

EXECUTIVE SUMMARY¹

We sought to obtain data from gay, lesbian, bisexual, transgender, queer, and questioning (GLBTQ/Q) young adults in Maine ages 18-25. When we planned this project, very little data existed on the physical and mental health of this population in Maine. National data suggests there may be substantial need for services. Given the rural nature of Maine and the limited number of social service and health care providers, it is essential that all providers take steps to ensure that lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQ/Q) young adults receive sensitive and appropriate care in their local communities.²

We used social network marketing and snowball sampling to recruit members of the target population to complete an anonymous survey. To assure anonymity, the link to the online survey and the data transmitted were both encrypted. IP addresses were not collected or stored in the vendor's back-up systems. Respondents completed an on-line informed consent and those who indicated that they were not in the target age group or were not Maine residents were not allowed to proceed. The SurveyMonkey™ tool also allowed us to utilize a skip question methodology that shortened the questionnaire for many and thus facilitated survey completion. The skip question methodology allowed us to minimize any potential risks related to having even asked a given question. For example, only smokers were asked about attempts to quit and utilization about various quit support strategies and services. Only those who had considered suicide were asked about suicide attempts and related health care treatment.

Unfortunately the response rate was low; just 81 people completed the informed consent process and most questions were answered by 62-69 respondents. Therefore the data is informative without being representative. Given the small numbers, we are limiting disclosure of demographic data to further protect the identity of respondents. When possible we compare our data to that from statistically valid samples from other surveys. This helps to distinguish outlier responses that are likely to be peculiar to our sample from those which may be representative and which may warrant further research.

In general we found that substance use rates among GLBTQ/Q were not necessarily higher than those of other populations in this age group. Access to substances and risk and protective factors appeared to be similar as well. Depression and suicide risk were high and there were high levels of access to health care insurance and utilization of health care services. Overall this generation of GLBTQ/Q young adults appears to be more well-adjusted and to have fewer issues and barriers to care than have been noted in prior generations.

There are several things that providers can do to make their programs and services more GLBTQ/Q-friendly. In general respondents indicated that they have high levels of trust for medical care providers and that they utilize the health care system. However, they would appreciate intake processes that use more inclusive language and providers who are more obviously willing and able to openly discuss issues of concern to GLBTQ/Q patients. These improvements can be made in the medical and social service environments through staff training, appropriate signage, greater openness in language in patient questionnaires, and through providers who are clearly at ease with GLBTQ/Q patients.

¹ This project was funded through a contract from the Maine DHHS Office of Substance Abuse, #26260.

² There is sensitivity in the community around whether the G or the L is listed first. In the survey and in our report we alternate GLBTQ/Q with LGBTQ/Q.

Background/Overview:

“Gay culture is as diverse as all its members. However, there is no question that many LGBT individuals experience a way of life that is considered a culture. Although lesbian, gay, bisexual, and transgender individuals from different backgrounds experience their communities differently, they share the belief in the legitimacy of their way of life. Substance abuse treatment providers should understand that the gay community possesses common knowledge, attitudes, and behavioral patterns and has its own legacy, argot, folklore, heritage, and history.”³

There is a lack of data on the lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQ/Q) population in Maine and throughout the country. The Maine Bureau of Health (now the Maine Center for Disease Control and Prevention) reported that “Although transgender is not a sexual orientation – it is considered by many a social identification, as the opposite of one’s own anatomical sex – very often transgender populations are considered along with lesbians, gays, and bisexuals as a sexual minority population. There is a tremendous lack of population-based data on transgender people.”⁴ For this reason, we made a particular effort to include language and questions that might help us better understand the behaviors and concerns of this segment of the population.

The Maine Bureau of Health also identifies the following challenges concerning the demographics of the gay, lesbian, bisexual, transgender, queer, and questioning (GLBTQ/Q) population:

- Very few of our health data systems ask sexual orientation. The Maine Youth Risk Behavior System, the US Census, and the Bureau of Health’s Infectious Disease Reports ask sexual orientation in very limited or indirect ways.
- There are no standard definitions for delineating sexual minority populations. For instance, definitions can be based on sexual behavior, self-identity, desire, and attraction.
- As a result, there is a scarcity of information on the health of Maine’s gay, lesbian, bisexual, and transgender populations.
- Because of social stigma, many people may be reluctant to share information regarding their sexual orientation or trans-gender identity with surveyors or their health care providers. This may also contribute toward a lack of data and understanding of health disparities.⁵

In the past, several studies have suggested that 20% to 30% of the gay, lesbian, bisexual, and transgender (GLBT) population have substance abuse problems. Gays and lesbians are believed to be at a much higher risk than the heterosexual population for alcohol and drug abuse.⁶ GLBT populations have been described as more susceptible to substance abuse than heterosexuals because irrational fear and negative attitudes toward non-heterosexuals (called homophobia) inhibits this population’s ability to live their lives fully. Substantially higher proportions of homosexual people are said to appear to use alcohol, marijuana or cocaine than is the case in the general population.⁷ It

³ U.S. Department of Health and Human Services, “A Provider’s Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual and Transgender Individuals.” (2003)

⁴ HealthyMaine 2010: Opportunity for All, p. 61. Accessed at <http://www.maine.gov/dhhs/boh/files/hm2010/oppforall/b10sexor.pdf>

⁵ Ibid., p.63. Accessed at <http://www.maine.gov/dhhs/boh/files/hm2010/oppforall/b10sexor.pdf>

⁶ U.S. Department of Health and Human Services, *Report of the Secretary’s Task Force on Youth Suicide: Gay Male and Lesbian Youth Suicide.* (1989)

⁷ 3. .McKirnan, D. J. & Peterson, P. L. (1989). “Alcohol and Drug Use Among Homosexual Men and Women: Epidemiology and Population Characteristics.” *Addictive Behaviors*, 14 (5). pp. 545-553.

has also been reported that 55% of gay men have had a substance abuse problem sometime in their life.⁸

Consequently, prevention service providers who sought to support the LGBTQ/Q population were encouraged to take into account that gay culture is often hidden in the community at large due to fear of being ostracized and victimized. There was and still is no way of identifying LGBTQ/Q people, apart from their own disclosure or identification. Our respondents suggest that by providing program features that are sensitive to the issues surrounding gender identity and homophobia, as well as by training staff to express this sensitivity clearly and appropriately, there is a much greater chance of reaching members of the LGBTQ/Q population. There was less priority placed on reflecting the challenges unique to the LGBTQ/Q community by utilizing peers as providers in order to help create a less threatening, non-judgmental and secure environment.

These findings may be peculiar to our respondent group or they may reflect the tremendous progress in Maine during the past five years. For example, the LGBTQ/Q community and its allies were able to build such sufficient support for passage of non-discrimination legislation that it withstood a statewide repeal initiative. The community has obtained statewide recognition of gay relationships through domestic partnership registration, and has secured policies requiring equal treatment of domestic partners in certain health care settings and insurance situations. But as in other parts of the country, there is little research-based data about members of the LGBTQ/Q community in Maine with regard to behaviors such as substance use, mental health, utilization of the health care system, social support, and trusted sources of information.

Despite the progress on the political front, information about the number and geographic distribution of LGBTQ/Q in Maine is also lacking. At least one national study suggested that Portland, for example, has a high proportion of lesbian couples compared to other geographic areas around the county (3rd after Santa Fe, NM and Burlington, VT in one report)⁹. The highest proportion of Maine residents live in the southern counties, so one might think that the majority of LGBTQ/Q would also live in southern Maine. Yet there have been public and active LGBTQ/Q groups active in all Maine counties during the civil rights campaigns of the past two decades so it is entirely possible that LGBTQ/Q are widely dispersed around the state, away from the hubbub and prying eyes of neighbors. Are there more lesbians in southern Maine than in northern areas? Are there a lot of gay men in Maine? Where are they located? Are there more transgender individuals now than in the past or are there the same number but society is more aware of their presence? These are questions that continue to exist and which were well beyond the scope of our effort.

However, advocates suggest that there are more “out” (publicly acknowledged) people in Maine who are part of the LGBTQ/Q community now than there were 5, 10, or 20 years ago. Proxy measures of this growth in the community include the growing size of the Equity Fund at the Maine Community Foundation, the establishment and growth of the Rainbow Business and Professional Association (a LGBTQ/Q Chamber of Commerce type group in southern Maine), increases in the number of people who attend the annual EqualityMaine dinner and the ability of EqualityMaine to establish and sustain an office and multi-person staff. These advances stand in contrast to the fact that there are fewer “out” state legislators and fewer bars and social venues for the LGBTQ/Q community. Although proxy measures such as these are all that advocates and social service agencies have had available to guide them over the years, this too is changing.

⁸ *Breaking the Silence for Lesbian, Gay and Bisexual Youth*. (1996) New Hartford, NY.

⁹ <http://www.maintoday.com/census2000/news/020714couples.shtml>

In 2004-2005, while we were developing this project and applying for funds with which to carry it out, there were two other surveys being created. One was a survey conducted by Youth Alternatives with financial support from the Maine Health Access Foundation. The second was a senior thesis project targeting LBGTQ/Q youth conducted by a student of Goddard College. Thus a few months after this project started in July 2005, we found it appropriate to restructure both our methodology and some of our questions to reflect what these other groups had learned about GLBTQ/Q youth needs, behaviors, and opinions. We also elected to have our survey mirror, in part, a survey being conducted among out-of-school young adults in Androscoggin County. We are grateful to the staff of Healthy Androscoggin's effort, as well as to Brenda Joly Ph.D. and Jordon Bosse for their willingness to share their data and to allow us to shape some of our questions to track with theirs. Our survey website was also changed at the last minute to include respondents up through age 29. However, the results that we present in the subsequent sections are limited to the responses from the 18-25 age group for whom the outreach and survey were originally designed.

FINDINGS ON NEEDS, RESOURCES, AND READINESS

There were 81 people age 18-25 who participated in the survey. Of those, between 62 and 69 answered most of the questions. Within the overall respondent group, we also reviewed results in two age subgroups. There were 32 respondents age 18-20 and 37 respondents age 21-25. The results are not statistically representative of the target population but are descriptive and as such may be of use to service providers and program planners. For each question, we indicate the question number, then the number of respondents to that question with a statement "[Q#, n=___]." Descriptions or comments about the data for that question are limited to those respondents.

Substance abuse prevalence data -- Core Measures

General substance use rates were lower than might have been expected for this population in the initial query based on the studies cited earlier in this report, with most respondents reporting little or no illegal drug use in the past 30 days. Alcohol, cigarettes, and marijuana were the notable exceptions.

Table 1: Number of days on which the respondent(s) used specific types of substances. [Q16]

How many days in the past 30 days have you...	0 days	1-2 days	3-5 days	6-9 days	10-19 days	20 or more	Response Total
...had at least one drink of any alcoholic beverage	22%	24%	22%	18%	12%	3%	N=67
...smoked cigarettes	78%	7%	4%	1%	1%	7%	N=67
...used smokeless tobacco	97%	1%	0%	0%	0%	1%	N=67
...used inhalants (huff or huffed)?	97%	1%	0%	0%	0%	1%	N=67
...used prescription drugs that were not prescribed for you	93%	5%	0%	0%	0%	3%	N=67
...used prescription drugs that were prescribed to you but you used more than recommended	91%	5%	0%	0%	0%	5%	N=67
...used marijuana	78%	12%	1%	0%	5%	5%	N=67
...used drugs (other than marijuana)	94%	3%	2%	0%	0%	2%	N=66

On this question, there were two notable differences between the 18-20 y.o. vs. 21-25 y.o. respondents. The younger group was more likely to report smoking cigarettes (32% vs 14%) on one or more days. The younger group was also more likely to report using marijuana on one or more days in the past 30 days (29% vs. 17%).

Alcohol use in past month / Binge alcohol use in past month

It was encouraging to note that nearly one in five respondents [19.4%, Q24, n=67] reported no alcohol consumption in the past 30 days. Of those who did report consumption, 70% reported drinking 5 or fewer drinks on average on the days when they did drink [Q24, n=67]. Unfortunately, 22.4% reported binge drinking behavior on 1-2 occasions in the last 30 days while 9% binge drank 3-5 times and 1.5% (1 person) acknowledged binge drinking 6-9 times in the past 30 days [Q26, n=67].

There was an age difference in reported average alcohol use in the prior 30 days. Among respondents aged 18-20 the largest number reported consumption of 3 to 5 drinks (12 of 31 respondents) on average when they drank. Among the 21-25 year olds, the majority reported consuming 1 to 2 drinks on days when they consumed alcohol (17 of 36 respondents) [Q26].

In the overall group, on those occasions when respondents drank alcohol, 52.5% of respondents purchased their own alcohol while 54.2% reported consuming alcohol purchased by friends [Q25, n=59: multiple answer selections were allowed on this question]. Only 3.4% (2 respondents) stole the alcohol from their parents while 27.1% “shared” alcohol. Nearly half of respondents (46.3%) reported having taken some college courses [Q10, n=67], and 63.9% reported being full-time students [Q68, n=61] so it is not surprising that friends are such notable purchasers of alcohol [Q25, n=59]. However, those figures are deceptive, masking what may be important differences in the drinking patterns of underage drinkers, as illustrated in the table below.

Table 2: If you used alcohol in the past 30 days, how did you get it? (check all that apply) [Q25]

Results by Age	18-25 Number	18-25 Percentage	18-20 Number	18-20 Percentage	21-25 Number	21-25 Percentage
Purchased/bought	31	52.5%	6	23.1%	25	75.8%
Friend purchased	32	54.2%	20	76.9%	12	36.4%
Stole from parent	2	3.4%	2	7.7%	0	0
Shared	16	27.1%	8	30.8%	8	24.2%
Did not use	6	10.2%	2	7.7%	4	12.1%
Other	5	9.4%	2	7.7%	3	9.1%
Total Respondents	59		26		33	

When we asked specifically about the most recent episode of binge drinking, there was a differential of more than 2:1 between the alcohol being purchased by a friend (65.2%) and by the respondents themselves (30.4%) [Q28, n=23]. When we asked about frequency of binge drinking behavior there again appeared to be possible differences in the age subgroups, as shown in Table 3.

Table 3: How many times during the past 30 days did you have five or more drinks of alcohol on one occasion? [Q26]

Results by age	18-25 Number	18-25 Percentage	18-20 Number	18-20 Percentage	21-25 Number	21-25 Percentage
0 times	44	65.4%	16	51.6%	28	77.8%
1-2 times	15	22.4%	9	29%	6	16.7%
3-5 times	6	9.0%	5	16.1%	1	2.8%
6-9 times	1	1.5%	0	0	1	2.8%
Other	1	1.5%	1	3.2%	0	0
Total Respondents	67		31		36	

Given the respondents' ages and school statuses, we noted that 13% reported binge drinking at a bar/club, 8.7% acknowledged bingeing at home, 21.7% were doing their binge drinking at the home of a friend, while 56.5% reported binge drinking on a college campus [Q27, n=23]. Twelve of the 15 respondents (80%) aged 18-20 who reported binge drinking in the past 30 days indicated doing so on a college campus. The 8 respondents in the 21-25 age group who reported binge drinking the past 30 days were about evenly distributed between their own home, a friend's home, a night club/bar, and a college campus.

Cigarette use in past month / Any tobacco product use in past month

Two of 69 respondents (3%) reported using smokeless tobacco of any kind in the past 30 days (chew, snuff, plug, dip, chewing tobacco) [Q16, n=67]. In contrast, 15 of 69 respondents (22%) had reported using cigarettes in the past 30 days. This is somewhat below tobacco use rates reported in the general population in this age group.¹⁰ On the days when they smoked, 7 of 16 smoked 10 or fewer cigarettes, 4 smoked 11-20 cigarettes per day, and 5 of 16 reported smoking "other" amounts [Q18, n=67]. Respondents ages 21-25 were less likely to smoke than their counterparts ages 18-20, 61.3% compared to 88.9% [Q18].

Among those who reported being current smokers, 5 of the 16 (32%) indicated that on one to five occasions they stopped smoking for at least 24 hours or longer during the past 12 months because they were trying to quit [Q19, n=16]. Three reported planning to quit in the next 30 days [Q20, n=16]. Current smokers who reported efforts to quit in the past year had utilized existing resources (four asked a friend for support, three had a quit buddy, three had used a medical aid such as the patch, gum, Zyban, or other, two had asked a mental or physical health professional for help or advice, and one called the Maine Tobacco Quit Line [Q21, n=7].

Any illicit drug use in past month

An interesting component to the reporting on drug use in the past month is the apparent absence of any middle ground. That is, the majority of respondents did not report drug use in the past 30 days. Most of those who did report drug use, reported using on 1-2 days in the past 30 days. We theorize that perhaps these respondents are "weekend" or "social" users. No-one indicated using these drugs in the 3-5, 6-9, or 10-15 day answer choices. Yet for these same substances there was a small but consistent group of users who reported using on 20 or more days: smokeless tobacco (1), inhalants (1), prescription drugs not prescribed to you (2), prescription drugs prescribed to you but you used more (3), and drugs other than marijuana (1). With a sample size of 67 on this question (#16), it is possible that this pattern is an anomaly. It is in fact likely that the outliers are bogus.

¹⁰ <http://www.whitehousedrugpolicy.gov/NEWS/press05/090805.html>

The majority of individuals giving the 20+ day responses were 18-20 years of age. But given the contrast of these substance categories to use patterns reported for tobacco, alcohol, and marijuana, there is at least a possibility that the use pattern is legitimate. In at least one other survey of GLBTQ youth, this pattern did not exist, but there were quite a few individuals who reported having already stopped using substances.¹¹

When we asked about lifetime use in Q36, the responses were similarly suggestive (N=65). In that question, 66% had used Marijuana and 33% had “used prescription drugs not prescribed for you” while 20% or fewer reported lifetime use of the other 9 drug categories presented. The question of use patterns, varying by drug type, has not been explored in this population and is one that we believe warrants further study. For example, even if higher numbers of LGBTQ/Q report substance use in their lifetime, is there a correspondingly higher rate of “weekend” users and “daily” users? Reported lifetime use of a “party drug” (Ecstasy 17%) as well as that of cocaine (16%) and misuse of ones own prescription drugs (19%) were substantially higher than those of “street drugs” such as Seroquel (3%), Suboxone (2%), Heroin (2%), Ketamine (6%), or Meth (6%).

Marijuana use in past month

As noted above, 66% (43 of 65 respondents) reported having used marijuana in their lifetime. In contrast to that, only 22% of 67 respondents as shown in Table 1 reported using marijuana in the past 30 days. Unlike other illicit drugs however, there was more consistency of use within this population, with 12% responding use on 1-2 days, 1% using on 3-5 days, 0% using on 6-9 days, 4% using on 10-19 days, and 4% using on 20+ days. This distribution tracks closely with tobacco use, while tobacco and marijuana use rates were both lower than alcohol use frequency.

Unique patterns of substance abuse that have implications for prevention

Use of prescription drugs not prescribed to you and using more than recommended of prescription drugs that have been prescribed to you appears to be a concern with this population. These categories were suggested by youth during our survey development phase and present unique opportunities for intervention among providers and prescribers for this population. Thirty-eight percent of 18-20 year olds and 29% of 21-25 year olds reported using prescription drugs “not prescribed for you” in their lifetime [Q36, N=31 and 34 respectively]. In conversations with HIV prevention educators and case managers there were suggestions that in this age group, the data for these categories may reflect misuse of drugs such as Viagra and do not necessarily reflect misuse of drugs such as Oxycodone. This presents another area for potential research and intervention.

We noted that the Maine Youth Drug & Alcohol Use Survey (MYDAUS) found higher rates of illegal use of prescription drugs. Among 11th graders completing MYDAUS, rates were higher in both 2006 and 2004 (9.4% in 2006¹² and 11.6% in 2004¹³). Nine percent (9%) of our survey respondents reported illegal use of prescription drugs in the past 30 days [Q16, n=67]. There are several possible explanations for this difference that are not mutually exclusive. First, the difference is not large and may not be significant. Second, our survey is small and not representative. Third, illegal prescription drug use may go down as people get older. Fourth, that there may be differences in the kinds of prescription drugs being used illegally among LGBTQ/Q young adults and the youth surveyed in MYDAUS which may cause the respondents to answer differently (e.g. a gay male may not think of his use of a friend’s Viagra as being illegal).

¹¹ Jordan Bosse, draft undergraduate thesis project report, page 19.

¹² http://www.maine.gov/maineosa/survey/summary.php?mode=&summary_chart_id=32

¹³ <http://www.maine.gov/dhhs/osa/data/mydaus/mydaus2004.htm> 2004 MYDAUS Summary Report, p.15.

We also noted that lifetime use of other drugs is higher in the GLBTQ/Q 18-25 age group than in the general population of students in 9th-12th grade as recorded in the Youth Risk Behavior Survey. While it is not surprising to find higher rates of use among those who are in college or have simply lived longer, the size of the differential suggests that there may be a disproportionate increase in drug use among LGBTQ/Q youth after high school.

- ◆ Lifetime cocaine/crack use, for example, is double at 16% (n=63) in our sample in contrast with 8% of YRBS respondents in 2005.
- ◆ Ecstasy use is 17% (n=63) vs. 5% for YRBS.
- ◆ Heroin use rates are similar at 3% in our sample, at 4% in YRBS.
- ◆ Marijuana use in the past 30 days is similar at 25% in our sample (n=57) and 22% in YRBS.

The MYDAUS data for 2006 tracks closely with the YRBS data.¹⁴ Further analysis of our sample also suggests that there may be an age factor. Use of LSD/mushrooms, Cocaine/Crack, and Ecstasy were higher among the 21-25 year old respondents than they were among the 18-20 year-old respondents [Q36]. Thus it may be appropriate to obtain further data and consider implementing prevention interventions that specifically target GLBTQ/Q youth who are 18-20 in a campaign to prevent the initiation of the use of club drugs such as cocaine and ecstasy.

Risk and Protective factors that influence substance abuse patterns in this population

Among the various risk behaviors, we noted that 12% of respondents reported having *ridden* in a car or other vehicle being driven by someone who had been drinking alcohol [Q31, n=66] while 18% had *ridden* with a driver who had been using marijuana [Q33, n=66]. Nine percent reported having *driven* a vehicle in the past 30 days when they themselves had been drinking [Q31]. Eleven percent had *driven* when they had been using marijuana [Q33]. These responses add support to national recommendations that communities seek to more intensively educate young adults about the risks of driving or riding with a driver who has used marijuana.

Another area for potential intervention is to reduce social access to alcohol for minors. A disturbing 10.6% of respondents indicated that in the last two weeks they had served alcohol to a minor while 28.8% had not done so in the past two weeks but are generally willing to provide a minor with alcohol [Q32, n=66]. These results are skewed, however, in that respondents in the 21-25 age range were less likely to be willing to provide alcohol to minors than were the underage respondents (74.3% of the older respondents and 67.7% of the younger respondents answered “not likely”). [Q32, N= 64]

In this population, as in others, it appears that people under age 21 in Maine continue to have ready access to alcohol. More than two thirds of respondents (67.3%) reported that it would be “Very Easy” to obtain alcohol and another 21.2% indicated that it would be “Somewhat Easy” to get [Q29, n=52]. When asked about perception of enforcement of underage drinking laws, respondents indicated overwhelmingly that it was “not likely” (65.6%) or “not at all likely” (25%) that someone under age 21 who drank alcohol would be caught by police [Q30, n=64]. These data were consistent across age groups in our survey as well as being consistent with perceptions reported in the 2006 MYDAUS.¹⁵

¹⁴ http://www.maine.gov/maineosa/survey/report.php?mode=state&mode=id=1&survey_id=1&report_id=30 2006 MYDAUS All Substances – Lifetime Use

¹⁵ http://www.maine.gov/maineosa/survey/report.php?mode=state&mode_id=1&survey_id=6&state_id=1&report_id=35 2006 MYDAUS Perceived Accessibility to Substances, Grades 9-12

Similarly, marijuana was reportedly somewhat easy (36.4%) or very easy (22.7%) to get [Q34, n=66]. Perceived enforcement was similar to that seen with alcohol, in which 65.2% of respondents indicated that someone who used marijuana was not likely (65.2%) or not at all likely (19.7%) to be caught by police [Q35, n=66].

Resilience

Interestingly, 36.4% of the 66 respondents answered “I don’t know” to the question about ease of access to marijuana [Q34]. While one might think that some respondents would use this answer choice to avoid any possible implications of use, we believe that to be an uncommon strategy. When we tested the survey with youth in the target audience the access questions for alcohol and marijuana did not have the “I don’t know” answer choice. The addition of “I don’t know” was one of the strongest pieces of feedback we received in piloting the survey. The youth who do not use did not like the assumption that they would be able to assess or rate how easy it is to get these substances and were resentful of the implication that they would.

More than half (55.2%) of the survey respondents indicated that they have support for their sexual orientation from their family [Q15, n=67]. This appears to be unprecedented in the published literature but is very consistent with anecdotal reports in Maine, and local proxy measures. A quarter of respondents answered “other” on this question. Among the comments offered from these individuals were situations in which one parent knew and was supportive but the other parent did not, or in which extended family knew and was supportive but nuclear family was not supportive and vice versa. Some of the “other” respondents explained that they had not yet come out to their families and elaborated on what they perceived the likely response would be when they do. Results for this “family support” protective factor are consistent with those reported by 12th grade students in the 2006 MYDAUS.¹⁶

There is reason to believe that GLBTQ/Q young adults today may also feel supported by their community. Nearly half reported that their religious or spiritual beliefs were important or very important in their day-to-day life [Q70, n=60]. Similarly, 30% reported that they felt connected to a religious or spiritual community [Q71, n=60]. More than half reported feeling connected to the community where they live [Q72, n=55]. These results were generally consistent among 18-20 and 21-25 year old respondents. While these reported rates are lower than those among the general population as measured in the 2005 YRBS and the 2006 MYDAUS¹⁷, they are higher than one might anticipate based on the published literature.

Assessment of the strengths of the subpopulation, especially related to self-care and problem solving on substance abuse issues, how have people in this subpopulation who have been successful in preventing/reducing substance abuse done it?

The survey respondents have access to health insurance at rates not inconsistent with those of the overall Maine population [Q38, n=66]:

¹⁶ http://www.maine.gov/maineosa/survey/report.php?mode=state&survey_idid6&state_id=1&report_id=73 2006 MYDAUS Protective Factors – Grade 12. Note that the MYDAUS survey questions are different than those used by the GLBTQ/Q assessment team but questions in both surveys attempt to get at the same issue, perceived support.

¹⁷ http://www.maine.gov/maineosa/survey/report.php?mode=state&survey_idid6&state_id=1&report_id=73 2006 MYDAUS Protective Factors – Grade 12. Note that the MYDAUS survey questions are different than those used by the GLBTQ/Q assessment team but questions in both surveys attempt to get at the same issue, perceived support.

- 15.2% without insurance (20% of 21-25 y.o., 10% of 18-20 y.o.)
- 57.6% have insurance through their parents (34% of 21-25 y.o., 84% of 18-20 y.o.)
- 10.6% are on MaineCare (14% of 21 – 25 y.o., 6% of 18-20 y.o.)
- 16.7% have insurance through their employer (31% of 21-25 y.o., zero 18-20 y.o.)

Access to care is reflected in their utilization of the health care system, in that 93.9% report having seen a doctor or other health care provider in the past 12 months [Q.40, n=66]. This utilization of the system presents an opportunity for prevention interventions which may not currently be maximized. For example, while 22% report smoking cigarettes in the past 30 days [Q16, n=67], only 11% report that the health care provider or a staff person asked if they were interested in quitting tobacco [Q41, n=64]. Even fewer were asked about decreasing substance use (8%) [Q41].

To measure potentially influential access points for interventions with this population, we asked respondents to rate a range of providers. Those who were least reliable or least preferable were scored as a 1, while those who were very reliable or very much preferred were scored as a 5 with gradations in between. This allowed us to use a response average to measure the providers relative to one another. In this way we found that just as in the general population, survey respondents feel that medical and mental health professionals as well as counselors are highly reliable and highly preferred sources of information. Friends and the web are also highly preferred, but are recognized as less reliable sources of information. Parents are rated as highly reliable, but less preferred [Q43, n=65 Q44, n=63]. Print materials such as leaflets, pamphlets, and flyers were perceived as less reliable but more preferred than parents or teachers.

Description of resources available to and within this subpopulation

As adults, this population has presumed access to the variety and range of social and medical resources available to the general population. However, fear of discrimination and social stigma may limit the likelihood that LGBTQ/Q individuals access services. For those who identify as part of the LGBTQ/Q community, there are some social groups that do exist, such as “Gay Like Us” and “Thrive.” There is also the Rainbow Business and Professional Association (RBPA) which provides professional networking opportunities and which functions along the lines of a cross between a gay Chamber of Commerce and a Rotary Club. Through groups such as RBPA it is possible to locate social service providers who are openly LGBTQ/Q or who specialize in services to those who are LGBTQ/Q.

These networks are valuable for people who are open about their orientation and gender or who have a clear preference for same orientation / gender providers. However, they do not necessarily have statewide reach and may not meet the needs of people who have same gender sex but do not think of themselves as LGBTQ/Q. In addition, the ethnic make up of the membership of these groups is reflective of the state’s limited ethnic diversity. Consequently, even for those clients who are based in southern Maine, these groups and resources may not be able to adequately respond to the needs or preferences of clients from diverse ethnic and cultural groups.

To the extent that there are large areas of the state in which LGBTQ/Q resources or providers may not be available, it is especially important that existing social service agencies and health care providers make clear and visible efforts to create a welcoming environment.

One resource emerging in recent years are those Unitarian Universalist congregations around the state that have become “Welcoming Congregations.” These church communities have undertaken a

process (typically two years in length) of exploring GLBTQ/Q issues in their congregation and within their faith and worked with the membership to establish policies and practices that foster an open and “welcoming” congregation. Providers interested in creating such a welcoming environment in their organization or agency may find information from these local congregations helpful.

Analysis of barriers programs/coalitions in Maine commonly face in trying to provide culturally competent services for this subpopulation

One of the primary barriers to programs and coalitions in Maine commonly face in trying to provide culturally competent services for GLBTQ/Q young adults is that there are rarely hints that a particular patient or client may be LBGQTQ/Q. So while we worry when providers make cultural assumptions based on skin color or name, in the absence of such potential clues, nearly all clients are presumed heterosexual male or female. This leaves the onus inevitably, and entirely, on the individual patient/client to disclose their sexual orientation or gender to the provider. This increases the chances that there will be difficulty in establishing rapport with the client and reduces the likelihood of treatment compliance.

Here is a sampling of comments made by individual respondents when asked “What else could providers do to make you feel more comfortable and more likely to use the program or services that they offer?” (responses are typed verbatim, as they appeared on the survey)

Education & sensitivity training & awareness – our issues may be different than the clients they are used to working with, and if they weren't informed already, it would be nice if they would listen non-judgementally and provide services based upon the new knowledge they have of us.

Pediatricians/Family Doctors should ask about your gender identity and sexuality at some point, maybe in the teenage years, and indicate they will not tell your parents anything. And ask again later. I hated that my pediatrician never brought it up after I had come out to myself (18).

A less heterosexist place, not bathed in pride stickers, the usual friendly “I care” attitude (but not OMG I want to be your parent, I think you've been treated horribly in the world).

To summarize, it would be helpful if providers would create more openings and more opportunities for the client to disclose by modifying their patient history and intake forms. Something as simple as adding the option of answering “transgender” in the gender section or “domestic partner” in the marital status area goes a long way in helping the client feel more welcome in the practice and makes it clear that the providers are at least aware that not all clients are the traditional heterosexual male or female. These kinds of structural changes are reported anecdotally to help increase client self-disclosure of gender variation or sexual orientation in conversation with the provider, regardless of how they answer the question on the form. It is essential though that if the organization or coalition wants to be more welcoming that there be more than structural changes. Staff training and sensitization to the concerns of members of the LBGQTQ/Q community are essential to give substance to the structural changes. The former without the latter will quickly be recognized by clients and will become a lost opportunity for providers and coalitions to become more culturally competent.

Safety and Mental Health

One of the few areas in which there has been data collected about members of the GLBTQ/Q community is suicide. The evolution of hate crime reporting has also brought into focus issues LGBTQ/Q face with regard to mental health, safety, and violence. In an effort to explore these issues, we included in our survey questions developed, tested, and used on other highly researched survey tools. Specifically, the questions we asked regarding depression, suicide were exactly those used in the 2005 YRBS survey of high school students in Maine. The results are intriguing. While there has been progress on the legal front, interpersonally and socially, the world can still be a very scary place for GLBTQ/Q young adults.

Q. 48. During the past 30 days, on how many days did you not go to school, work, or errands outside your home because you felt you would be unsafe? More than one in six respondents, 17.7% answered that this was true for them on one or more of the past 30 days [N=62].

Q. 49. During the past 12 months how many times...
 ...has someone threatened or injured you with a weapon such as a gun, knife, or club? 6.4% answered one or more
 ...were you in a physical fight? 9.7% answered one or more
 ...were you in a physical fight in which you were injured and had to be treated by a doctor or nurse? 1.6% answered one or more [n=62]

Q. 50. Have you ever been physically forced to have sex when you did not want to? Yes = 27% [n=63] Age appears to make a difference in responses to this question, with 21% of 18-20 y.o. respondents and 31% of 21-25 y.o. respondents answering Yes to this question [n=28 and n=35 respectively].

Despite the relatively low rates of substance abuse and strong access to the health care system, nearly half of respondents (48.4%) reported during the past 12 months feeling so sad or hopeless every day for two weeks or more in a row that they stopped doing some usual activities [Q. #51, n=62]. Younger respondents were more likely to have responded Yes to this question (57.1% or 16 of 28 respondents aged 18-20 versus 41.2% or 14 of 34 respondents aged 21-25 y.o.).

The responses to suicide questions were worse than other Maine specific rates and better than other state or national GLBTQ/Q data. Respondents to our survey reported that in the past 12 months:

- 21% had seriously considered suicide [Q. #52, n=62],
 - ◆ 32% of 18-20 y.o. versus 12% of 21-25 y.o.
- 11.3% had a plan about how they would attempt suicide [Q. #53, n=62],
 - ◆ 18% of 18-20 y.o. versus 6% of 21-25 y.o., and
- Of those who had a plan (n=7), one (14.3%) had attempted suicide [Q.#54, n=7].

With the exception of actual suicide attempts, these figures are substantially worse than those reported by 9th-12th graders in the 2005 YRBS.¹⁸ Our GLBTQ/Q young adults reported worse rates of depression (Q51: 48.4% vs. YRBS: 21%) and higher numbers giving serious consideration to suicide (Q52: 21% vs. YRBS: 13%). Thankfully a lower percentage created a plan for suicide (Q53: 11.3% vs. YRBS: 10%). Unfortunately these high depression rates are consistent with the studies referenced earlier and may not be an anomaly of our small survey response rate.

¹⁸ *Maine Youth Risk Behavior Survey 2005, High School Statewide Highlights*, Maine DOE and Bureau of Health.

The suicide rate attempts reported by our survey respondents were better (lower) than those reported elsewhere. Advocates for Youth note in their fact sheet on GLBTQ Youth the following:

In a recent survey, 33 percent of gay, lesbian, and bisexual high school students reported attempting suicide in the previous year compared to eight percent of their heterosexual peers;^a in another study, gay and bisexual males were nearly four times more likely to attempt suicide than were their straight peers.^b

^a Massachusetts Dept. of Education. *Massachusetts High School Students and Sexual Orientation: Results of the 1999 Youth Risk Behavior Survey*. Boston, MA: The Dept. 1999.

^b Garofalo R et al. Sexual orientation and risk of suicide attempts among a representative sample of youth. *Arch. Pediatr Adolesc Med* 1999; 153:487-93.

However, data from the 2005 Massachusetts YRBS indicate that “Students who described themselves as gay, lesbian, or bisexual were significantly more likely than their peers to report attacks, suicide attempts and drug and alcohol use.”¹⁹ Specifically, it was found that 24.8% of the gay, lesbian, or bisexual-identified youth had attempted suicide in the past year.²⁰ While this still represented a rate four times higher than the other students in the YRBS, it also reflects a significant decrease since 1999.

Given the improvement seen in Massachusetts between 1999 and 2005, it seems possible that the differences seen in Maine between YRBS data and our respondents in the areas of suicide and depression are likely to reflect both the specifics of our survey respondent group and some true variance from these other state or national data. However, it is also possible that some of the differences could be attributed to the extensive suicide prevention work that has been done in Maine since 1999 and the previously mentioned changes in the social and political environment for GLBTQ/Q young adults in Maine.

Sexual Activity

In our section on sexual behavior we replicated the questions asked in the 2005 YRBS with one significant difference. The YRBS asks specifically about sexual intercourse. We asked about sex, and defined that term in the initial question in this section. Our question #56 read, “Have you ever had sex (genital contact with anyone regardless of gender)?”

Among our respondents 14% had never had sex and nearly 51% had sex for the first time at age 17 or older [Q57, n=63]. However, our data suggests that those GLBTQ/Q young adults who became sexually active before age 17 were likely to have had their first sexual experience while quite young. This should be an area of concern and warrants further study and exploration of interventions.

Table 4 [Q#57, n=63]

Age when first had sex	GLBTQ/Q Survey Respondents
Never had sex	14%
Age 11 or younger	5%
Age 12 or 13	8%

¹⁹ www.massachusetts.gov (search “YRBS 2005”) “Massachusetts High School Students and Sexual Orientation Results of the 2005 Youth risk Behavior Survey.”

²⁰ www.massachusetts.gov (search “YRBS 2005”) “Massachusetts High School Students and Sexual Orientation Results of the 2005 Youth risk Behavior Survey.”

Age 14 or 15	8%
Age 16	14%
Age 17 or older	51%

Nearly 26% of respondents report having had sex with six or more people in their lifetime [Q58, n=62]. However, more than 71% reported only one sex partner in the past three months [Q59, n=49]. Only one in five (21.6%) reported having used alcohol or drugs before their most recent sex encounter [Q60, n=51], while 32% used a condom or other latex barrier [Q61, n=50].

Six percent of respondents (3 people) indicated that they had ever had sex in exchange for drugs, money, or other goods or services [Q62, n=51]. Contrary to recent media reports of MySpace being used to arrange hookups, only 6% of our respondents indicated having met their most recent sexual partner through, “Blogging (MySpace or similar)” or an “Internet chat room (Manhunt or other)” [Q63, n=50].

Who we are –information about the respondents

After the three screening questions, the first four questions invited open-ended narrative responses. Below we group them by type for presentation purposes. In Q8 we offered a wide assortment of answer choices from which respondents were asked to select one. They are presented here as “traditional” or “additional” for descriptive purposes.

While the respondents are not necessarily representative of the LGBTQ/Q population of Maine in the 18-25 age range, their ways of identifying themselves and their self concept is as individualistic as that of others in their generation. To help this population “see themselves” in an agency or practice, incorporating some of their language may be useful.

Table 5: What was your birth sex [Q4, n=69]

Traditional Answer Choice	#	Traditional Answer Choice	#
Female	55	Male	14

Table 6: How do you identify your gender? [Q6, n=69]

Open Ended Answers	#	Open Ended Answers	#
“Female”	32	“Male” or “Man”	12
“Woman”	6	“Androgynous”	1
“Butch” or “Masculine Female”	3	“Questioning”	1
“Queer” or “Gender Queer”	4	“Male/trans/mtf/queer”	1
“femme, woman”	2	“genderqueer, transgender, boy”	1
“FTM”	1	“I don’t believe in gender”	1
Other (grouped by author)	3	“I look like a man”	1

Table 7: How does your family perceive your gender? [Q12, n=67]

Open Ended Answers	#	Open Ended Answers	#
“Female” or “Woman”	41	“Male” or “Man”	12
Other	14		

Yet, When we asked, “When you think about those you find sexually appealing, how would you label or describe their gender?” [Q7, n=67] only 20 respondents indicated singular word “male” or “female.” Most answers were mixed, combined, or fluid. Sexual orientation was similarly fluid.

Table 8: How do you identify your sexual orientation? [Q8, n=69]:

Traditional Answer Choices		Additional Answer Choices	
Lesbian	15.9%	Queer	17.4%
Gay	15.9%	I don't label my sexual orientation	8.7%
Bisexual	14.5%	Pansexual	4.4%
Straight	13.0%	Questioning	1.5%
Dyke	5.8%	Asexual	0.0%
Other	2.9%		

This contrasts to responses to our question, “How does your family perceive your sexual orientation?” [Q14, n=66]. Among the 66 respondents, 24 provided single word answers (gay, straight, etc). The remainder required multi word answers, phrases, or (frequently) multiple sentences to describe their family’s perceptions.

Then when we asked, “Do you have support for your sexual orientation from your family?” The response were Yes 55%, No 19%, Other 25%. Comments in the “other” responses were primarily explanations of gradations in support or coming out. [Q15, n=67]

Ethnicity. Respondents were 87% White/European American with 13% identifying with another race/ethnicity. This is a slight improvement over Maine population figures. [Q9, n=69]

Table 9: Education [Q10, n=67]

12 th grade	9%	Some college courses	46.3%
GED	6%	Bachelor's Degree	26.9%
2 year college degree	6%	Other	6%

Recommendations or “What can providers do to be more GLBTQ/Q friendly?”

We asked, “If a business or service provider wanted to do something that would help you feel more welcome and safe what should they do? Here are some things that others have suggested. Would they help you feel more comfortable or help you be more willing to use certain agencies or services? Please tell us how important you think it would be for providers to implement these different strategies.”

This is one of the questions in which we were purposely building on the work done by Youth Alternatives in 2005. They had asked youth what things providers could do to make the program or agency more GLBTQ/Q friendly. We took the answers given to YA and asked our respondents to rank their importance. Thus our work re-affirms the recommendations made by YA and gives providers guidance on how to proceed, if like many organizations they need to implement recommended actions incrementally over time.

Respondents were asked to rate potential actions on a scale in which “Not At All Important” was the lowest possible ranking (#1) and Very Most Important was the highest rank (#5).

Table 10 [Q#46, n=62]

Action Step / Responses (listed in rank order based on response average)	Percentage of respondents ranking this as Important, Very Important, or Very most Important	Response average (range 1-5)
Train staff to be comfortable discussing gender and sexual orientation issues with clients and patients.	100%	4.42
Publicize staff training and sensitivity to GLBTQ/Q concerns.	98%	3.95
Have signs that explain that all clients are to receive equal treatment regardless of sexual orientation or gender identity.	94%	3.95
Have signs for “hate free zones” or other no tolerance policies.	90%	3.72
Incorporate gender neutral bathroom access (e.g. dual use or single stall facilities).	84%	3.71
Indicate on signs and forms that the provider staff will not leave information on answering machines that could identify anything about a person’s sexual orientation or gender identity, or any other health-related information (then follow this policy).	92%	3.69
Include a space for self-identified information about sexual orientation and gender identity on intake forms, surveys, and other places where they collect information.	89%	3.61
Have materials that reflect the experience of LGBTQ/Q youth in waiting rooms and other office spaces.	87%	3.60
Hire “out” LGBTQ/Q staff.	84%	3.59
Ask people what pronouns they prefer for themselves	81%	3.40
Hang rainbow flags, pink triangles, or other LGBTQ/Q safe zone symbols on doors, buildings or exam rooms.	81%	3.35

There are two interesting things about the responses to this question.

First, it is important to recognize that the reason they are listed by response average is because it summarizes the intensity of the support. The place in which this is most clearly demonstrated is in the score for gender neutral bathroom access. While only 84% of respondents thought this was important, for those for whom it is important, it is VERY important, which reflected in the response rate, 3.71. Similarly while two possible actions might both have obtained 81% of respondents indicating that this was an important step for service providers, the response average gives an indication of whether that importance is more intense (3.40 vs. 3.35 for example). That is, the response average gives you a weighted measure of whether the action was rated as “very most important” (a “5”), “very important” (a “4”), or simply “important” (a “3”). Something with support from 80% of respondents is an important action, but a 3.40 is more important to more people than an action with a 3.35 response average.

The second thing that was of interest to the project team was what did not make it into the rank of important and this included only one possible action. The respondents did not feel that it was important for service providers to “Have special clinic hours or services for LGBTQ/Q clients.” The response average was only 2.95 despite 65% of respondents having given it a rank of “Important” or higher.

The sample size for our survey does not allow us to be representative of the GLBTQ/Q community of 18-25 year olds in Maine. But these young adults did take the time to complete the 74 question survey and clearly want social service agencies and care providers to know more about who they are and how the services can be made more accessible to them. We hope you will give their experiences and recommendations some thought and take action to make your programs and services more accessible to all Maine residents.