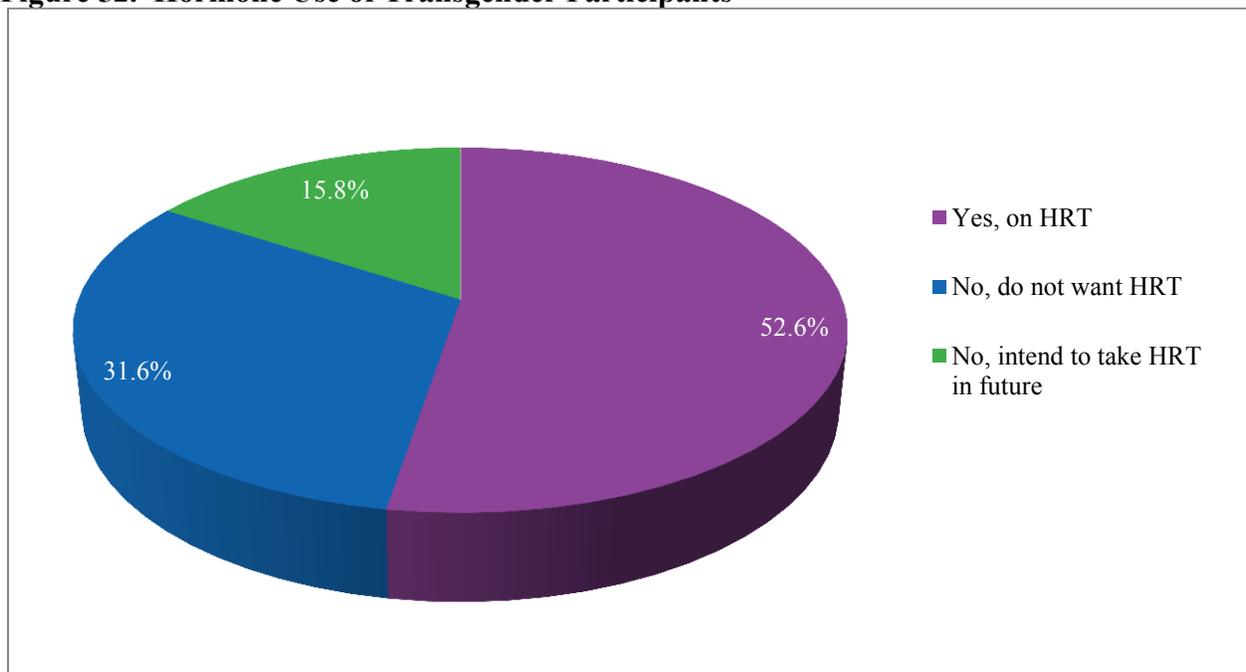
Hormone Replacement Therapy

Hormone replacement therapy, or HRT, is a major part of many people’s transition and life as a transgender person. However, HRT has some risks and side effects, and should be supervised by a healthcare provider. Some transgender people may be forced to use HRT without a physician’s supervision, due to reasons such as lack of willing/competent physicians, or a lack of letter of support from a mental health professional.

In order to assess HRT use, participants were asked, “Are you currently taking hormones/hormone replacement therapy (HRT)?” Response options included “Yes”, “No, I do not want to take hormones”, and “No, but I intend to take hormones in the future”.

As illustrated in Figure 52, about half of transgender participants are currently on HRT. However, it is important to note that not all transgender participants want to take hormones—about a third are not currently using hormones and have no plans to in the future.

Figure 52. Hormone Use of Transgender Participants



Note. $n = 19$.

Participants that indicated they are currently taking hormones were subsequently asked, “How do you obtain your hormones?” Results showed that the majority of those participants that are currently taking hormones (84.6%) obtained them by prescription from a healthcare professional ($n = 11$). However, two of the participants currently using hormones obtain their hormones without a prescription, such as from a friend or the internet, which indicates a potential health risk, as they are presumably not under the supervision of a physician.

Availability of Transgender-Specific Healthcare Services

While the survey addressed the availability of culturally competent services for LGBT people in general, transgender people often have very specific health needs that are not applicable to L, G, and B people. In order to assess the availability of transgender-specific services in the Coachella Valley, transgender participants were asked, “Are you able to get the following transgender-specific medical services here in the Coachella Valley?”

As illustrated in Table 53, about half of participants who needed it received HRT and primary care in the Coachella Valley. In contrast, very few were able to receive facial or breast-related surgery in the Coachella Valley, and genital-related surgery is completely unavailable in the Coachella Valley.

Table 53. Availability of Local Transgender Health Services

Type of Services	Location of Services		
	Receive this care in Coachella Valley	Have to go elsewhere to receive this care	Do not need or seek this type of care
HRT	37.5% (6)	37.5% (6)	25.0% (4)
Facial or breast-related surgery	12.5% (2)	50.0% (8)	37.5% (6)
Genital-related surgery	0.0% (0)	56.3% (9)	43.8% (7)
Primary care/ general everyday trans care	37.5% (6)	37.5% (6)	25.0% (4)

Note. n = 16.

The lack of transgender-specific healthcare in the Coachella Valley was illustrated by this participant’s comment: “I’m a post-op transsexual female, while I truly think all of the services from counseling to trans related surgeries should be here in the valley... they don't apply to me as I have finished the physical part of my life's journey.. and I couldn't be happier....!! In 2005 when I fully transitioned I lived in Riverside County only service I was able to receive was therapy at the Kaiser mental health facility in Riverside all needed surgeries were done else where at my cost.. FFS face surgery in Chicago, breast Augmentation in Orange County and GRS gender surgery in Trinidad Colorado.”

Another participant stated, “‘Trans’ specific Primary/Endo care is SORELY lacking. I have an established Dr/Patient relationship for almost 8 years now, but I could only get it (at the time) by traveling to Los Angeles. Also, It took MANY years before any therapists in the CV even understood what Trans is... Better now, but I think there are not enough choices. I have not seen a “regular” Dr. since I came out 8 years ago - SOLELY because of the lack of understanding I have been met with so often, I just refuse to put myself through that kind of agony. So the times I was in dire need of professional health care, I always go to the E.R. when most of the cases could have been handled by an ‘office’ type physician.”

Transgender-Specific Summary

Transgender participants present an especially diverse group. While other groups examined in this study have some attributes that remain relatively constant (e.g., nearly all of the participants in the “gay” category are males who are oriented to men, nearly all of the participants in the “lesbian” category are females who are oriented to females, etc.), the transgender participant group represents all genders and all sexual orientations.

In addition to this diversity, the transgender participants have a very diverse experience as well. Some are currently on HRT, others will be on HRT in the future, and still others have no intention of using HRT. This underscores the fact that the transition process is not identical for all transgender people. In fact, it is highly individualized, and the health needs in relation to the transition can vary greatly from person to person.

It is clear that there is a distinct lack of transgender-specific services here in the Coachella Valley. The most obvious of these is genital surgery, however, even everyday trans-specific care is unavailable for some participants. It is clear, especially from the open-ended responses, that the Valley had a long way to go in terms of being competent providers of trans-specific care.

Future Research

The last question on the survey was open-ended: “Is there anything else you think we should know in order to have an accurate picture of LGBT health and wellness in the Coachella Valley?” While many of these responses have been integrated into the other sections of the report, this section presents the result of a qualitative analysis of these open-ended responses that did not fit within the existing topic framework of the report. For each of these themes, three sample quotes are presented to illustrate, in the participants’ words, that particular theme. These themes represent topics that should be explored further in the LGBT community of the Coachella Valley.

Services for the Deaf

- “There needs to be emphasis on inclusion of Deaf LGBTQ people in the valley. We are an invisible part of the community. Sign Language interpreting services are nonexistent. I was an in patient at Desert Regional and was denied Sing Language Interpreters the whole time I was there and my doctors were Gay and did not seem the least bit concerned about that. There is a large Lesbian and Gay Deaf Community and yet none of the events at The Center are interpreted. There are no ASL classes at The Center. I come from the SF Bay Area and I am accustom to the LGBTQ organizations being leaders in including the Deaf and I have not seen that here at all.”
- “Need to take into consideration disabled LBGTs, especially Deaf and Hard of Hearing and the importance of having communication access for services.”
- “LGBT community has internalized homophobia so ready to tear its member down. There are lot of social castes/ classes within the LGBT community. Apathy is a huge problem. Very few members try so hard to improve quality of life for LGBT community and they're being worn down by challenges and lack of support. Good example is deaf/ hard of hearing segment of LGBT community being excluded from mainstream LGBT services and activities ... not just organizational level but also individual level. Does your Center have any DEAF sign language instructors or participants? If you do offer interpreters or accommodations, do you promote Center's accessibility to deaf/ hard of hearing community?”

Services for Lesbians and/or Women

- “The lgbt centers that serve the valley need to be more inclusive of women and women's activities, for example supper clubs and exhibits, speakers etc who include lesbian interests and points of view. Especially, the boards of the centers need to include women and take their views seriously, which has not always been the case in the recent past.”
- “Services for women, especially elder women ie menopausal and post menopausal medical counseling and support is needed, as well as activities for active women 55 plus like hiking etc groups. Thank you for asking and doing this work.”
- “I do believe, at times, that the Lesbian community is ignored and pushed aside. The Gay (male) community seems to believe the valley is theirs and should be run their way or else. We really need a coming together rally or support in some way. I believe we have all come a long way but there are miles yet to travel.”

Services for Youth

In designing this survey, the survey design team made a conscious decision to exclude LGBT youth from participating in this study. This was based on the fact that LGBT youth typically have very different health needs and issues than LGBT adults, and that to combine the two would muddy the clarity of conclusions for both groups. However, a youth study has always been enthusiastically recommended as a separate study. Some of the open-ended responses confirmed that this is an important topic worthy of future study in the Coachella Valley:

- “We need to be more involved and concerned about our LGBT youth and help them live open and productive lives, free from bullying and oppression.”
- “The support of LGBT Teens and Young Adults, especially in Foster Care is missing...”
- “There aren't enough group activities for the younger generation. All of the events that are listed in the DDG, for example or even at The Center are geared toward an older generation or are held during the day or at a bar. My husband and I would participate in a lot more activities if we related to them or if they weren't during the normal work week. Where are all the evening and weekend activities and groups or are we supposed to just accept that going to Hunters or Toucans is the norm for the younger LGTB community to find support?”

Services for Seniors

- “More emphasis should be placed on seniors. The Center was founded as a senior center. Senior care is now secondary. Even the word senior has been removed from the name.”
- “Seems to be an above average number of LGBT residents of the Valley are Seniors. Our needs are unique to the LGBT community should be addressed, as such. An example is Openhouse in San Francisco, and SAGE. Senior issues have now been lumped together w/ other LGBT. This move does not reflect the studies that have been done and document re LGBT Senior needs. A mistake has been made. Please correct it, before going any further.”
- “We need specialized services to elderly LGBT people. Most programs (activities) focus on sexual needs. (men onlh??) that attract younger sexually active people.”

Specifically, LGBT-Specific Assisted Living

- “There is a lack of assisted living, retirement facilities, nursing homes and residential communities specifically for LGBT persons. I think fostering a community living situation for LGBT persons that supports us thru all phases of life would do a lot to enhance social, interpersonal, health and wellness issues.”
- “I think there is a huge need for GLBT related retirement venues that do not cost a fortune.”
- “I am concerned (for others in the LGBT community) about long term care that respects LGBT relationships & sexual orientation.”

Assistance with Socialization:

- “Lesbians seem to be home bodies, thus on our arrival in the desert, it was difficult to find & or make friends. Some sort of welcome committee might be useful. No idea how one might do that! Sorry”
- “As a new member (and my partner) 7 years ago, we were somewhat younger than what we saw as the primary population as being older (we were 42 and 46) and had a difficult time integrating ourselves into the community. Both of us are long term survivors of HIV/AIDS (since the early 80s) but are very healthy and hoped that we would find a bit more of a community similar to what we thought we would find. We have since found that Palm Springs to be a very social place to live and enjoy going to the many benefits for charitable causes. However, it would be great if this community had some sort of outreach to new members of the community so that they can more seamlessly become part of the gay and HIV community.”
- “I would like to see the center offer social activities, for the purpose of meeting people, not just fundraising events.”

Conclusion

The goals of this study were as follows:

- Describe the LGBT population demographically
- Describe the current health and wellness status of the LGBT community
- Identify health and wellness needs in the LGBT community
- Describe the current availability of culturally competent health services

Describe the LGBT Population Demographically

As described in this report, results indicate that the majority of participants are older gay men who are permanent residents in Palm Springs. Most participants identify as white, non-Hispanic, and are highly educated.

Describe the Current Health and Wellness Status of the LGBT Community

Most participants rated their health positively, and most are insured and have seen a healthcare provider recently. Additionally, rates of substance use, misuse, and abuse are relatively low. However, over half of participants are overweight or obese, and the majority of participants have been diagnosed with one or more chronic illnesses. Many participants, particularly gay participants, and, to a lesser degree, bisexual participants, engage in risky sexual behaviors that put them at risk for infection of HIV and other sexually transmitted diseases. In terms of mental health, self-esteem is relatively high and loneliness rates are relatively low. However, about half of the population has been diagnosed with a mental illness in the past, and over a quarter have considered suicide, rates that are far higher than those of the larger population.

Identify Health and Wellness Needs in the LGBT Community

As described above, current health risks include obesity, unsafe sexual practices, high chronic illness burden, and high rates of mental illness and suicidal ideation. These are all areas where services can be provided to address and reduce these problems.

This study also identified a great need for additional primary care services and mental health care services for the LGBT community. Low-cost LGBT-specific mental health care services were rated as “extremely important” to these participants.

Describe the Current Availability of Culturally Competent Health Services

Most participants felt that the Coachella Valley did a relatively good job of providing LGBT-friendly services, although there is always room for improvement. However, results made it clear that there are more culturally-competent services available for gay, lesbian, and bisexual participants than there are for transgender participants. Responses in several areas make it clear that local services have a long way to go to become truly transgender-welcoming.

References

- American Society of Consultant Pharmacists. (October 14, 2012). STAMP Out Prescription Drug Misuse & Abuse! Tool Kit. Available online at: <https://www.ascp.com/sites/default/files/SO-Background-v3.pdf>
- Cobb, S. (1976). Social support as a moderator of life stress. *Psychosomatic Medicine*, 38, 300-314.
- Coker, A.L., Davis, K.E., Arias, I., Desai, S., Sanderson, M., Brandt, H.M., & Smith, P.H. (2002). Physical and mental health effects of intimate partner violence for men and women. *American Journal of Preventive Medicine*, 24, 260-268.
- Cornwell, E.Y. & Waite, L.J. (2009). Social disconnectedness, perceived isolation, and health among older adults. *Journal of Health and Social Behavior*, 50, 31-48.
- Balsam, K.F., & Mohr, J.J. (2007). Adaptation to sexual orientation stigma: A comparison of bisexual and lesbian/gay adults. *Journal of Counseling Psychology*, 54, 306-319.
- Berkman, L.F., Glass, T., Brissette, I., & Seeman, T.E. (2000). From social integration to health: Durkheim in the new millennium. *Social Science and Medicine*, 51, 843-857.
- Centers for Disease Control and Prevention. (2011). *Physical Activity and Health*. Atlanta, GA: Centers for Disease Control and Prevention, Division of Nutrition, Physical Activity and Obesity, National Center for Chronic Disease Prevention and Health Promotion. Available online at: <http://www.cdc.gov/physicalactivity/everyone/health/index.html>
- Centers for Disease Control and Prevention. (2013). *Smoking & Tobacco Use*. Available online at: http://www.cdc.gov/tobacco/data_statistics/fact_sheets/fast_facts/index.htm
- Centers for Disease Control and Prevention. (2013). STD trends in the United States: 2011 National data for chlamydia, gonorrhea, and syphilis. Available online at: <http://www.cdc.gov/std/stats11/trends-2011.pdf>
- Hays, R.D. & DiMatteo, M.R. (1987). A short-form measure of loneliness. *Journal of Personality Assessment*, 51, 69-81.
- Institute of Medicine (2009). America's Uninsured Crisis: Consequences for health and health care. Available Online at <http://www.iom.edu/~media/Files/Report%20Files/2009/Americas-Uninsured-Crisis-Consequences-for-Health-and-Health-Care/Americas%20Uninsured%20Crisis%202009%20Report%20Brief.pdf>
- Krug, E.G., Dahlberg, L.L., Mercy, J.A., Zwi, A.B., & Lozano, R. (Eds). World report on violence and health. (2002). Geneva: World Health Organization. Available online at: http://whqlibdoc.who.int/publications/2002/9241545615_eng.pdf

Mohr, J. & Fassinger, R.E. (2003). Measuring dimensions of lesbian and gay male experience. *Measurement and Evaluation in Counseling & Development*, 33, 66-90.

Murphy, S.L., Xu, J., & Kochanek, K.D. (2013). Deaths: Final Data for 2010. *National Vital Statistics Reports*, 61.

National Heart, Lung, and Blood Institute (1998). Clinical Guidelines on the identification, evaluation, and treatment of overweight and obesity in adults. National Institutes of Health. NIH Publication No. 98-4083. Available online at:
http://www.nhlbi.nih.gov/guidelines/obesity/ob_gdlns.pdf

National Institute of Alcohol Abuse and Alcoholism. (2004). NIAA council approves definitions of binge drinking. *NIAA Newsletter*, 3, 3. Available online at:
http://pubs.niaaa.nih.gov/publications/Newsletter/winter2004/Newsletter_Number3.pdf

Rosenberg, M. (1979). *Conceiving the Self*. New York: Basic Books.

Steele, L.S., Tinmouth, J.M., & Lu, A. (2006). Regular health care use by lesbians: A path analysis of predictive factors. *Family Practice*, 23, 631-636.

Surgeon General. (2013). Overweight and obesity: Health consequences. Available online at:
http://www.surgeongeneral.gov/library/calls/obesity/fact_consequences.html

Tomaka, J., Thompson, S., & Palacios, R. (2006). The relation of social isolation, loneliness, and social support to disease outcomes among the elderly. *Journal of Aging and Health*, 18, 359-384.

U.S. Department of Agriculture & U.S. Department of Health and Human Services. (December, 2010). *Dietary Guidelines for Americans, 2010*. 7th Ed. Washington, DC: U.S. Government Printing Office, December 2010. Available online at:
<http://www.health.gov/dietaryguidelines/dga2010/DietaryGuidelines2010.pdf>

U.S. Department of Health and Human Services. (2004). *The Health Consequences of Smoking: A Report of the Surgeon General*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health. Available online at:
http://www.cdc.gov/tobacco/data_statistics/sgr/2004/complete_report/index.htm

Wilson, D., Cutts, J., Lees, I., Mapungwana, S., & Maungandize, L. (1992). Psychometric properties of the revised UCLA loneliness scale and two short-form measures of loneliness in Zimbabwe. *Journal of Personality Assessment*, 59, 71-81.