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Midlands Sexual Health Research Collaborative

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The Midlands LGBT Needs Assessment

Community Report

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I. Acknowledgements

The Midlands Sexual Health Research Collaborative (MSHRC) is indebted to the numerous community partners who helped to make this study possible. In particular, we thank our sponsors who provided financial and in-kind support to make the study possible. We are also grateful to our community partners who helped design and advertise the study, and who provided valuable feedback as we analyzed the results.

Sponsors

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UNL Queer Student Alliance

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UNL LGBTQA Resource Center

Inspiring Communities Conference

UNMC Public Relations

Prairie Fire Newspaper

Planned Parenthood of the Heartland

And the numerous businesses, health clinics, schools, and places of worship that allowed us to advertise the study in their facilities.

The MSHRC especially would like to thank the graduate assistant for this project, Molly McCarthy, for her significant contributions to the study and writing of this report.

II. Introduction

Health disparities research seeks to understand specific health-related needs and outcomes for groups of people, particularly minority groups. In 2011, the Institutes of Medicine (IOM) released a report commissioned by the National Institutes of Health entitled *The Health of Lesbian, Gay, Bisexual, and Transgender (LGBT) People: Building a Foundation for Understanding*. For the first time, research on the health and well-being of LGBT persons has been prioritized by research funders at the highest levels.

There are known health disparities for LGBT populations include physical health (for example, increased rates of smoking and alcohol consumption, HIV/AIDS, and the possibility of higher rates of some cancers)[1,2] and mental health (for example, depression, suicide, and other responses to stress and discrimination)[3-7]. Studies of doctor-patient communication provide evidence that disclosure to a health care provider regarding one's sexual orientation or gender identity increases the quality of care provided [8-11]. Furthermore, there are known barriers to health care access among LGBT populations, including issues with providing health care coverage for partners, finding supportive and competent care, and feeling comfortable with health care professionals, which is doubly problematic for racial and ethnic LGBT person[9, 12-14].

Community and social health, also known as social determinants of health, play a large role in the overall health of individuals. Access to or being a part of a larger LGBT community, sometimes referred to as social capital or social networks, has also been shown to be important to the health and general well-being of LGBT populations[15-17]. Further, an individuals' sense of empowerment at the individual, organizational and community level has been shown to be an important component of overall individual and community-level health[18]. Internalized homophobia and internalized transphobia, or the internalization of negative beliefs and emotions regarding the LGBT population that a person uses to evaluate her or his own self, is also severely damaging to one's sense of self and physical and mental health[1, 19-21].

Hate crimes and discrimination based on sexual orientation and gender identity remain a problem for LGBT individuals within the United States[22, 23]. According to the Uniform Crime Report from the FBI, approximately 18% of all hate crimes reported in 2008 were motivated by anti-homosexual bias

Sexual health disparities have been shown to exist among LGBT populations[22, 24], particularly with regards to HIV among gay and bisexual men[25]. Sexual health knowledge, perceived risk and HIV and STD status are important areas in which to develop a better understanding in order to influence ways to promote better sexual health and well-being, including new approaches to HIV and STD prevention, screening, and treatment.

Most of the current information on LGBT health comes from large cities such as New York, Atlanta, and Los Angeles. Missing from the conversation is concrete data on LGBT persons living outside the big cities and population centers of the US. In particular, no known research has looked at the health and well-being of LGBT persons in the Midlands in a comprehensive, in-depth manner.

Purpose

The purpose of the Midlands LGBT Community Needs Assessment was to gather descriptive data of the health and well-being of LGBT people who live, work, and 'play' in Nebraska. Specifically, data on the physical, mental, social, and sexual

health of the community were measured through a survey conducted by researchers with the Midlands Sexual Health Research Collaborative (MSHRC) from the University of Nebraska Medical Center's College of Public Health and the University of Nebraska at Omaha.

Survey Design

In late 2009, the study leader, Dr. Christopher M. Fisher, began to engage a number of community members and organizations to better understand the needs of the LGBT community and how research might be helpful in supporting those needs. As noted earlier, no known research with LGBT populations in Nebraska had occurred. Many organizations expressed the struggle of obtaining funding and social and political support to sustain and/or expand their efforts to improve the health and well-being of their LGBT constituents. Further, data was missing that could support efforts to address social and structural inequalities which contributed to poor health outcomes.

Over the course of nearly a year, Dr. Fisher and Dr. Irwin engaged organizations and community leaders for the purpose of developing a statewide community survey to address the gap in data for Nebraska. The survey was developed and refined based on feedback from key community contacts. A semi-final version was pilot tested with 10 members of the LGBT community. At Omaha Pride 2010 (July), the survey was launched. Data collection continued through November of 2010.

The survey consisted of up to 225 closed-ended questions and 2 open-ended questions. Transgender respondents receive an additional 22 close-ended questions. In addition to basic demographic data, questions sought to assess the physical, mental, social, and sexual health of those participating in the survey. The survey also included questions about larger structural issues around access to health care, experiences with discrimination and violence, and community empowerment.

Survey Measures

The survey included the following domains:

- Demographic and other participant characteristics
- Overall physical and mental health status
- Health care access and usage
- Alcohol, drug and tobacco use
- Suicide ideation
- Social engagement
- Sense of identity related to sexual orientation and gender identity (where appropriate)
- Disclosure levels of sexual orientation/gender identity
- Perceived discrimination and experienced violence
- Depression
- Multi-level community empowerment
- Community concerns and resources
- Sexual health

A brief description of each of the domains can be found below. Unless otherwise noted, measures were developed by the MSHRC research team.

Demographic and other participant characteristics. The following information about respondents was collected: zip code, length of residency, age, sexual orientation, gender, gender identity, race/ethnicity, relationship status, educational attainment, employment status, income, housing status, citizenship, and number of underage dependents. Gender was assessed separately from gender identity. Unlike most surveys which use a binary description of gender (male/female), we included intersex and an 'other' option. A separate question asked if participants identified as transgender/transsexual or gender-nonconforming. If yes, an additional question inquired as to whether the person was male to female/transwoman, female to male/transman, genderqueer or gender-nonconforming, or other.

Overall physical and mental health status. A short series of standardized questions from the Behavioral Risk Factor Surveillance Survey (BRFSS)[26] asked about perceived general health, number of days physical and mental health was not good, and impact of poor physical and mental health on usual activities.

Health care access and usage. A series of questions were designed to better understand participants' health care situation. Questions assessed health information seeking via the internet, insurance status, types of health care providers (for example, doctor, dentist, mental health) seen in the last year, access issues due to cost, prevention care, and outness to provider (and if not out, reason[s] for not being out to provider).

Alcohol, tobacco, and drug use. Standardized questions from the BRFSS[26] were used to assess tobacco and alcohol use in order to be able to compare results to state and national averages. Drug use was assessed listing a series of drugs (such as inhalants, cocaine, marijuana) asking if participant had used in the past 90 days. Additionally, drug use before or during sex was assessed for the same list.

Suicide ideation Standard suicide ideation questions "Have you ever seriously considered suicide?" and "Have you ever attempted suicide?" were included in the survey. Additionally, for those who had seriously considered suicide, we asked at what age(s). Due to the sensitive nature of the suicide questions, a statement directing participants to The Trevor Project hotline and website for those who wanted to talk to someone about suicide was provided.

Social engagement. A scale developed by the MSHRC team based on the work of Fisher and colleagues[27] and Kippax and colleagues[28] was used to assess the frequency of various social activities of participants. Options ranged from 'never' to 'a lot (at least once a week)' were provided. Questions include items like, 'I went to an LGBT bar,' 'I watched an LGBT themed movie/film,' 'I chatted with other LGBT people in chat-rooms,' and 'I went to a religious service for LGBT people.' Socio-sexual activities were assessed with questions like 'I hooked up for sex over the Internet.'

Sense of identity related to sexual orientation and gender identity. A modified self-acceptance scale[29] was used to assess the degree to which participants had a positive sense of identity related to their sexual orientation/gender identity. Items include statements such as 'I feel that being LGBT is a gift,' and 'For the most part, I enjoy being LGBT.' Response options ranged from 'strongly agree' to 'strongly disagree.' Transgender respondents received an additional scale about their feelings as a transgender man or woman which was developed by Bockting and colleagues at the University of Minnesota. Items, scored 'strongly agree' to 'strongly disagree', included statements such as 'Being transgender makes me feel special and unique,' and 'I am proud to be a transgender person.'

Disclosure levels of sexual orientation/gender identity. A short series of questions asked participants to indicate how out they were to friends, family and other interaction groups such as employers. Participants could indicate that 'none of them know' to 'everyone.' The scale was adapted from Wright and colleagues[29].

Perceived discrimination and experienced violence. Frequency of events of perceived discrimination and experienced violence due to LGBT status were measured with a series of statements for each. Participants could indicate that for each statement if that happened to them never, once, twice, or three or more times. For perceived discrimination, items included statements such as 'someone called you a derogatory name' and 'you were treated unfairly by coworkers.' For experienced violence, statements such as 'you were hit, beaten, or physically attacked' and 'someone tried to rape you or sexually assault you, but they were stopped or you got away' were included. These scales were adapted from Wright and colleagues[29].

Depression. Depression, a common mental health condition for LGBT populations, was assessed using the Center for Epidemiologic Studies-Depression (CES-D) scale[30], one of the most widely used scales for assessing symptoms of depression among many distinct populations.

Multi-level community empowerment. Items measuring perceived levels of individual, organizational, and community level empowerment; that is, the level of influence a person believes they have over what happens to themselves, an organization they are involved in, or their community, were adapted from Israel and colleagues[18]. Participants identified up to 3 LGBT organizations they were involved in and then answered a series of questions related to their sense of empowerment.

Community concerns and resources. Several questions were developed to ascertain participants' level of concern (great concern to not a concern) on a series of health-related topics such as tobacco, hate crimes, and chronic disease. Another question asked participants to select their top three policy issues which included items like safe schools, HIV/AIDS, and immigration. A final series of questions asked participants to indicate the type of LGBT organization(s) they would most likely engage with and if such resources existed in their community.

Sexual health. A series of questions were designed to measure STD history[31], STD and HIV testing behavior, reasons for not being tested for HIV (adapted from Kellerman and colleagues[32]), perceived risk for STDs and HIV, and HIV/AIDS knowledge[33].

Survey Administration

The Midlands LGBT Community Needs Assessment survey was administered via the internet on a UNMC website. The survey took approximately 30 minutes to complete and participants were able to choose to receive a $5 gift card to one of three national retailers for completing the survey.

Recruitment, Sampling, and Eligibility

It is difficult to get a truly representative sample for studies of this nature[34, 35]. Therefore, the research team attempted to get as many respondents as possible. A recruitment e-mail was sent to a list of LGBT leaders, organizations, and allies who were then asked to repost the e-mail via listservs and through their own contacts (for example, snowball sampling). At the beginning and the end of the survey, a message asking participants to pass the survey website on to others was also used. Advertisements, generously designed by Rebel Interactive, were posted at local merchants throughout Omaha and Lincoln as well as passed on to LGBT community leaders in other parts of the state. Palm cards, also generously designed by Rebel Interactive, were passed out at Omaha Pride 2010 and Star City Pride 2010 as well as through numerous community partners throughout the state. Ads were also placed in select local newspapers. Finally, a press release was issued in September and subsequently picked up by the

Associate Press wire. The majority of responses came right after the press release was picked up by several Nebraska newspapers and other media agencies.
Respondents read a written introduction to the survey and then a consent statement approved by the IRB at UNMC. After agreeing to participate, eligibility was determined by these questions:

- Are you 19 years of age or older?
- Do you self-identify as lesbian, gay, bisexual, or transgender?
- Do you live, work, or 'play' in Nebraska?

Those answering 'yes' to all three questions were then taken to the survey. For the purposes of this study, 'play' was defined as coming into Nebraska for social activities including entertainment, shopping, utilizing services, and other similar activities. The research team in consultation with community partners determined that, for example, LGBT persons living in Council Bluffs, IA often come to Nebraska for many of the above stated activities and therefore make up a part of our community and utilize services provided for LGBT persons and their allies in Nebraska.

The final survey had over 1,000 respondents of which 770 completed the entire survey.

Analyses

The analyses for the community report were both descriptive and comparative. Frequencies were used to describe participants' responses to the survey questions. Comparisons were made primarily based on geography and gender identity; participants who lived in the Omaha metro (including Council Bluffs, IA), Lincoln metro, and all others who lived outside of these two areas, referred to as rural in this report, were compared on numerous measures. Transgender and non-transgender participants were also compared on similar questions throughout the survey.
Appropriate statistical tests were used in the comparative analyses including Pearson Chi-square tests, t-tests, correlation, and one-way analysis of variance; results of statistical tests are reported where appropriate. All tests were conducted using PASW 18.0. Findings were considered statistically significant if the significance level – the "p value" – reached 0.05 or below (for example, $p < .05$).

Limitations

As with any survey, there are limitations to the findings of this report. First, the sample, as noted above, was ultimately one of convenience since it is impossible to obtain a true representative sample of LGBT persons in Nebraska. The final sample was relatively large compared to other similar surveys given the size of the general population. However, there were few economically disadvantaged participants, African Americans, Latino/as, and people from certain areas of the state (for example, Scottsbluff). Therefore, these findings are not representative of the entire LGBT community of Nebraska, only those who responded to the survey. Second, although we had a number of participants who identified as transgender, the multiple ways of being transgender both in terms of strategies for presenting one's gender identity (for example, surgery, hormones, clothing) and where one is at in the journey toward what they consider fully transitioned were not documented in this survey. Therefore, beyond some very basic categories of description, we were unable to provide a more nuanced description of the experiences of our transgender participants. Finally, not all participants answered all questions. As a part of ethical research, we did not force people to answer any question they did not want to. A few participants did not answer some of the questions on the anonymous survey. However, most participants answered all questions thus minimizing any impact on results.

Organization of the report

This report is organized based on the larger domains described earlier. Specifically, the sections are General Health, Mental Health, Sexual Health, and Social and Community Health. Each section of the report contains a short list of key findings for the section followed by subcategories with fuller descriptions of findings for the overall sample and comparison results by geographic location (Omaha metro versus Lincoln metro versus all other respondents [rural]) and gender identity (transgender versus non-transgender).

The organization of the report was determined in conjunction with community partners over the course of three townhall style meetings. Meetings were held in Hastings (Inspiring Communities Conference), Lincoln (hosted by Nebraskans for Peace) and Omaha (hosted by P-FLAG Omaha). Basic descriptive results from the survey were presented at each meeting followed by a facilitated discussion on how community members wanted to see the results presented in a community report and what additional comparisons/analyses were of interest to them. This information was invaluable to the development of the report.

For each chart or table, the total number of persons who responded to the question is indicated at the top. For example, n=765 indicates that 765 persons answered the question. Participants had the option to not answer any question. Additionally, depending on answers to some questions, a participant may not have received later questions (for example, if a participant indicated they did not identify as transgender, they did not get a subsequent question on the type of transgender identity they claimed, such as transman or transwoman). Therefore, not every question had the same number of people answering that particular question.

Final decisions as to content and format of the report were made by the MSHRC team. As community members become familiar with the results reported here, we anticipate more questions of the data will need to be answered. To this end, an Information Request Form for this study is available on our website (www.unmc.edu/publichealth/mshrc).

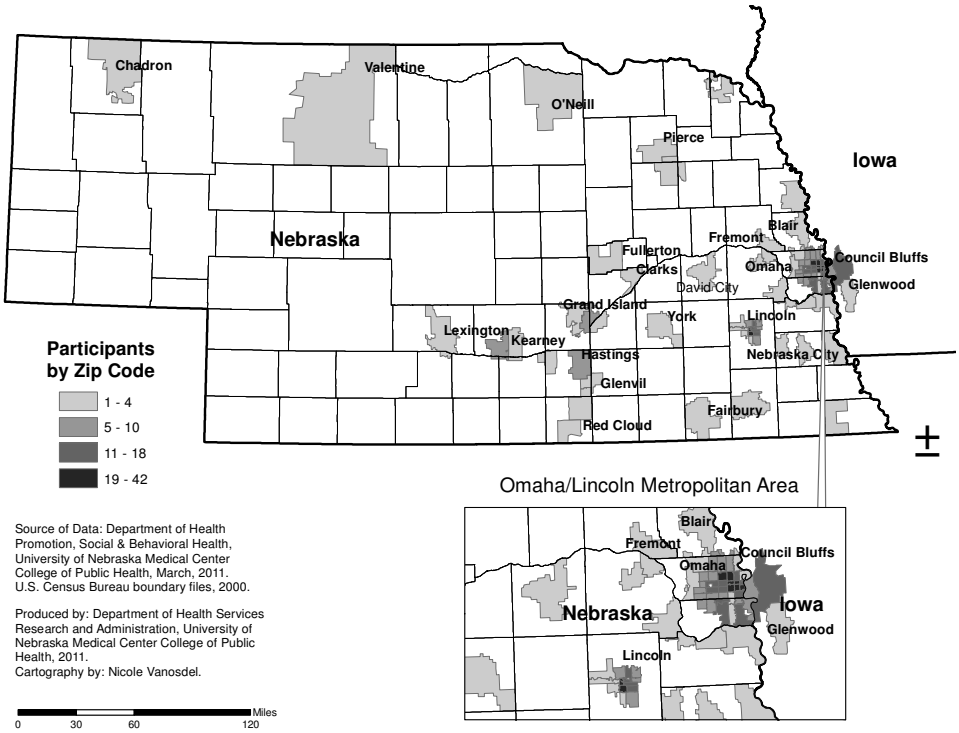
III. Respondent Characteristics

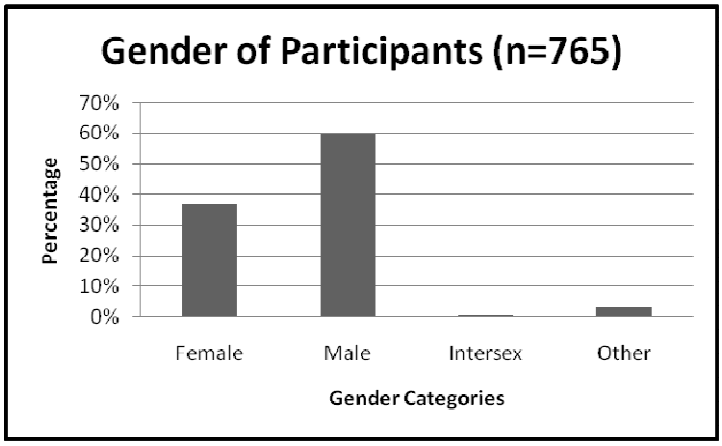
There is a growing body of research pertaining to Lesbian, Gay, Bisexual, and Transgender (LGBT) individuals. However, there is little information about LGBT populations in the state of Nebraska. The hidden nature of LGBT populations can create methodological challenges such as finding a generalizable sample. In this study, we sought to obtain a diverse sample of LGBT individuals through multiple recruitment strategies including local press releases, fliers and handouts posted at local LGBT-friendly businesses, email invitations to LGBT individuals, as well as fliers distributed at LGBT events such as the Omaha Pride Festival.

Key findings from the Midlands LGBT Community Needs Assessment Related to Respondent Characteristics:

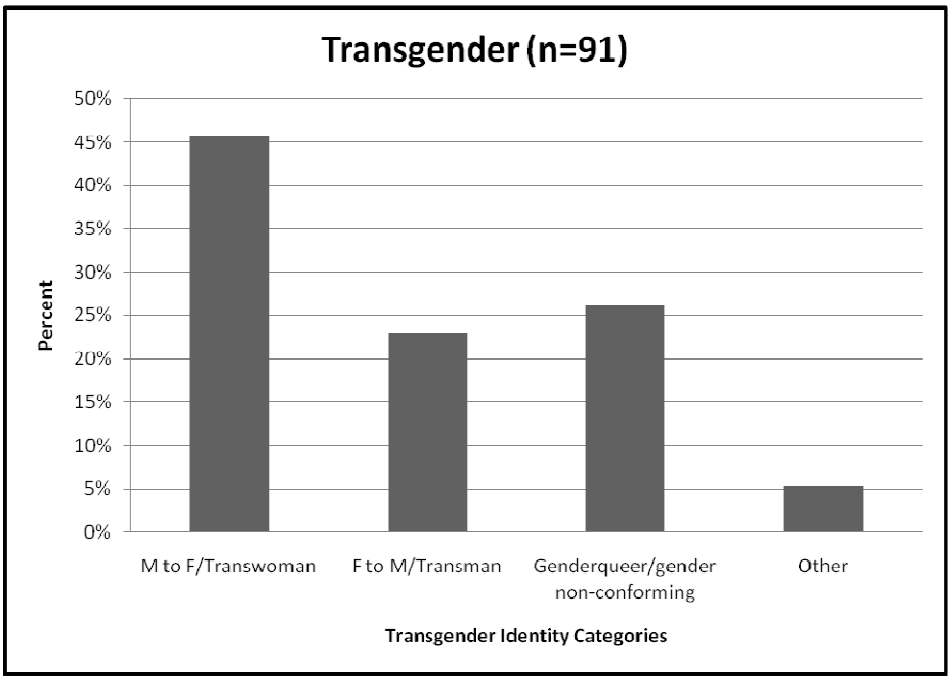
- Most of the survey respondents were white, well-educated, employed, and had a relatively high income.
- About 1 in 3 participants were female; roughly 60% were male; very few indicated they were intersex or identified their gender as 'other.'
- Twelve percent of respondents were transgender.
- The age of participants ranged from 19 to 79 years; the average age was 36 years.
- A majority of respondents lived in the Omaha-Metro area (68%) or in the Lincoln-Metro area (20%). About 10% of participants were from rural areas of the state.
- Many participants in this study were either legally married to or exclusively dating a member of the same sex (46%). Very few were single and dating more than one person (6%).

Figure 1: Geographic Distribution of Survey Respondents

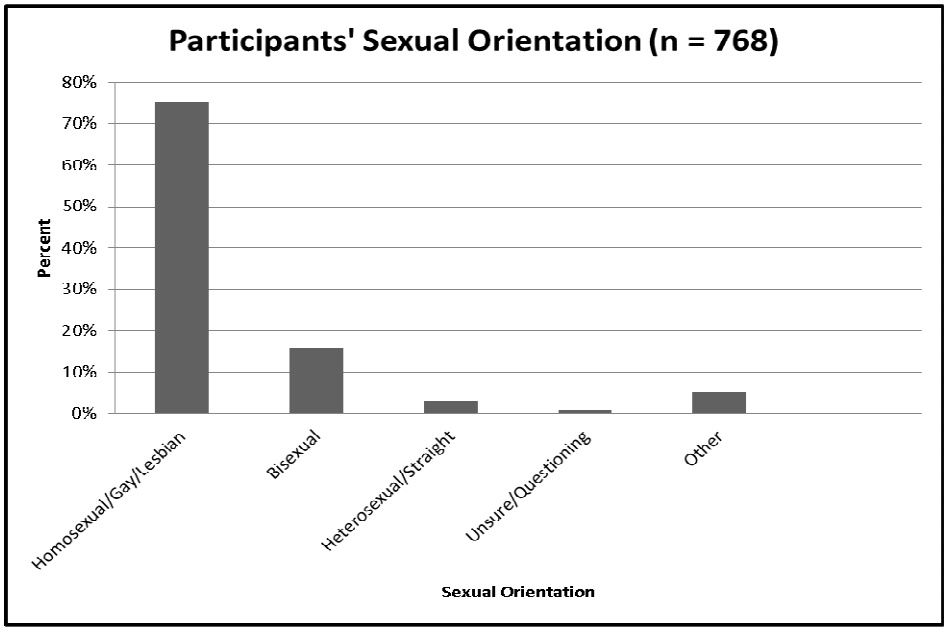




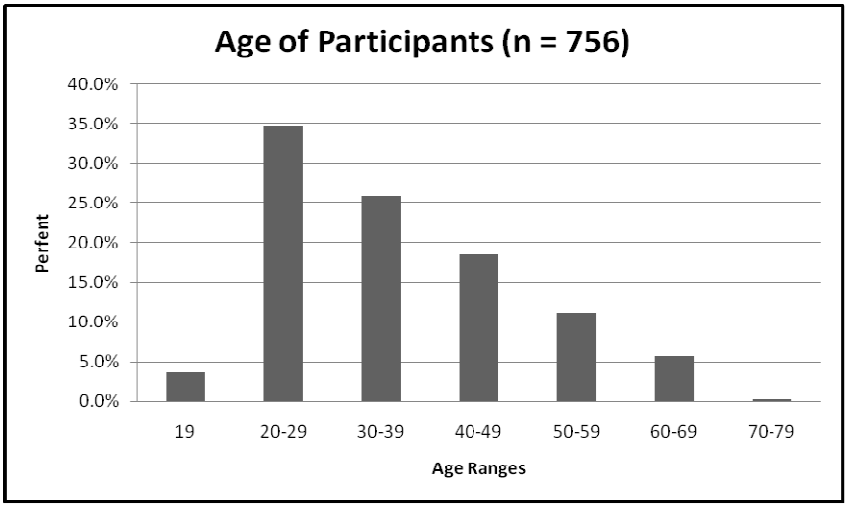
Most participants in this study were male (59.74%). Fewer respondents were female (36.99%). There were very few respondents in this study who were intersex (.39%) or identified their gender as 'other' (2.88%). The low sample sizes of intersex individuals and other groups necessitated that gender analyses compare males and females only. For more information about participants' gender, please see Appendix A.



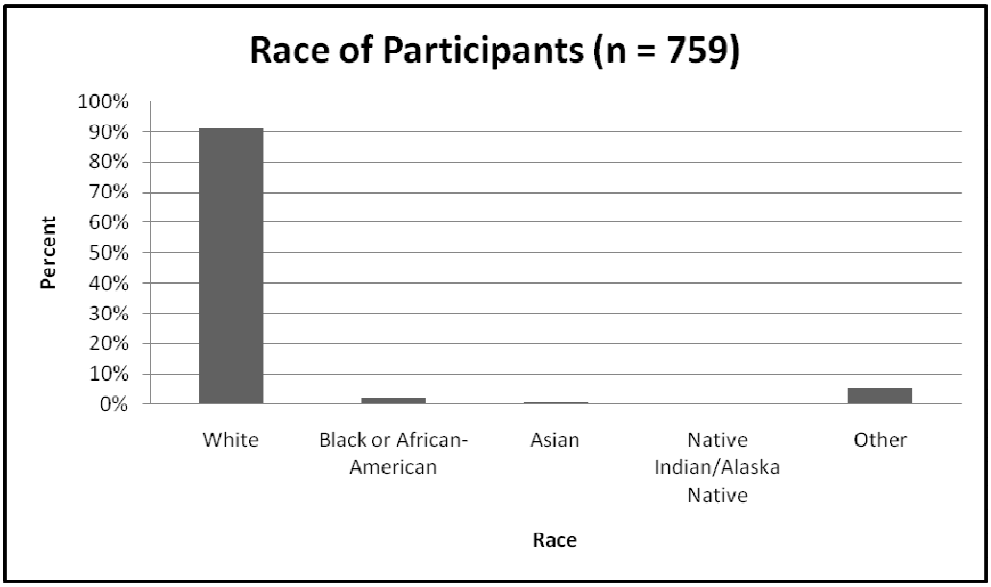
Ninety-one transgender individuals participated in this study, most of whom were male-to-female (MTF) (45.65%). There were more genderqueer/gender non-conforming participants (26.09%) than those who were female-to-male (FTM) (22.83%). There were a few respondents who identified as another transgender identity category (5.43%). The term "transgender identity category" is used in this report when MTF, FTM, genderqueer/gender non-conforming, and other transgender identity groups are compared. For information about gender identity categories and geographic location, please see Appendix A.



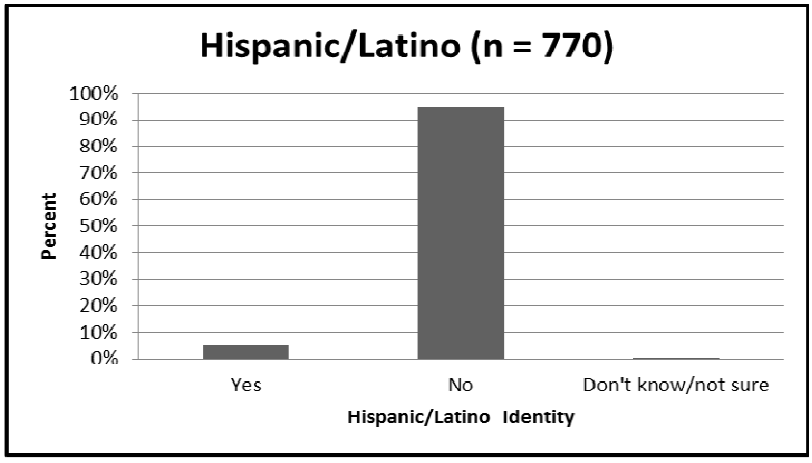
Most of the people in this study identified as homosexual, gay, or lesbian (75.26%). A significant number of participants were bisexual (15.89%) and fewer were heterosexual or straight (2.86%) or unsure/questioning (0.78%). All but one participant who identified as heterosexual/straight also identified as transgender. A few individuals (5.21%) selected 'other' for their sexual orientation. Participants who identified their orientation as 'other' were asked to describe their sexual orientation. Most described their orientation as queer or pansexual.



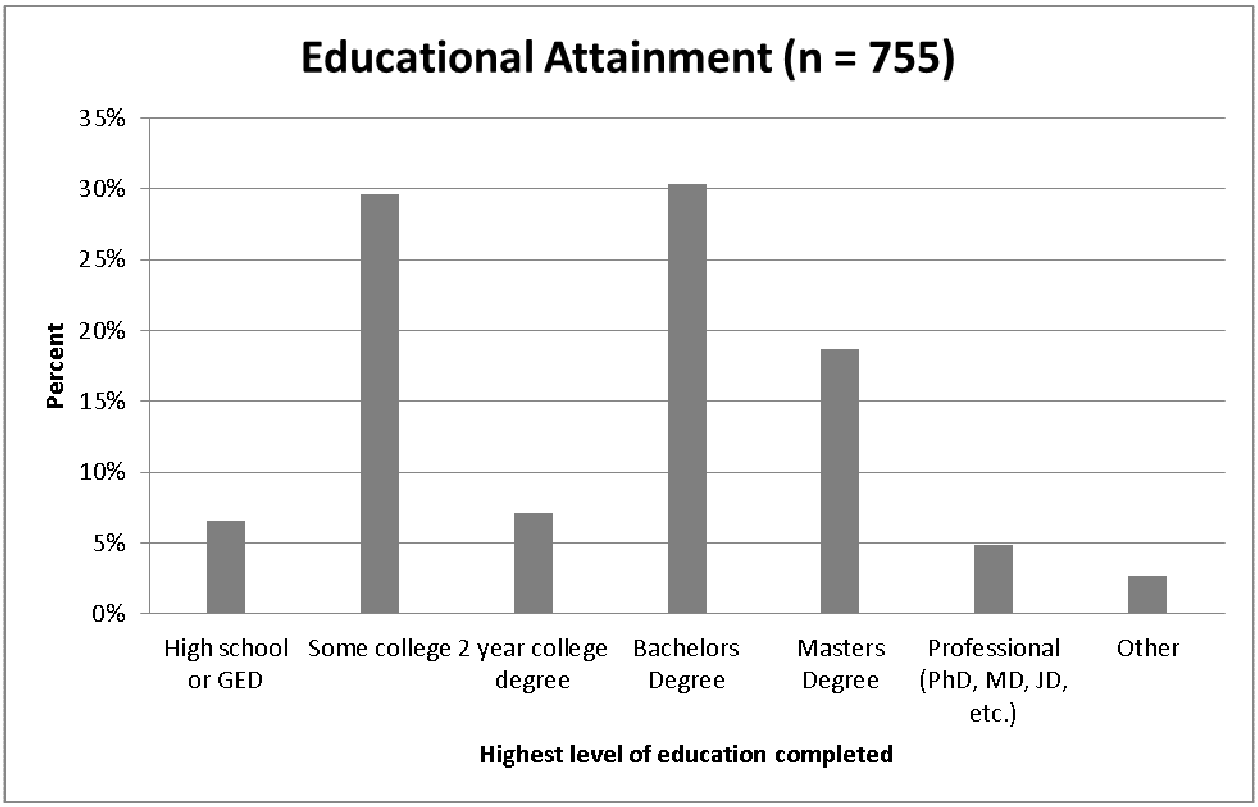
The ages of participants in this study ranged from 19 to 70 years. Most respondents (64.29%) were between the ages of 19 and 39years. The average age was nearly 36 years. The age of respondents did not vary considerably by geographic location and sexual orientation/gender identity.



The chart above shows that a majority of the survey respondents were White (94.6%). Other races represented in this sample included Black or African-American (2.2%), Asian (0.9%), and American Indian/Alaska Native (0.8%). In the state of Nebraska, over 90% of individuals are White; almost 5% are Black; about 2% are Asian; 1.1% are American Indian/Alaska Natives[36]. More information about race and geographic location is included in Appendix B.



Federal standards draw a distinction between race and ethnicity and mandate that they be measured separately by the U.S. Census. According to the Hispanic Population 2010 Census Brief[36], the 2010 Census defined "Hispanic or Latino" as "a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race." Consistent with the federal standards, race and ethnicity were measured separately in this study. The graph above indicates that nearly 5% of the sample identified themselves as Hispanic or Latino. Nationally, about 16% of individuals consider themselves to be Hispanic or Latino[36], but it was estimated that almost 8% of Nebraskans were Hispanic/Latino in 2009[37].



Above, the bar chart indicates that most participants in this study had a high level of education. Over half (56.5%) had earned a Bachelor's degree or higher. There were few (6.6%) who had not completed at least some education at the college level. The chart below represents the income level reported by participants. Many people in the study had a relatively high income; however, over one-fourth earned less than $20,000 per year which is roughly equivalent to 200% of the Federal Poverty Guideline[38]. Average income did not vary according to sexual orientation or gender identity, although those results are not shown in the table below.

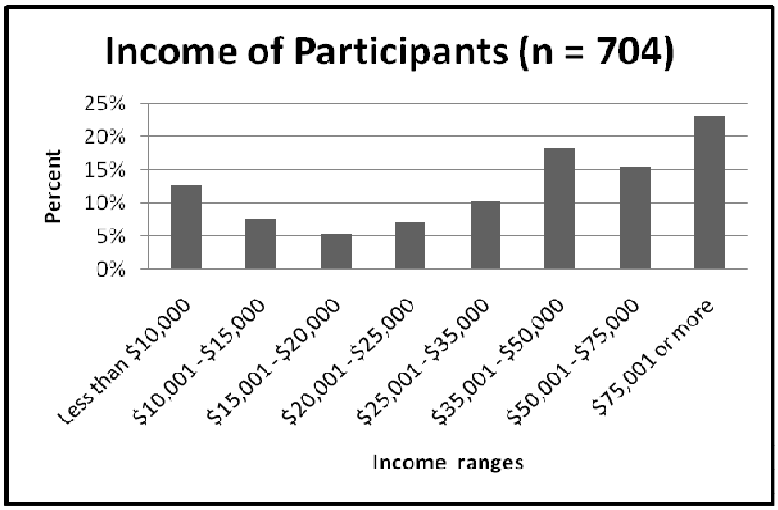
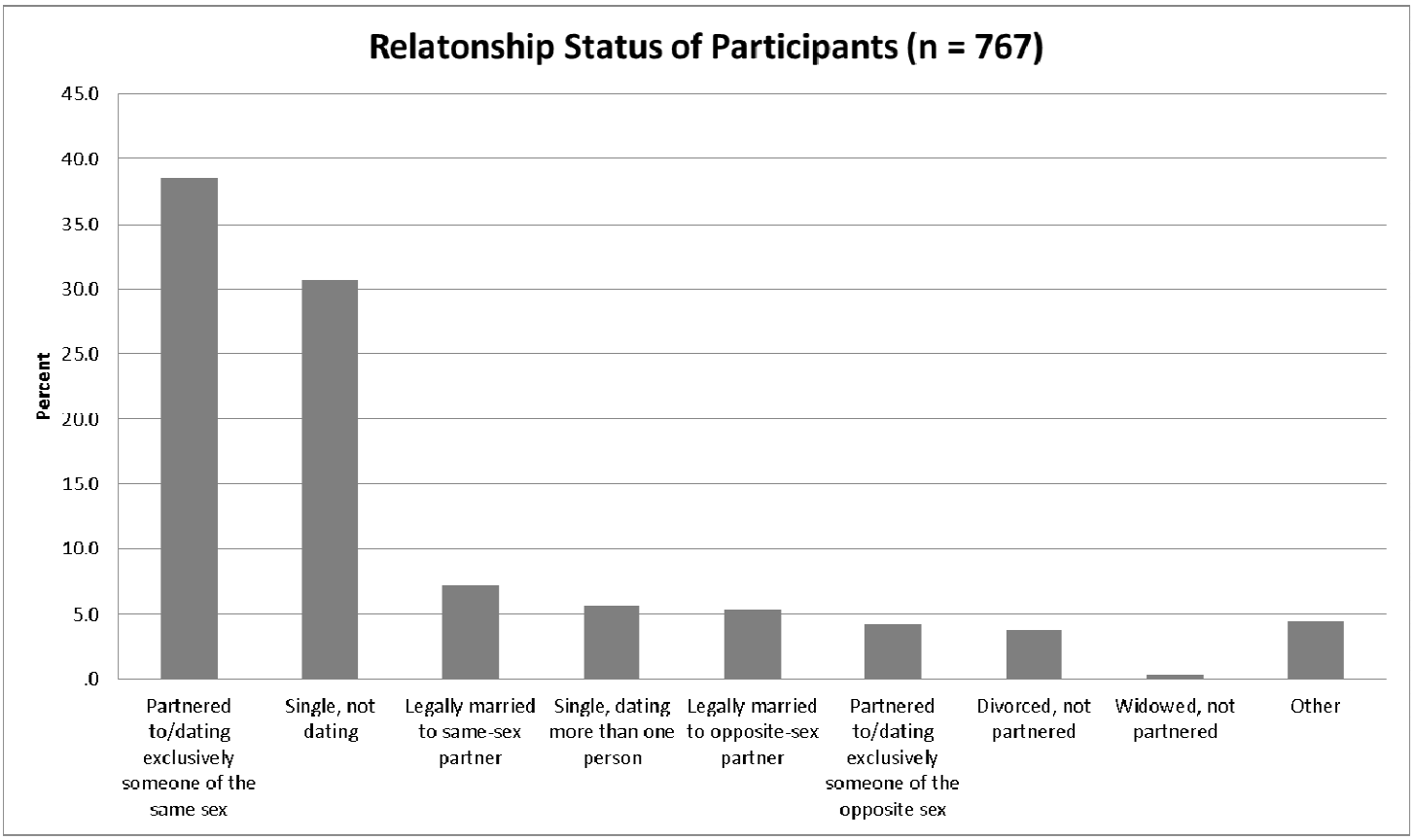


Table 1: Employment Status

Category	Frequency	Percentage
Employed for wages	**553**	**71.8**
Self-employed	53	6.9
Out of work > 1 year	28	3.6
Out of work < 1 year	42	5.5
Homemaker	9	1.2
Student	**190**	**24.7**
Retired	28	3.6
Unable to work	20	2.6

A majority of the survey participants were employed for wages, self-employed, and/or students. Some respondents were homemakers, retired, or unable to work. Of those who were out of work, most were unemployed less than one year. For the most robust possible understanding of participants' employment status, survey instructions indicated to check all applicable employment options.



Many participants were either dating exclusively or legally married to a partner of the same gender (46.3%). Nearly one-third of participants were single and not dating (30.6%). Very few respondents were single and dating more than one person (5.6%).

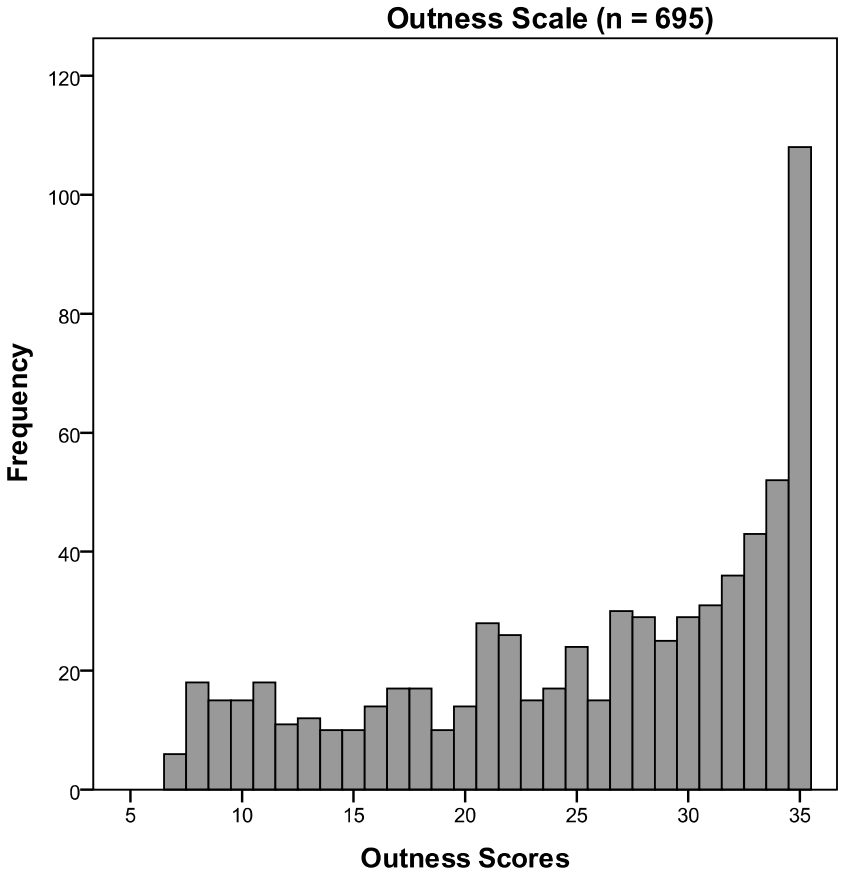
About 14% of respondents reported having children. The number of children respondents reported having varied from one to eleven but most respondents with children had either one or two.

Note:

Given the hidden nature of LGBT populations and the lack of data about LGBT people in Nebraska, it is impossible to know how closely the demographic makeup of this sample resembles that of LGBT populations in the Midlands and generalizations about LGBT Midlanders must be made with caution. Future research should focus on reaching individuals from various socioeconomic positions, as well as targeting racial and ethnic minority individuals and people from a wide age range.

The Outness Scale

"Coming out" is a multidimensional and complex process consisting of acknowledging a gay, lesbian, bisexual, or transgender identity to oneself and to others. Outness is relevant to the wellness of LGBT individual because not only has it been found to be negatively associated with suicidality[39] and anxiety[40] but also because it is positively associated with self-esteem and overall social support[41]. Outness was a concept used in this study as well as other research to assess the degree to which participants are "out" about their LGBT status to people including family members, friends, and acquaintances.



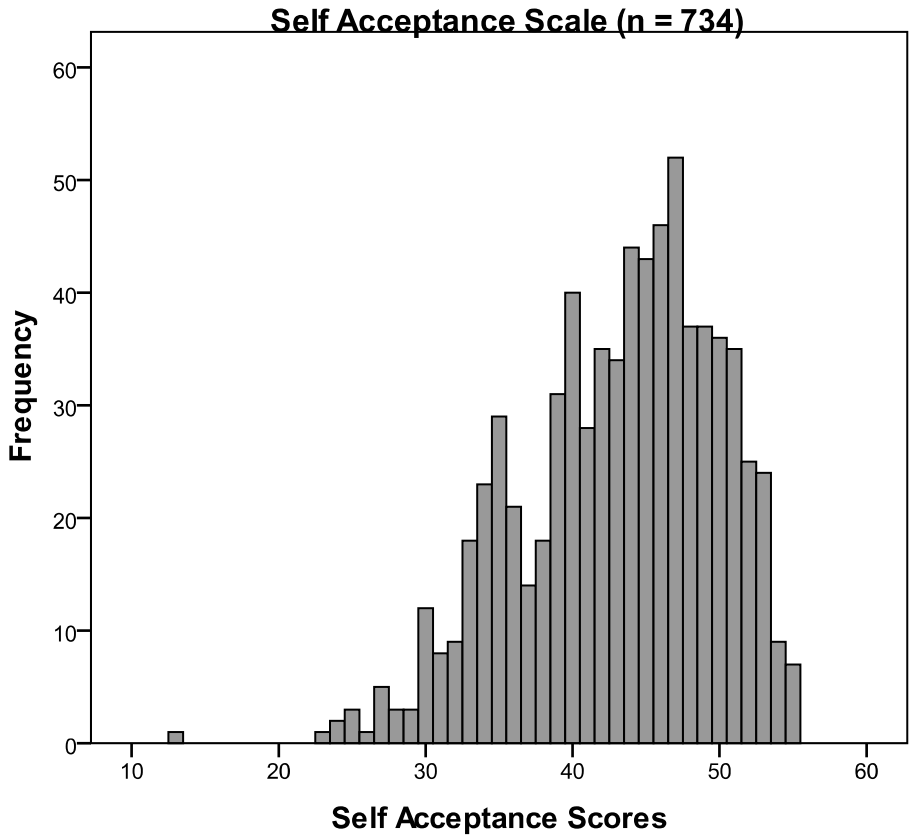
Most of the participants in this study were out to many of their friends, family, co-workers, employers, and acquaintances.

A series of questions were adapted from Wright and colleagues[29] for use in this study to understand the degree to which participants were out about their sexual orientation/gender identity. On a five-point scale ranging from nobody to everybody, the proportion of friends, parents, siblings, other family members, co-workers, employers, and acquaintances were aware of participants' LGBT status was assessed. The scale had high reliability (α=.916).

Outness scores ranged from 7 to 35, with higher scores indicating a greater degree of outness; for example, a score of 7 would indicate that the participant was not out to anybody while a score of 35 would mean that a person was out to everybody. In this study, the most frequently occurring score was a 35 and the average score was 26 (sd=8.5). Few people (n=6) were not out to anybody. The chart above illustrates the distribution of outness scores.

Self-Acceptance Scale

Many LGBT individuals internalize the negative stereotypes about and stigmatization of sexual minorities. By utilizing self-acceptance and other processes, LGBT individuals are able to reject such negative ideology and live comfortably with their LGBT status. Acceptance of one's LGBT status was included in this study because it has implications on psychological and social well-being such as quality of interpersonal relationships and ability to cope with discrimination [42].



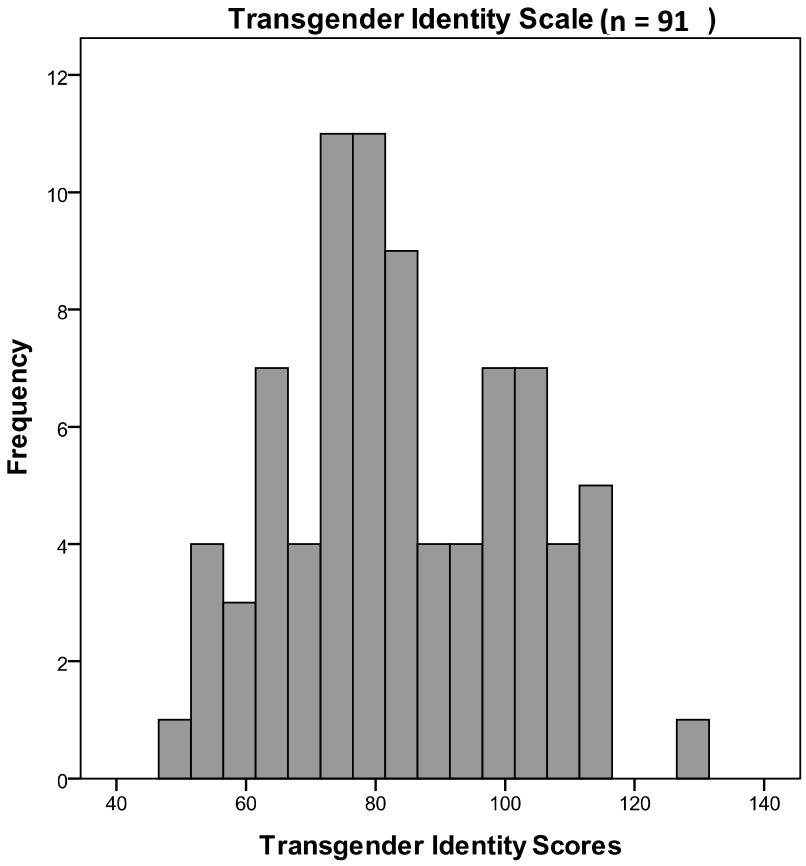
Most of the participants in this study were comfortable with being LGBT.

A scale was adapted from Wright and colleagues[29] to assess how comfortable individuals were with their LGBT status. The self-acceptance scale examined a participant's feelings about being an LGBT person by asking them to rate their level of agreement with 11 statements; level of agreement ranged from "strongly agree" to "strongly disagree". Statements included items such as "I am positive about being LGBT" and "I feel that being LGBT is a gift." The self-acceptance scale had good reliability (α=.804).

Possible self-acceptance scores ranged from 11 to 55, with higher scores indicating a greater degree of self-acceptance of one's sexual orientation/gender identity. The average self-acceptance score of participants in this sample was 43 (sd=7). There were no significant differences in self-acceptance based on geographic location. Similarly, there was no difference between transgender people and non-transgender people in terms of their self-acceptance, nor was there a difference between transgender identity categories. However, women overall had a higher average self-acceptance score than men ($t=4.018$, $p<.001$). Above, a chart displays the frequency distribution of self-acceptance scores.

Transgender Identity Scale

The transgender identity scale, as developed by Bockting and colleagues[43], is a measure of the incorporation of one's transgender identity into the overall self-identity of an individual. There are four components to this scale which measure distinct aspects of transgender identity formation: alienation, passing, pride, and shame. Individuals with great acceptance of their transgender identity are expected to exhibit greater health and well-being, similar to gay and lesbian individuals who score higher on self-acceptance measures.

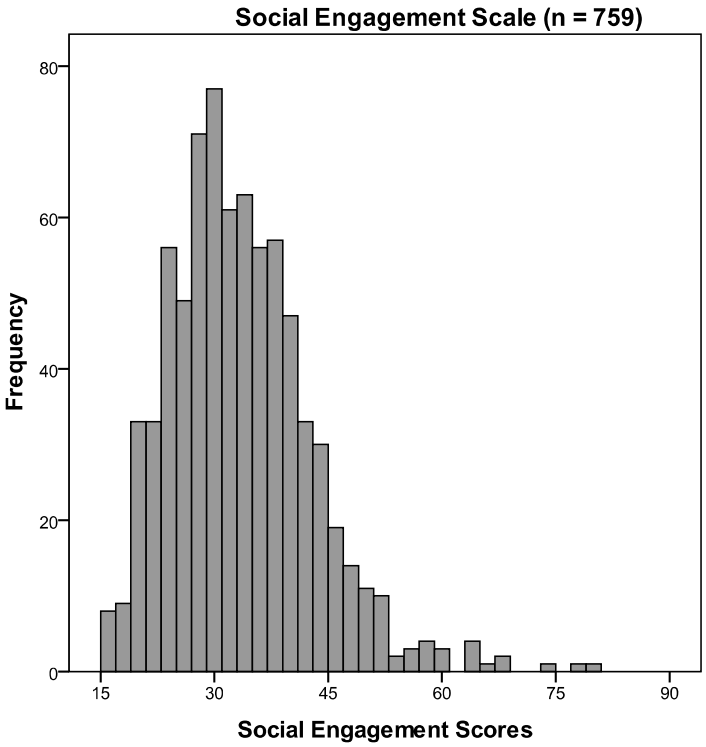


There was considerable variation in transgender identity scores but many people were comfortable with their transgender identity.

Transgender identity scores ranged from 26 to 130, with higher scores indicating participants had a greater degree of acceptance of their gender identity. The average transgender identity score for all participants who identified themselves as transgender or gender non-conforming was 84 (sd=18). There were no significant differences in the average transgender identity scores based on transgender identity category, but people who lived in the Omaha-Metro and Lincoln-Metro areas tended to have a higher average transgender identity score compared to those who lived in rural areas of the state ($F=3.993$, $p=.019$). Above, the frequency distribution of transgender identity scores is represented. The transgender identity scale had high reliability ($\alpha=.912$).

Social Engagement Scale

The social engagement scale, modified from work by Kippax and colleagues[28] and Fisher and colleagues[27], was designed to measure a participant's level of participation in a variety of socially based activities. Other research such as that of Kippax and colleagues[28] suggests that social engagement might be correlated to protective factors that increase health and reduce risk factors for negative outcomes. The scale collectively looks at 5 areas of social engagement: bars (for example, going to LGBT bars, clubs, circuit parties), internet (for example, chat rooms, dating), media (for example, watched LGBT TV, films), other community involvement (for example, going to Pride events, community centers, seminars), and socio-sexual engagement (for example, hooking up for sex via the internet, going to sex clubs or private sex parties).



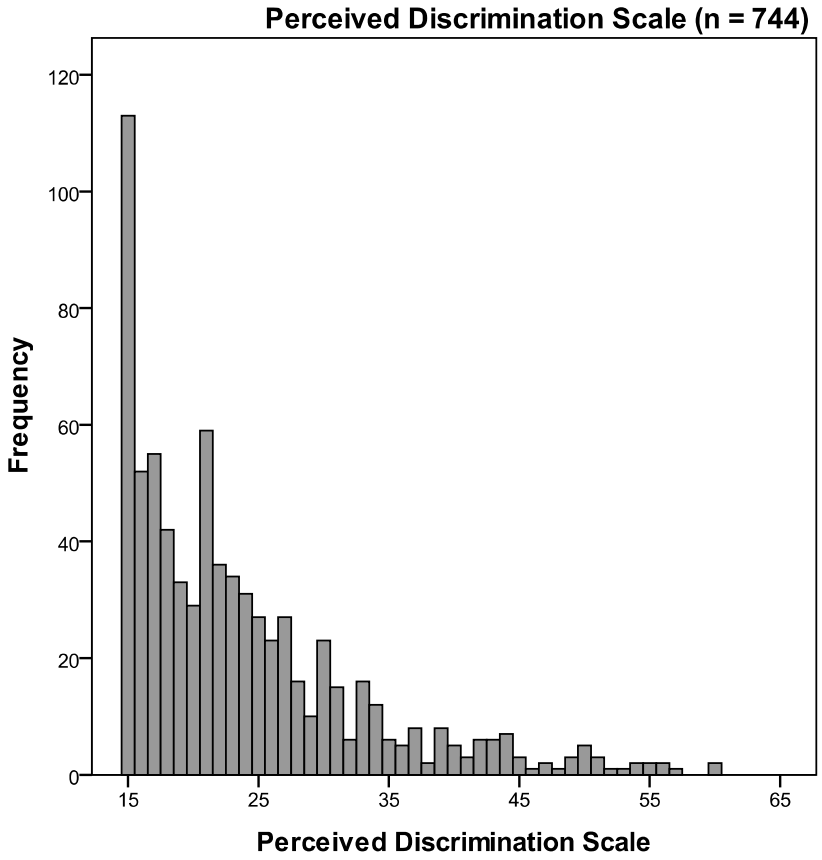
Most respondents indicated they were moderately involved with the LGBT community.

Social engagement scale scores ranged from 16 to 80, with higher scores indicating a greater degree of engagement with the LGBT community. The average social engagement score of this sample was 33 (sd =9). People who identified as transgender had a lower average social engagement score compared to people who did not identify themselves as transgender (t=-2.168, p=.030). Among transgender persons, there was no difference in average social engagement scores based on transgender identity categories. There was a difference in average social engagement scores based on geographic location; participants from the Omaha-Metro area had a higher average social engagement score than participants from rural parts of the state (F=2.937, p=.018). The social engagement scale had good reliability (α=.884).

Participants who indicated higher levels of social engagement at bars (t=3.227, p<.01), via the internet (t=2.242, p<.05), or at community events (t=2.729, p<.01) such as Pride were significantly more likely to have had an HIV test, which supports the notion that being socially engaged relates to the protective behavior of getting tested for HIV. The frequency of social engagement scores is depicted in the graph above.

Perceived Discrimination Scale

Despite the growing social acceptance regarding LGBT identities, LGBT people still constitute a stigmatized group and as such, face discrimination and marginalization at multiple levels. The chronic stress that results from stigma-related prejudice can negatively impact the well-being of LGBT individuals. Respondents' perceptions of discrimination resulting from their LGBT identity were measured using a series of fifteen statements adapted from Wright and colleagues[29], such as "someone verbally insulted or abused you" and "you were treated unfairly by employers, bosses, or supervisors." Respondents indicated how often occurrences arose (never, once, twice, or three or more times). The scale had high reliability (α=.900).

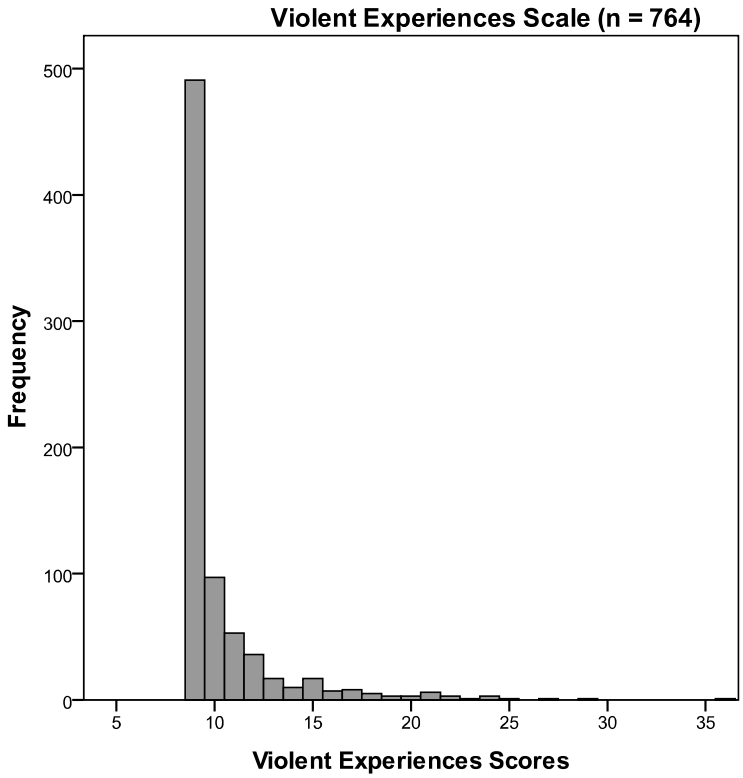


A majority of the participants in this study reported they had experienced at least some discrimination because someone perceived them to be LGBT.

Perceived discrimination scores ranged from 15 to 60; the average perceived discrimination score of the sample was 24 (sd=9). Average perceived discrimination scores did not vary based on geographic location or gender. Transgender respondents had a higher average perceived discrimination score compared to non-transgender people (t=2.882, p=.005). There was no difference in the average perceived discrimination score based on transgender identity categories. The above graph depicts frequency distribution of the perceived discrimination scores. Appendix F contains a breakdown of individual items and participant responses to discrimination questions.

Violent Experiences Scale

Violence and hate crimes directed toward LGBT people are a problem in the United States. According to the FBI Uniform Crime Report, nearly 18% of hate crimes were perpetrated because of anti-LGBT biases[44]. The Violent Experiences Scale described below was used to assess the amount of violence participants endured due to their sexual/gender minority status. Respondents indicated how frequently they experienced events including attempted or completed physical/sexual assault, robbery, vandalization, or the deliberate killing of a friend or relative. The Violent Experiences Scale was adapted from Wright and colleagues[29] and had good reliability (α=.817).

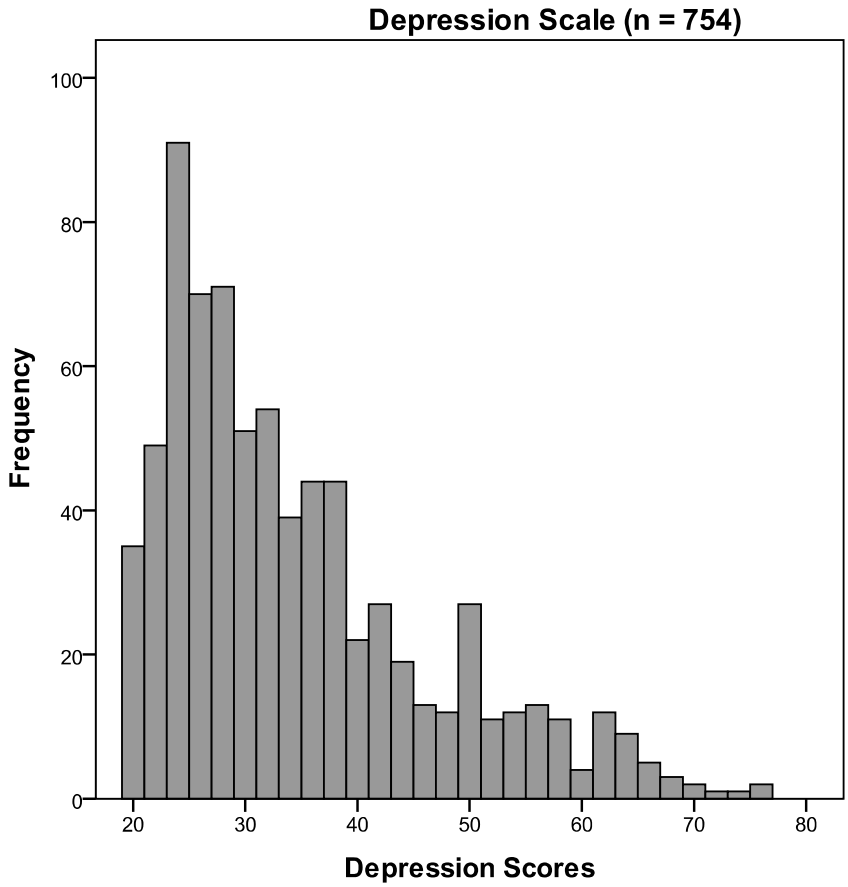


Many participants reported never experiencing violence because someone perceived them to be an LGBT person.

Perceived violence scores ranged from 9 to 36. The average score was 10 (sd=3). Males experienced more verbal abuse than females (F=4.211, p=.013). Average perceived violence scores did not vary according to age, race, geographic location, transgender status, or transgender type. The above is a graph depicts the frequency distribution of perceived violence scores; it indicates that a majority of participants did not perceive that they experienced a great deal of violence due to their LGBT status. Please see Appendix F for details regarding the forms of violence experienced by participants.

Depression Scale

Previous studies have demonstrated LGBT individuals to have higher rates of mental health problems than their heterosexual counterparts[45]. These studies do not show that being LGBT makes one mentally ill; instead the experience of marginalization in society is usually cited as the source of such mental health issues. The experiences of stress, discrimination and homophobia experienced by LGBT individuals may translate to poor mental health outcomes – specifically experiences of depression and depressive symptoms[45].



Many respondents had low depression scores.

Depressive symptoms were assessed in this study using the CES-D scale[30]. It evaluated depressive symptoms by asking participants to indicate how frequently in the past week they experienced twenty symptoms that are normally associated with depression; for example, irritability, changes in appetite, feeling depressed, having crying spells, and feeling lonely were some of the items examined in this scale. The scale has high reliability (α=.912).

The depression scale scores ranged from 20 to 76. Scores of 36 or higher usually indicate the participant is likely experiencing clinical depression. The average CES-D score of this sample was 34 (sd=12) with no variation in mean depression scores according to geographic location. The average depression score of people who identify as transgender was significantly higher than that of people who did not identify as transgender ($t=3.544$, $p<.001$) but there was no variation according to transgender category or according to gender. Depression scores reported in this study are presented in the graph above.

IV. General Health

LGBT identity is an important social determinant of health, which has been recognized by the Institutes of Medicine (IOM) which issued a report calling for research about the health of LGBT people[46] (IOM, 2011). According to the Gay and Lesbian Medical Association (GLMA), LGBT individuals are more likely than their heterosexual, non-transgender peers to develop conditions such as HIV/AIDS, obesity, some kinds of cancer, cardiovascular problems, and osteoporosis[47-49]. Similarly, LGBT populations tend to have elevated rates of smoking and alcohol consumption[1, 2].

The questions used in this study regarding general health come from the 2010 Behavioral Risk Factor Surveillance System Questionnaire (BRFSS). In this study, self-rated health, tobacco use, number of days in the last month that participants were ill, number of days in the last month that participants' illnesses interrupted normal activities, alcohol use, and drug use were used to estimate participants' overall physical health.

Key findings from the Midlands LGBT Community Needs Assessment Related to General Health:

- Most participants considered their general health to be excellent or very good (72%).
- Nearly 1 in 4 participants smoked cigarettes every day or some days.
- The average number of sick days in the last month reported by this sample was 2.2.
- Number of sick days in the last month was correlated with CES-D depression score.
- Almost half of the respondents did not experience an episode of binge drinking in the last month.
- Nearly 3 in 4 respondents had not used drugs in the last 90 days.

Self-rated health

Self-rated health was assessed in this study by asking participants to indicate how healthy they were using a scale that ranged from excellent to poor. Nearly 3 in 4 people reported that their health was very good or excellent which was considerably higher than findings from a national survey, in which only about half of the respondents reported being in very good or excellent health. Male respondents tended to rank their health higher than females, intersex individuals, and others, $\chi^2(15, 763) = 26.513$, p=.002. Transgender individuals ranked their health higher than non-transgender individuals did, $\chi^2(5, 765) = 16.907$, p=.005. General health of transgender individuals did not vary according to transgender identity category. No differences by geographic location were found.

Tobacco use

A variety of measures of tobacco use were utilized, including lifetime smoking, current smoking status, number of quit attempts in the last 12 months, length of time since a person smoked regularly, and the use of chewing tobacco.

Consistent with other research that showed tobacco use was more common in LGBT populations compared to other populations[50], the prevalence of tobacco use was higher among participants in this study compared to that of the U.S. as a whole. In the United States, about 20.6% of residents were current smokers in 2009[51]. In 2007, about one in five Nebraska residents were current smokers[52]. Over 26% of the respondents in this study indicated they smoke cigarettes and over 2% reported chewing tobacco. Of the smokers in this study, 61.9% (n = 125) smoked every day and 38.1% (n = 77) smoked some days. Smoking status was not associated with geographic location, gender, and transgender status or transgender identity category. Very few people in this sample chewed tobacco daily (n=6) or some days (n=11); about half of the people who ever chewed tobacco were from rural areas of the state.

Smoking was also measured by asking participants if they had ever smoked more than 100 cigarettes (5 packs) in their life. Although only 26.2% of the sample reported smoking cigarettes everyday or some days, nearly half of the sample (46.4%) had smoked more than 5 packs in their life. About 1 in 5 smokers in this study reported an attempt at quitting smoking in the last 12 months. Having smoked more than 5 packs of cigarettes and attempting to quit smoking were not associated with gender, geographic location, transgender status, or transgender identity category.

Number of sick days in the last month

Overall health was assessed by asking how many days during the last month participants had been ill and how many days during the last month illness kept them from doing usual activities. The average number of days that participants were sick in the last month was 2.2, which did not vary according to geographic location, transgender status, or transgender identity category. Compared to males, females reported more sick days in the last month (2.85 days compared to 1.71 days) ($t=2.739$, $p=.006$).

The number of sick days participants felt ill in the last month was positively correlated with participants' depression score ($R=.211$, $p<.001$), meaning that as depression scores increased, so did the number of sick days people reported. People who were more socially engaged in the local LGBT communities reported fewer sick days in the last month ($R=-.091$, $p=.014$).

The average number of days that participants' illness interfered with normal activities was 2.19; interference of illness with usual activities was negatively correlated with self-acceptance ($R=-.171$, $p<.001$) and outness ($R=-.143$, $p<.001$), meaning that as self-acceptance and outness scores increase, a person's likelihood of being so ill that he or she cannot perform normal tasks decreases. The average number of days that illness interfered with normal activities was positively correlated with depression ($R=.485$, $p<.001$), meaning that when depression scores were lower, the number of sick days that interrupted normal activities tended to also be lower.

Alcohol Use

Drinking among LGB populations is reportedly the highest of any social group[53]. For example, among young men ages 18-29 living in San Francisco, 17% of gay and bisexual men reported frequent or heavy drinking compared to 8% among heterosexual men. In the same study, problematic alcohol use was reported by 23% of gay and bisexual men, but only 8% of heterosexual men reported alcohol problems[54]. Similar findings have been seen for lesbian and bisexual individuals when compared to heterosexual women[55]. There is a general lack of data regarding alcohol consumption among transgender individuals. The lack of socialization among LGBT individuals outside of bar cultures has been cited as a possible explanation for the high rates of alcohol consumption, as well as a way to deal with stressors. Alcohol consumption has been found to negatively affect one's health; health problems predicted by alcohol use include neurological issues, stomach disorders, cardiovascular problems, and hormone production issues[56].

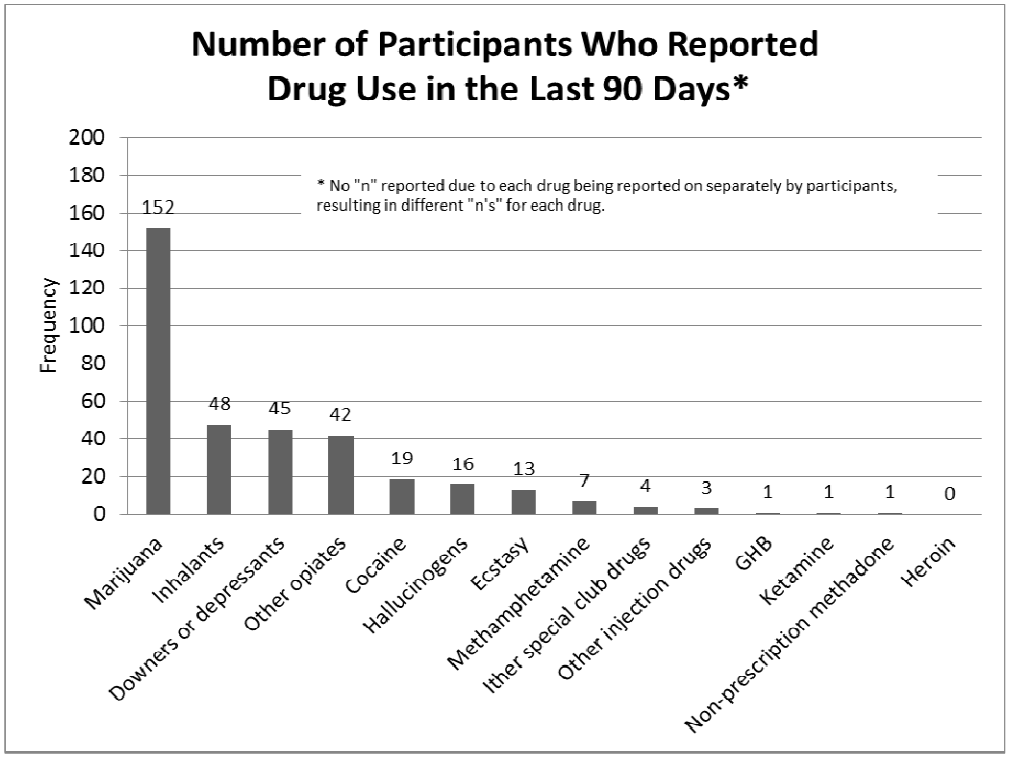
Alcohol use was assessed in this study by asking participants a number of questions about their recent drinking behaviors including if they had consumed at least one alcoholic beverage in the last 30 days, the number of days participants consumed at least one alcoholic drink in the last 30 days, the average number of drinks consumed on occasions in the last 30 days when participants drank, and the largest number of drinks consumed on one occasion. To gauge binge drinking, males and MTFs were asked the number of times they consumed more than 5 drinks on one occasion and females and FTMs were asked the number of times during the last 30 days that they consumed more than 4 drinks on one occasion.

Nearly half of the respondents in this study did not report experiencing an occasion of binge drinking in the last 30 days. Binge drinking was not associated with demographic variables including geographic location, gender, transgender status, and transgender type. Unlike other studies that have shown binge drinking to be more commonly in people who have depressive symptoms, this study did not show evidence that there was a relationship between the average number of binge drinking episodes and scores on the depression scale. These findings may be limited by the broad definition of binge drinking used in this study.

Drug Use

Previous studies have shown that LGBT populations are more likely to use drugs when compared to non-LGBT populations[54, 57, 58]. However, it is important to understand that much of this research has utilized clinical samples or has taken place in the context of understanding HIV transmission and acquisition. No known previous studies have examined drug use among a non-clinical sample of LGBT people.

Overall, very few participants reported using drugs in the last 90 days. The most commonly used drug reported by respondents was marijuana, which was used by about 20% of the sample; fewer individuals (16% of the sample) used other drugs. Consistent with other research, individuals who reported using drugs tended to have higher depression scores compared to those who did not use drugs ($t=-4.083$, $p<.001$). Further, participants who reported using drugs in the last 90 days were significantly more likely to have engaged in binge drinking on at least one occasion in the last 30 days, $\chi^2(1,595) = 23.355$, $p<.001$



V. Mental Health

In a 12 month period in the United States, approximately 26% of the adults suffer from a diagnosable mental health disorder. Of these, about 22% are classified as "severe", referring to seriously debilitating mental health problems. Overall, about 5% of the adult U.S. population could be classified as having a "severe" mental health problem in any year period[59]. For adults aged 18-65 years, in the United States, suicide is the 4th leading cause of death[60].

Key findings from the Midlands LGBT Community Needs Assessment Related to Mental Health

- Overall depression was not high, though it was significantly higher for transgender respondents.
- Almost half of the respondents in this study reported seriously considering suicide.
- The onset of suicide ideation ranged considerably, but was frequently reported during individuals' late teens or early 20s.
- Females in this study were more likely to report suicide ideation compared to others.
- Individuals who earned a relatively high income were significantly less likely to consider suicide compared to those who earned a relatively low income.
- Transgender individuals were more likely than others to report suicide ideation.

Depression

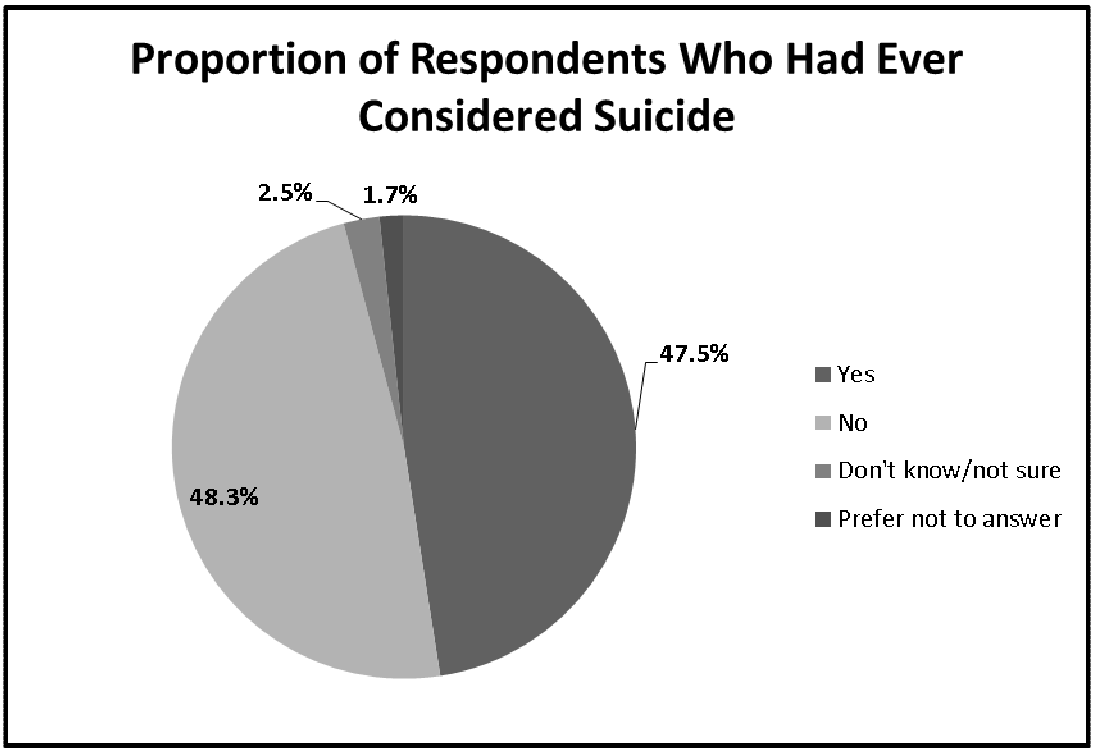
Depressive symptoms were assessed in this study using the CES-D scale, on which scores ranged from 20 to 76. The average score of the sample was 34 ($\bar{x}$ =34, sd=12). A score of 36 approximates what could probably be considered clinical depression. The average depression score of people who identify as transgender was significantly higher than that of people who did not identify as transgender (t=3.544, p<.001) but there was no variation according to transgender category or according to gender. No differences in depression scores were found based on geographic location. Additional information on depression can be found on page 23.

Suicide

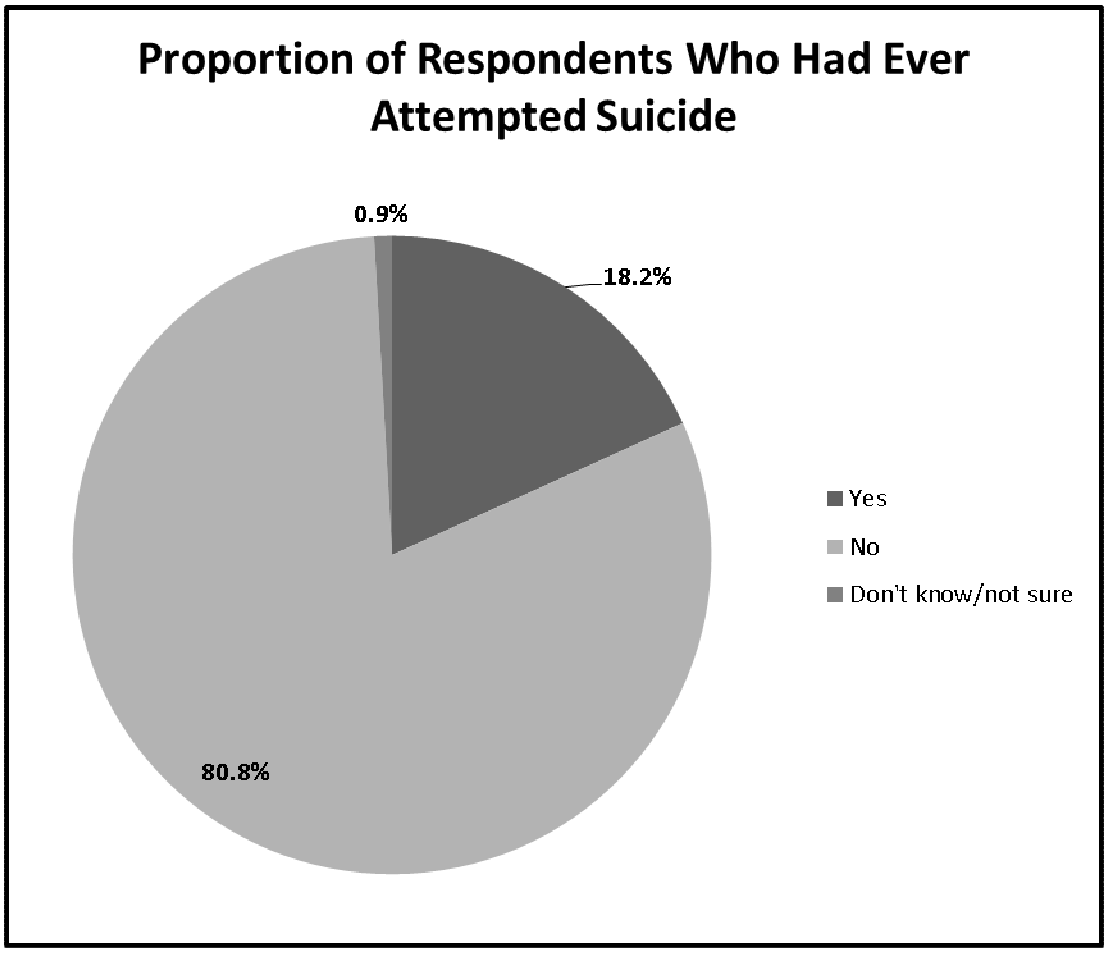
In studies of all U.S. adults, regardless of sexual orientation, approximately 3% of the population has seriously considered committing suicide within the last 12 months[59]. For serious suicidal thoughts over the lifespan, this number increased to 13% of general population with just over 4% of the general population having attempted suicide[61]. Females, individuals under the age of 25, individuals with lower educational attainment, people who report being previously married, individuals who suffer from depression, and alcoholics are more likely to think about committing suicide[61].

In national studies of LGB populations, gay and lesbian youths were 2 to 3 times more likely to attempt suicide[62] and researchers have found rates of seriously thinking about suicide as high as 41% for gay and lesbian populations[63].

In our study, nearly half of the respondents (n=366, 47.5%) had seriously considered suicide. Transgender people were more likely to report suicide ideation compared to those who were not transgender. About 2/3 of transgender participants reported they had ever considered suicide. Women were more likely to consider suicide than men, χ^2(6, 753) = 17.457, p=.008.



There was also a significant relationship between income and suicide ideation (t=-4.239, p<.001); people who reported a higher income tended to report considering suicide less frequently compared to people reporting a lower income. Suicide ideation was not associated with geographic location or other demographic variables such as race/ethnicity; about half of the sample from every racial/ethnic category considered suicide. The age at which people seriously thought about committing suicide varied considerably, ranging from 4 to 63 years. For most people who reported suicide ideation, its onset was often in the teen years and early 20s. Other studies have shown that typically, about one-third of LGBT youth report suicide ideation[7, 64, 65]; however, this sample includes people ages 19 to 70 and demonstrates that suicide ideation among LGBT individuals occurs across the lifespan.



Nearly one-fifth of participants had attempted suicide (n = 137, 18.2%). Suicide attempts were associated with income, gender, and transgender status but not geographic location. Less than 7% of participants who reported being in the highest income bracket had attempted suicide; however, nearly 40% of people who reported being in the lowest income bracket said they had attempted suicide. Women were more likely than men to have attempted suicide, $\chi^2(6, 754) = 13.373$, $p<.05$. Transgender individuals were more likely than non-transgender individuals to report attempting suicide, $\chi^2(2, 756) = 26.169$, $p<.001$. Nearly 37% of transgender participants reported having attempted suicide. There was no relationship between education, age, or race/ethnicity and suicide attempts.

VI. Sexual Health

In assessing LGBT health, STD and HIV testing behaviors and diagnosis are crucial to understanding not only the health of the community but also the success of prevention and education efforts. The following results show STD and HIV testing rates, how many people had been diagnosed with an STD or HIV, how much people know about HIV, and the relationships between HIV testing and geographic location, as well as outness.

Key findings from the Midlands LGBT Community Needs Assessment Related to Sexual Health

- Over 1 in 4 respondents had been tested for STDs in the last year and 3 in 4 had ever been tested for HIV.
- People who had a greater outness score were more likely to be tested for HIV compared to those who did not disclose their sexual orientation or gender identity to as many people.
- Overall HIV/AIDS knowledge was high among participants.

Table 2. Sexually Transmitted Diseases and HIV Rates for Study Sample*

	Total		Rural**		Lincoln-Metro**		Omaha-Metro**	
	n	%	n	%	n	%	n	%
Genital warts/HPV	65	9.3	4	5.3	11	7.4	50	10.5
Herpes	44	6.3	3	4	6	4.1	35	7.4
HIV	33	4.7	3	4.1	1	0.6	29	6.2
Hepatitis B	18	2.6	3	4.0	5	3.4	10	2.1
Hepatitis C	13	1.9	3	4	3	2	7	1.5
Gonorrhea***	12	1.7	1	1.3	7	4.7	4	0.8
Hepatitis A	10	1.4	2	2.7	3	2.0	5	1.1
Chlamydia***	8	6.5	2	2.6	2	1.4	4	0.8
Syphilis***	5	0.7	1	1.3	1	0.6	3	0.6

*Percentages are based on total number of respondents to the question

**Percentages are of based on total number of respondents to the question from that geographic location

***Data are based on being diagnosed in the last 2 years

The rates above are ONLY for this sample and should NOT be seen as representative of all LGBT persons. The most prevalent sexually transmitted infections for this sample were genital warts/HPV, herpes, and HIV, in that order. Least common were Chlamydia and syphilis. Many participants in this study indicated they had been tested for HIV in their lifetime (70.5%). Further, over 1 in 4 respondents had been tested for STDs in the last year. HIV and STD testing services were most frequently accessed at county health departments, health clinics, and AIDS services organizations.

HIV Testing

People from the Omaha-Metro area were significantly more likely than participants from Lincoln-Metro and other areas of Nebraska to have ever been tested for HIV, $\chi^2(1, 646) = 15.221$, $p<.001$. Not surprisingly, men were more likely than women to have been tested for HIV, $\chi^2(3, 761) = 20.180$, $p<.001$. Transgender participants were also more likely than non-transgender persons to have been tested for HIV, $\chi^2(1,763) = 12.430$, $p<.001$. For those who had been tested for HIV, more than half had been tested more than a year ago. Table 3 details when people were last tested for HIV.

Table 3. Last time tested for HIV for those who have been tested (n = 530)

	Total	
	n	%
Within the last 3 months	82	15.5
3-6 months ago	62	11.7
6 months to a year ago	77	14.5
More than a year ago	309	58.3

For participants who had not been tested, the two most common reasons indicated were a perception of no risk and/or no infection; table 4 details all reasons measured. Participants answering this question were asked to indicate all reasons that applied to them.

Table 4. Reasons for not having had an HIV test

	Total
	n
I'm not doing anything risky that could give me HIV	127
I don't think I have HIV	110
I just haven't gotten around to it	31
I don't know where to go get tested	21
I don't have the money or resources, like transportation, to get to a testing site	16
I'm afraid to find out the results	13
I'm afraid of needles	9
I'm afraid of the test itself	7
I'm afraid someone will find out I got tested	6

There was a positive relationship between HIV testing and outness scores, $\chi^2(1, 761) = 23.523$, $p<.001$, meaning that people who told more of their friends, family, co-workers, and acquaintances about their LGBT identity were more likely to be tested for HIV.

HIV/AIDS Knowledge

Overall, participants were well-educated about HIV. The HIV Knowledge Scale, on which scores ranged from 0 to 18, was used to assess how much participants knew about transmission and acquisition of HIV. Participants were asked to agree or disagree with statements such as "coughing and sneezing DO NOT spread HIV" and "all pregnant women infected with HIV will have babies born with AIDS." The average score for this sample was about 16 ($\bar{x}$ =15.7, sd= 2.6). Participants who had been tested for HIV had a higher average HIV Knowledge scale score compared to those who had not been tested (t=-4.812, p<.001).

Drug Use Before/During Sex

Virtually none of the participants in this study indicating drug use before or during sex. The only reported use in conjunction with sex was marijuana (n = 30, 3.9%) and inhalants (for example, poppers; n = 15, 1.9%) All other reported drug use related to sex was negligible (3 participants or less).

Other Sexual Health

As with many surveys of this nature, space was limited. Therefore we focused on sexual health topics that were brought up as most important to our community partners. There were several important aspects of sexual health that were also seen as important by both community partners and the research team. Concepts such as sexual behaviors (including condom use), pleasure and satisfaction, and more detailed questions pertaining to relationships were not asked in this survey. However, it is the belief of the MSHRC that all of these components of sexual health are important to develop a robust and ecologically broad understanding of an individual's and a community's sexual health. It is our hope that future studies can incorporate such ideas. In the meantime, if you are interested in these topics, we are happy to refer you to other studies which have explored these areas of sexual health nationally and in specific regions of the country.

VII. Social and Community Health

Many experts agree that the health and well-being of any individual is not only based on individual behaviors, but the contextual factors surrounding that individual. It has been suggested that things like being socially engaged in a community can have many health benefits[27, 28]. Further, it has been suggested that the level of empowerment a person feels towards their life, the organizations they belong to, and the communities they are a part of can not only be indicative of the success of all three, but to the community's overall health and well-being[18]. In order to mobilize for action to improve the physical, mental, social, and sexual health of a community, it is important to map out the health-related concerns and resources as well as identify the issues which have the most support.

Key Findings from the Midlands LGBT Community Needs Assessment Related to Social and Community Health

- Overall social engagement was moderate with differences based on geography and gender identity.
- Most participants identified at least one LGBT-related organization which they engaged with in the past year.
- While individual perceived empowerment was relatively high, community and organizational empowerment were somewhat low.
- A wide range of health-related issues were a concern for LGBT Midlanders with sexual health related issues topping the list.
- Policy issues of importance for the community varied with marriage equality topping the list, followed by ENDA, safe schools, and HIV/AIDS.
- Most participants agreed the community would benefit from a resource-rich organization dedicated to the needs of the community, but that such an organization was not clearly identifiable.

Social Engagement

As described in the Respondent Characteristics section (page 20), social engagement was examined as a multi-faceted concept which included bars (for example, going to LGBT bars, clubs, circuit parties), internet (for example, chat rooms, dating), media (for example, watched LGBT TV, films), other community involvement (for example, going to Pride events, community centers, seminars), and socio-sexual engagement (for example, hooking up for sex via the internet, going to sex clubs or private sex parties). In addition to general findings of the social engagement scale found on page 20, a more detailed analysis showed participants living in Omaha and Lincoln metro areas were significantly more likely than those living in more rural parts of the state to be socially engaged in bar and internet activities ($p<0.01$). Omaha metro participants were also more likely than those in non-metro areas to be involved in other community events such as Pride ($p<0.01$). Transgender participants were less likely than non-transgender persons to be engaged in bar ($p<0.01$), socio-sexual ($p<0.01$), and media activities ($p<0.05$).

Community Empowerment

Community empowerment was measured using a scale developed by Israel and colleagues[18]. The scale looked at perceived control at the individual, organizational, and community levels. For perceived control at the organizational level, participants were asked to identify an LGBT serving organization in which they were involved. A majority of participants (n = 694, 90.1%) identified at least one LGBT-related organization in which they were involved. A vast range of organizations were identified, with the majority being related to university groups, religious institutions, sports leagues, professional groups, and health-related organizations. Most

participants (n = 580, 75.4%) felt they had sufficient individual control over their own lives. However, many participants felt they had little perceived control of what happened at the LGBT organization they were involved in (n = 296, 68.5%). Many also expressed low empowerment at the community level (n = 515, 78.6%). Men were significantly more likely to indicate slightly higher levels of community level empowerment (t=2.196, p=.028). Transgender respondents were significantly more likely to indicate slightly lower levels of individual empowerment (t=-3.509, p<.01). No differences in community empowerment were found at the geographic level.

Community Concerns

Two questions in the survey asked participants to indicate their level of concern on a range of issues and the top three policy issues important for the community to address. The figures below show the details of the results of these questions. Topics of concern for the community, predominantly, were centered around sexual health, followed by alcohol use and drinking and driving, as well as hate crimes and emotional and mental health. Politically, LGBT Midlanders were closely aligned with national priorities of marriage rights, as well as a priority around the Employment Non-Discrimination Act (ENDA) which currently does not exist for the state. Although the state has a no bullying policy for Nebraska schools, many were still concerned with improving the safety of schools for LGBT youth. Due to the robust nature of data collected on community concerns, analyses by geography and transgender identity are on-going and will be reported at a later date.

Table 5. Community Concerns on Health -related Topics

For the LGBT community in Nebraska, please select the category that describes the level of concern for each topic below.	A Great Concern	A Concern	Not much of a Concern	Not a Concern at all
HIV/AIDS	**52.1%**	**37.5%**	**8.2%**	**2.2%**
Safer Sex	**48.6**	**40.7**	**8.4**	**2.3**
Emotional/Mental Health	**47.9**	**35.3**	**13.8**	**3.0**
Other STDs	**46.8**	**42.7**	**8.5**	**2.1**
Hate Crimes/Bias	**41.9**	**36.3**	**17.2**	**4.5**
Drinking and Driving	**39.1**	**38.5**	**16.1**	**6.3**
Illegal Drugs	**37.0**	**38.5**	**17.1**	**7.3**
Alcohol	**33.5**	**36.5**	**21.8**	**8.3**
Relationship Violence	**25.7**	**40.3**	**26.5**	**7.5**
Prescription Drug Misuse	**23.2**	**40.2**	**27.0**	**9.5**
Tobacco	**19.7**	**34.3**	**29.5**	**16.5**
Cancer	**18.1**	**41.4**	**31.4**	**9.1**
Nutrition/Physical Activity	**16.8**	**41.4**	**33.4**	**8.4**
Chronic Disease	**15.5**	**36.1**	**36.8**	**11.5**

Table 6. Top Policy Issues

Policy	%	Policy	%
Marriage	**71.0**	**Hate Crimes**	**22.7**
ENDA	**50.5**	**Transgender rights**	**14.0**
HIV/AIDS	**29.6**	**Military**	**13.9**
Safe Schools	**29.0**	**LGBT public services**	**9.1**
Adoption/Foster rights	**24.7**	**Income security**	**7.5**
Access to health care	**23.4**	**Immigration**	**3.0**

Community Resources

A majority of participants (n = 653, 88.4%) agreed that the LGBT community in their area would benefit from an organization that could provide community resources, provide referrals for services, coordinate educational and social events, and help bring the community together to increase awareness and social justice. However, most (n = 423, 71.1%) indicated that such organizations did not exist in their community. Many indicated a need for such an organization (n = 359, 66.6%). Participants outside of the Lincoln and Omaha metro area were more likely to indicate that such an organization did not exist, χ^2 (6, 547) = 23.913, p=.001. No other differences were found based on geographical location or gender identity.

VIII. Health Care

Appropriate access to healthcare, is an important step in achieving healthy populations. Health insurance, culturally competent care, and feelings of trust with healthcare providers (HCP) are crucial to quality of health. Individuals without health insurance coverage receive less medical care and have worse health outcomes when compared to individuals with health care coverage[46]. Coming out to one's HCP is an important step in receiving appropriate care[66], though LGBT individuals may not feel safe due to fear of negative reactions from providers[67].

Key findings from the Midlands LGBT Community Needs Assessment Related to Healthcare

- About half of the respondents were out to their healthcare providers.
- Over 80% of the sample reported having some kind of healthcare coverage, but transgender individuals were less likely than others to have insurance.
- People from the Omaha-Metro area who are out to their healthcare providers were more likely to have had an STD test in the last year compared to those who are not out to their providers.
- About 1 in 3 respondents indicated that there was a time in the last year that they could not visit a doctor when they wanted to due to the expense.
- Transgender people were more likely than others to see a mental health care professional.

Outness to Health Care Provider (HCP)

In this study, about half of the participants were out to their healthcare providers. The probability of being out to one's healthcare provider varied by geographic location, with respondents from Omaha being most likely to disclose their sexual/gender identity and respondents from rural areas of the state being least likely to do so, $\chi^2(6, 731) = 18.908$ p=.004.

The proportion of participants who were out to their providers did not vary between transgender individuals and those who do not identify themselves as transgender. However, people who consider themselves to be genderqueer were less likely to be out to their healthcare providers compared to transmen and transwomen, $\chi^2(6, 91) = 13.014$, p=.043.

Of the people who indicated they were not out to their providers (n=267), nearly half did not believe that sexual orientation and gender identity had any bearing on health. Participants from Omaha were the least likely to believe that their sexual/gender identity was not any of the healthcare provider's business. Respondents from rural areas were the most likely to be concerned about being refused service and to be concerned that their healthcare provider would tell others about their sexual orientation/gender identity.

Table 7. Reasons for not coming out to healthcare provider	Total	
	n	%
My sexual orientation/gender identity is none of their business	155	20.1
My sexual orientation /gender identity has no bearing on my health	199	25.8
My healthcare provider might be uncomfortable with my sexual orientation/gender identity	124	16.1
My healthcare provider might tell other people of my sexual orientation/gender identity	44	5.7

Many participants indicated they were fearful that by disclosing their sexual orientation/gender identity, they would make their healthcare provider uncomfortable, refuse to serve them, or inform others of their sexual orientation/gender identity. Given the impact of LGBT status on individuals' health and the benefits that being out to one's provider can have, it is important that healthcare providers foster LGBT-friendly environments.

Participants who are out to their healthcare providers differ from those who are not out to their providers in terms of their average social-engagement, self-acceptance, depression, and outness scores. People who are out to their healthcare providers are also more likely be out to other people in their lives including friends, employers, family, co-workers, and employers (F=128.077, p<.001). Further, individuals who are out to their HCP are less likely to display depressive symptoms compared to people who are not (F=18.045 p<.001).

People who are out to their HCP have a higher average self-acceptance score (F=33.908 p<.001) and higher average social engagement score (F=6.351 p=.02) compared to those who are not out to their HCP. However, the average social engagement scores of people who do not know if they are out to their HCP and people who are out to their HCP do not differ significantly from one another.

Other research indicates that outness to provider is associated with being tested for STDs and HIV[68]. In this study, being tested for STDs and being out to one's HCP were not associated for participants from the Lincoln-Metro area and those from rural areas of the state. However, of participants from the Omaha-Metro area, those who are out to their provider were more likely to have been tested for STDs in the past year compared to those who are not out to their HCP, χ^2 (2.953, p=.228). Similarly, of the participants from the Omaha-Metro area, outness to HCP was also associated with being tested for HIV, χ^2(2, 497) = 37.212, p<.001, but this association was not present among participants from the Lincoln-Metro or those from rural areas of the state.

Health Insurance

In 2009, about 84% of Americans had health insurance[69]. Most people in this study (82.2%) reported having some kind of healthcare coverage such as insurance, HMOs, or Medicare. However, significant disparities exist. For example, nearly 30% of individuals who identify as transgender or gender nonconforming reported not having any kind of healthcare coverage while only 15% of people who did not identify as transgender or gender nonconforming did not have healthcare coverage; this illustrates a significant disparity in healthcare coverage, χ^2(2, 764) = 13.411, p=.001. Similarly, respondents from the Omaha-Metro and Lincoln-Metro areas were more likely to be insured compared to people living in other parts of the state, χ^2(6, 731) = 13.130, p=.009. About 84% of

participants from the Omaha-Metro and Lincoln-Metro areas had some kind of insurance, while only 73% of participants from rural areas of the state had insurance.

Health Care Access

Given that a relatively large proportion of the sample did not have healthcare coverage, it was not surprising that nearly 30% of the respondents experienced a time in the last 12 months in which they could not see a doctor because of the cost. One quarter of non-transgender respondents experienced a time in the last year in which they had to forego visiting a doctor due to the cost; however, that proportion is significantly lower than the 40% of transgender individuals who experienced the same, $\chi^2(2, 765) = 10.996$, $p=.004$.

Many people in this sample saw a physician/nurse provider (87%), dentist (67%), and/or a mental health practitioner (31%) in the last year. Transgender participants were more likely than others to report seeing a mental health care provider in the last year, $\chi^2(2, 762) = 61.005$, $p<.001$; however, this result was likely due to needing to see mental health professionals in order to receive other transgender-related medical procedures.

Fewer people utilized the services of case managers (4.3%), housing assistance professionals (3%), substance abuse treatment professionals (2.5%), and/or treatment education professionals (1%). Transgender individuals in this sample were more likely than others to seek the services of housing assistance professionals, $\chi^2(2, 762) = 9.404$; $p=.009$.

IX. Conclusions and Recommendations

The Midlands LGBT Community Needs Assessment was the first known comprehensive study of lesbian, gay, bisexual, and transgender health for those who live, work, and 'play' in the state of Nebraska. This study of general physical, mental, social, and sexual health provides a rich source of data for organizations serving the LGBT community as well as new information for advancing the understanding of LGBT communities in a Midwestern, predominately rural state.

Though the findings of the study are limited to those who responded to the survey and not representative of all LGBT persons in Nebraska, the large sample size allows for some conclusions and recommendations. Thus, it is our hope that this report provides information to assist community leaders as they move forward in creating and expanding services to address the needs of the community. A list of all key findings from the report is included at the end of this section.

Physical Health Recommendations

Most participants rated their general health as very good to excellent, had relatively low numbers of sick days, and reported relatively normal levels of alcohol use (which was not related to depression). However, respondents indicated that alcohol use and drinking and driving were important issues to address. Similar to findings from other studies, smoking rates were considerably higher than those of the general population. To improve the physical health of LGBT Midlanders, we recommend community leaders and others to:

- Develop strategies to address the disproportionate rates of smoking reported by LGBT Midlanders.
- Encourage Health Care Providers to discuss smoking reduction/cessation strategies with LGBT patients who smoke.
- Seek resources to develop smoking reduction/cessation programs for LGBT Midlanders.
- Continue to encourage responsible use of alcohol.
- Create community-based programs and messages about drinking and driving.
- Offer safe and affordable transportation options for intoxicated individuals.

Mental Health Recommendations

Survey respondents from the Midlands LGBT community showed resiliency to depression commonly associated with social stigma, internalized homophobia/transphobia, and discrimination. Reported levels of depression were not high. However, a significant minority of participants experienced symptoms that may be associated with clinical depression. Participants' reported rates of suicide ideation and suicide attempts across all ages were alarmingly high in this study. For community organizations interested in improving mental health and related outcomes for LGBT Midlanders, we recommend that they:

- Design messages and community-based programs specifically for LGBT Midlanders that raise awareness about the importance of good mental health.
- Develop relationships across multiple fields, such as business, government, and health care, to address suicide ideation among LGBT Midlanders.
- Create anti-stigma campaigns to reduce the environmental stressors that contribute depression and suicide ideation for LGBT Midlanders.

Sexual Health Recommendations

Self-reported rates of sexually transmitted diseases were relatively low, although testing rates for such infections were also low. This finding is interesting considering the high level of community concern around STDs. Conversely, HIV testing rates were considerably high, especially compared to general population testing rates. It appears that HIV testing campaigns (for example, 'Know Your Status') are working within the LGBT community. Self-reported HIV infection rates were commiserate with Nebraska statistics. HIV/AIDS knowledge among this sample was very high which suggests that long-term HIV/AIDS knowledge campaigns in the LGBT community have been successful. Very few participants indicated drug use before or during sexual activity. This finding is not surprising given the relatively low levels of general drug use reported in this sample; however, it should again be noted this is not a representative sample – segments of the LGBT community prone to higher rates of drug use may not have taken the survey. Given this information, we recommend community organizations and others:

- Seek resources to develop culturally competent STD testing campaigns for LGBT persons.
- Create messages and community-based programs about what constitutes risk for HIV.
- Continue educational efforts around HIV/AIDS and testing campaigns.
- Develop outreach to transgender populations to increase awareness, testing, and treatment of STDs and HIV.
- Promote anti-stigma messages to facilitate increased acceptability, accessibility, and availability of STD and HIV testing opportunities.

Social and Community Health Recommendations

Not surprisingly, levels of social engagement for this sample of LGBT persons were only moderate. Given the small overall population of Nebraska, with only two metropolitan areas closely situated to each other (Lincoln and Omaha), few resources exist for the LGBT community. Thus, opportunities for LGBT persons to engage in social activities specifically designed for the community, particularly in more rural parts of the state are limited. Despite only moderate levels of engagement, a wide variety of LGBT organizations were identified (for example, sports leagues, religious institutions, professional and student groups). For the organizations identified, participants reported low levels of empowerment. In other words, many individuals did not feel a sense of control to help guide the direction and growth of the LGBT organization with which they were involved and more generally the LGBT community.

Beyond engagement and empowerment related to community organizations, perhaps most telling were the multiple relationships to "outness." Generally speaking, the more out individuals were to a myriad of social and familial circles, the more likely they were to demonstrate healthful behaviors (for example, getting tested for HIV). We recommend that community leaders and organizations:

- Create inter-organizational networking opportunities to maximize resources and services provide to LGBT Midlanders.
- Develop coalitions focused on top policy issues identified in this study with a focus on how such changes can improve the health and well-being of LGBT Midlanders.
- Develop a sustained anti-stigma campaign to reduce environmental barriers that prevent LGBT Midlanders from coming out to more people with a focus on the multiple health benefits of being out.

Health Care Recommendations

Although many participants had health insurance and access to health care, others had to forgo health care due to cost. This finding is not unlike experiences of the general population. Transgender respondents were the most likely not to have health insurance. While some survey respondents were out to a HCP, others were not. Many cited a belief that it was not relevant to their health care needs. However, several other studies have documented the unique health issues for LGBT, including breast cancer, colorectal cancer, and as documented in this study, higher smoking rates. Like being out to social and familial circles, being out to a HCP was associated with better health outcomes. Organizations dedicated to the health of LGBT Midlanders should, based on this study:

- Create curricula to educate health care providers on creating a safe and welcoming environment for LGBT patients.
- Develop messages and community-based programs to educate LGBT Midlanders on the importance of being out to their health care providers.
- Continue to develop a robust network of resources for transgender Midlanders that facilitates improved access to health care, both financially and with regards to culturally appropriate care.

Below is a summary of all the key findings found in the report.

General Findings

- Most of the survey respondents were white, well-educated, employed, and had a relatively high income.
- About 1 in 3 participants were female; roughly 60% were male; very few indicated they were intersex or identified their gender as 'other.'
- Twelve percent of respondents were transgender.
- The age of participants ranged from 19 to 79 years; the average age was 36 years.
- A majority of respondents lived in the Omaha-Metro area (68%) or in the Lincoln-Metro area (20%). About 10% of participants were from rural areas of the state.
- Many participants in this study were either legally married to or exclusively dating a member of the same sex (46%). Very few were single and dating more than one person (6%).

Physical Health Findings

- Most participants considered their general health to be excellent or very good (72%).
- Nearly 1 in 4 participants smoked cigarettes every day or some days.
- The average number of sick days in the last month reported by this sample was 2.2.
- Number of sick days in the last month was correlated with CES-D depression score.
- Almost half of the respondents did not experience an episode of binge drinking in the last month.
- Nearly 3 in 4 respondents had not used drugs in the last 90 days.

Mental Health Findings

- Overall depression was not high, though it was significantly higher for transgender respondents.

- Almost half of the respondents in this study reported seriously considering suicide.
- The onset of suicide ideation ranged considerably, but was frequently reported during individuals' late teens or early 20s.
- Females in this study were more likely to report suicide ideation compared to others.
- Individuals who earned a relatively high income were significantly less likely to consider suicide compared to those who earned a relatively low income.
- Transgender individuals were more likely than others to report suicide ideation.

Sexual Health Findings

- Over 1 in 4 respondents had been tested for STDs in the last year and 3 in 4 had ever been tested for HIV.
- People who had a greater outness score were more likely to be tested for HIV compared to those who did not disclose their sexual orientation or gender identity to as many people.
- Overall HIV/AIDS knowledge was high among participants.

Social and Community Health Findings

- Overall social engagement was moderate with differences based on geography and gender identity.
- Most participants identified at least one LGBT-related organization which they engaged with in the past year.
- While individual perceived empowerment was relatively high, community and organizational empowerment were somewhat low.
- A wide range of health-related issues were a concern for LGBT Midlanders with sexual health related issues topping the list.
- Policy issues of importance for the community varied with marriage equality topping the list, followed by ENDA, safe schools, and HIV/AIDS.
- Most participants agreed the community would benefit from a resource-rich organization dedicated to the needs of the community, but that such an organization was not clearly identifiable.

Health Care Findings

- About half of the respondents were out to their healthcare providers.
- Over 80% of the sample reported having some kind of healthcare coverage, but transgender individuals were less likely than others to have insurance.
- People from the Omaha-Metro area who are out to their healthcare providers were more likely to have had an STD test in the last year compared to those who are not out to their providers.
- About 1 in 3 respondents indicated that there was a time in the last year that they could not visit a doctor when they wanted to due to the expense.
- Transgender people were more likely than others to see a mental health care professional.

X. Appendices

Appendix A

Gender, Transgender Status, and Sexual Orientation								
	Total*		Rural		Lincoln-Metro		Omaha-Metro	
	n	%	n	%	n	%	n	%
Gender								
Male	457	59.7	49	6.4	79	10.3	300	39.2
Female	283	37	25	3.3	60	7.8	183	23.9
Intersex	3	0.4	0	0	0	0	3	0.4
Other	22	2.9	1	0.1	10	1.3	10	1.3
Total	**765**	**100**	**75**	**9.8**	**149**	**19.4**	**496**	**64.8**
Transgender Identity Category								
M to F/Transwoman	42	5.5	5	0.7	9	1.2	21	2.7
F to M/Transman	21	2.7	1	1	8	1	12	1.6
Genderqueer/gender non-conforming	24	3.1	1	1	7	0.9	16	2.1
Other	5	0.7	1	1	1	0.1	3	0.4
Total	**92**	**12**	**8**	**1**	**25**	**3.2**	**52**	**6.8**
Sexual orientation								
Heterosexual/straight	22	2.9	2	0.3	6	0.8	8	1
Homosexual/gay/lesbian	578	75.2	55	7.2	93	12.1	396	51.5
Bisexual	123	15.9	16	2.1	33	4.3	70	9.1
Unsure/questioning	6	0.8	0	0	2	0.2	3	0.4
Other	40	5.2	2	0.3	15	2	22	2.9
Total	**769**	**100**	**75**	**9.8**	**149**	**19.4**	**499**	**64.9**

*The total column may not reflect the values contained in the Rural, Lincoln-Metro, and Omaha-Metro columns due to missing data

Appendix B

Age, Race, and Ethnicity								
	Total*		Rural		Lincoln-Metro		Omaha-Metro	
	n	%	n	%	n	%	n	%
Age range								
19	29	3.8	3	0.4	11	1.5	12	1.6
20-29	273	36.1	30	4.0	63	8.3	162	21.4
30-39	173	22.9	13	1.7	32	4.2	122	16.1
40-49	146	19.3	14	1.9	15	2.0	112	14.8
50-59	88	11.6	11	1.5	15	2.0	58	7.7
60-69	45	6	4	0.5	9	1.2	29	3.8
70-79	2	0.3	0	0	2	0.3	0	0
Total	**756**	**100**	**75**	**10**	**147**	**19.4**	**495**	**65.5**
Race								
White	718	94.6	73	9.6	141	18.6	462	60.9
Black or African American	17	2.2	0	0	1	0.1	15	2
Asian	7	0.9	1	0.1	3	0.4	2	0.3
American Indian/Alaska Native	6	0.8	0	0	1	0.1	5	0.7
Multi-racial	8	1.1	0	0	3	0.4	4	0.5
Other	3	0.4	0	0	0	0	3	0.4
Total	**759**	**100**	**74**	**9.7**	**149**	**19.6**	**491**	**64.7**
Ethnicity								
Hispanic/Latino	37	4.8	3	0.4	9	1.2	23	3.2

*The total column may not reflect the values contained in the Rural, Lincoln-Metro, and Omaha-Metro columns due to missing data

Appendix C

Education, Income, and Employment Status								
	Total*		Rural		Lincoln-Metro		Omaha-Metro	
	n	%	n	%	n	%	n	%
Education								
High School/GED	50	6.6	11	1.5	7	0.9	23	3.0
Some college	224	29.7	27	3.6	51	6.8	137	18.1
2 year college degree	54	7.2	7	0.9	6	0.8	35	4.6
Bachelors degree	229	30.3	10	1.3	40	5.3	168	22.3
Masters degree	141	18.7	11	1.5	34	4.5	93	12.3
Professional (PhD, MD, JD)	37	4.9	2	0.3	6	0.8	26	3.4
Other	20	2.6	4	0.5	4	0.5	20	2.6
Total	**755**	**100**	**72**	**9.5**	**148**	**19.6**	**502**	**66.5**
Income								
Less than $10,000	89	12.6	15	2.1	27	3.8	37	5.3
$10,001 - $20,000	91	12.9	13	1.8	30	4.3	45	6.4
$20,001 - $35,000	123	17.5	8	1.1	24	3.4	85	12.1
$35,001- $50,000	129	18.3	19	2.7	20	2.8	85	12.1
$50,001 - $75,000	109	15.5	9	1.3	15	2.1	83	11.8
$75,001 or more	163	23.2	3	0.4	23	3.3	128	18.2
Total	**704**	**100**	**67**	**9.5**	**139**	**19.7**	**463**	**65.8**
Employment								
Employed for wages	553	59.9	46	5	107	11.6	379	41.1
Self-employed	53	5.7	5	0.5	4	0.4	39	4.2
Out of work > 1 year	28	3	2	0.2	6	0.7	17	1.8
Out of work < 1 year	42	4.6	7	0.8	6	0.7	26	2.8
Homemaker	9	1	2	0.2	0	0	6	0.7
Student	190	20.6	16	1.7	64	6.9	94	10.2
Retired	28	3	2	0.2	4	0.4	18	2
Unable to work	20	2.2	7	0.8	4	0.4	9	1
Total	**923****	**100**	**87**	**9.4**	**195**	**21.1**	**588**	**63.7**

*The total column may not reflect the values contained in the Rural, Lincoln-Metro, and Omaha-Metro columns due to missing data

** Total exceeds sample size as participants could select multiple items for employment.

Appendix D

Relationship Status and Number of Children								
	Total*		Rural		Lincoln-Metro		Omaha-Metro	
	n	%	n	%	n	%	n	%
Relationship status								
Legally married to same-sex partner	55	9	2	0.3	6	0.8	45	5.9
Legally married to opposite-sex partner	41	4.4	5	0.7	10	1.3	22	2.9
Dating exclusively someone of the same sex	296	41.2	26	3.4	49	6.4	205	26.7
Dating exclusively someone of the opposite sex	32	3.6	2	0.3	11	1.4	18	2.3
Divorced, not partnered	29	3.6	2	0.3	8	1	18	2.3
Widowed, not partnered	2	0.4	0	0	0	0	2	0.3
Single, dating more than one person	43	4.6	7	0.9	11	1.4	23	3
Single, not dating	235	28.1	28	3.7	50	6.5	140	18.3
Other	34	5	3	0.4	4	0.5	25	3.3
Total	**767**	**100**	**75**	**9.8**	**149**	**19.4**	**498**	**64.9**
Have children under 18 years of age?								
Yes	102		7		16		76	
How many children?								
1	48	53.3	3	3.3	8	8.9	35	38.9
2	26	28.9	2	2.2	4	4.4	19	21.1
3	12	13.3	2	2.2	2	2.2	8	8.9
4	3	3.3	0	0	0	0	3	3.3
11	1	1.1	0	0	0	0	1	1.1
Total	**90**	**100**	**7**	**7.8**	**14**	**15.6**	**66**	**73.3**

*The total column may not reflect the values contained in the Rural, Lincoln-Metro, and Omaha-Metro columns due to missing data

Appendix E

Housing and Citizenship Status								
	Total*		Rural		Lincoln-Metro		Omaha-Metro	
	n	%	n	%	n	%	n	%
Housing status								
Rent apartment/house	313	41.5	19	2.5	87	11.5	191	25.3
Own home	296	39.3	29	3.8	43	5.7	209	27.7
Residential treatment facility	2	0.3	0	0	0	0	2	0.3
Live with friends (no rent)	3	0.4	0	0	0	0	2	0.3
Live with partner (no rent)	36	4.8	4	0.5	5	0.7	25	3.3
Live with family	60	8.0	12	1.6	7	0.9	34	4.5
Other	44	5.8	8	1.1	6	0.8	29	3.8
Total	**754**	**100**	**72**	**9.5**	**148**	**19.6**	**492**	**65.3**
Citizenship								
US citizen	745	98.2	70	9.2	143	18.8	488	64.3
Legal resident	7	0.9	1	0.1	1	0.1	5	0.7
Non-immigrant visa holder	3	0.4	0	0	3	0.4	0	0
Prefer not to answer	4	0.5	1	0.1	1	0.1	1	0.1
Total	**759**	**100**	**72**	**9.5**	**148**	**19.5**	**494**	**65.1**

*The total column may not reflect the values contained in the Rural, Lincoln-Metro, and Omaha-Metro columns due to missing data

Appendix F

One or more instances of perceived discrimination because of LGBT Status		
	Total	
	n	%
Form of Discrimination		
Someone called you a derogatory name like fag, queer, dyke, etc.	564	73.7
Someone verbally insulted or abused you	545	71.2
Someone threatened you with violence	302	39.5
You were treated unfairly by coworkers	254	33.6
You were discriminated against in a job	230	30.7
You were treated unfairly by employers, bosses, supervisors	218	29.0
You were treated unfairly by neighbors	195	25.6
Someone chased or followed you	180	23.4
You were treated unfairly by institutions like schools or the courts	170	22.3
Someone threw an object at you	149	19.5
You were treated unfairly by people in helping jobs, like doctors	147	19.3
You were discriminated against for services	128	16.8
You were treated unfairly by teachers and/or professors	116	15.2
Someone spit on you	96	12.5
You were discriminated again for housing	61	8.0

One or more instances of violence experienced because of LGBT Status		
	Total	
	n	%
Form of violence		
Participants' property was purposely damaged or vandalized	171	22.4
Participant was hit, beaten, or physically attacked	118	15.4
Someone attempted to assault participant	115	15.0
Participants' property was stolen, as in a break-in, burglary, or theft	69	8.9
Participant was raped or sexually assaulted	62	8.1
Someone attempted to sexually assault participant	40	5.3
Someone attempted to steal or vandalize participants' property	39	5.1
Participant was robed, as in a holdup or mugging	33	4.3
Participant saw a friend or relative deliberately killed or murdered	11	1.5

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