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RHODE ISLAND MEDICAL JOURNAL

SPECIAL SECTION

LGBTQ+

GUEST EDITORS: PHILIP A. CHAN, MD, MS; C. KELLY SMITH, MSW

JUNE 2026 VOLUME 109 • NUMBER 6 ISSN 2327-2228

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Cover image: The Rhode Island Department of Health (RIDOH) Sexual Orientation and Gender Identity (SOGI) Equity Work Group. https://health.ri.gov/health-equity/sogi-equity

JUNE 2026
VOLUME 109 • NUMBER 6

RHODE ISLAND MEDICAL JOURNAL

RHODE ISLAND MEDICAL JOURNAL (USPS 464-820), a monthly publication, is owned and published by the Rhode Island Medical Society, 225 Dyer Street, 2nd Floor, Providence RI 02903, 401-331-3207. ISSN 2327-2228. Published articles represent opinions of the authors and do not necessarily reflect the official policy of the Rhode Island Medical Society, unless clearly specified. Advertisements do not imply sponsorship or endorsement by the Rhode Island Medical Society.

Introduction: Addressing the Health of Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ+) People in Rhode Island

PHILIP A. CHAN, MD, MS; C. KELLY SMITH, MSW; THOMAS BERTRAND, MPH; JASON R. RAFFERTY, MD

KEYWORDS: LGBTQ+ Health; MSM; HIV; Substance Use; Mental Health

Lesbian, gay, bisexual, transgender, and queer (LGBTQ+) individuals in the United States represent diverse populations that face distinct health challenges related to minority stress associated with sexual orientation and gender identity. Although LGBTQ+ individuals are often considered as a single group, this term includes a diverse number of subgroups, each with separate health considerations. Sexual orientation refers to a person's romantic or sexual attraction to other people (i.e., heterosexual, gay/lesbian, bisexual, etc.). Gender identity refers to a person's inner sense of self as male, female, having elements of both, or none of these. Gender may be the same as the sex assigned at birth (i.e., cisgender) or may be different (i.e., transgender). LGBTQ+ individuals experience health disparities across a spectrum of diseases and conditions, including mental health, substance use, sexual health (i.e., HIV and other sexually transmitted infections [STIs]), cancer and chronic diseases [**Figure 1**]. Many of these disparities are linked with societal attitudes toward LGBTQ+ individuals and the barriers to care they often create. Understanding these disparities and the specific health needs of the LGBTQ+ community is the first step in addressing and implementing approaches to mitigate them.

LGBTQ+ individuals have much higher rates of mental health diagnoses compared to non-LGBTQ+ individuals. In a study of over 400,000 individuals, LGBTQ+ individuals had higher odds of depression (Adjusted Odds Ratio [AOR] 2.11), bipolar disorder (AOR 1.87–2.35), post-traumatic stress disorder (PTSD, AOR 2.77–3.67), attention-deficit/hyperactivity disorder (ADHD, AOR 2.19), and personality disorder (AOR 2.71) compared to non-LGBTQ+ populations.[1] In addition, transgender individuals are at 19x higher risk of dying by suicide than the general population, and 20–40% of transgender people have attempted suicide in their lifetime.[2] Tobacco, cannabis, and heavy alcohol use is also markedly elevated in the LGBTQ+ populations, which exacerbates mental health and chronic disease risks.[3] Certain populations such as gay, bisexual, and other men who have sex with men (MSM) report substance use at much higher rates than non-MSM populations (i.e., stimulant use).[4] The use of stimulants and specifically methamphetamine is well known to increase the risk of acquiring HIV and other sexually transmitted infections. MSM are much more likely to be diagnosed with HIV than non-MSM.[5]

LGBTQ+ individuals may also have higher rates of chronic diseases, including cancer, chronic respiratory diseases,

Figure 1. Characterizing LGBTQ+ Health Disparities in the United States

Mental Health	Substance Use	HIV/STIs	Cancer	Chronic Disease
The odds of mental health illness are 2-3x higher in LGBTQ+ individuals including depression, bipolar disorder, PTSD, ADHD, etc. (Anderson et al., 2025)	Tobacco, cannabis, and heavy alcohol use is significantly elevated among LGBTQ+ populations (Schuler et al., 2020).	Men who have sex with men have a 1 in 6 lifetime risk of HIV compared to heterosexual men who have a 1 in 524 risk (Hess et al., 2017).	Men who have sex with men are less likely to be screened for prostate cancer compared to heterosexual men (Herriges et al., 2022).	LGBTQ+ individuals have higher odd of chronic diseases including diabetes, renal disease and cardiovascular disease (Pinnamaneni et al., 2022).
Transgender individuals are at 19x higher risk of dying by suicide than the general population; 20-40% of transgender people have attempted suicide in their lifetime (Wolford et al., 2017).	LGBTQ+ individuals have higher rates of substance use than other groups. For example, gay men have 2-4x higher odds of past-year stimulant use (Rosner et al., 2021).	Men who have sex with men are at much higher risk of bacterial STIs including syphilis and gonorrhea than the general population (Werner et al., 2018).	Lesbian and bisexual women are less likely to be screened for cervical and breast cancer than heterosexual women (Agenor et al., 2022; Herriges et al., 2022).	Lesbian and bisexual women are more likely to have higher rates of obesity and other chronic diseases (Gonzales et al., 2017).

diabetes, obesity, renal disease, and cardiovascular disease among others.[6] Among a survey of almost 65,000 LGBTQ+ individuals, this group had higher odds of being diagnosed with diabetes (17% higher), renal disease (31% higher), hypertension (8% higher), cardiovascular disease (14% higher), and stroke (24% higher) compared to non-LGBTQ+ individuals.[6] In terms of cancer, MSM are less likely to be screened for prostate cancer compared to heterosexual men.[7] Lesbian and bisexual women are less likely to be screened for cervical and breast cancer than heterosexual women.[7,8] These and other health conditions highlight the significant disparities that exist between LGBTQ+ and non-LGBTQ+ individuals. Improved clinical and public health approaches are needed to improve health outcomes among the LGBTQ+ community.

There are many mechanisms which lead to health disparities faced by LGBTQ+ individuals compared to heterosexual and cisgender populations.[9] "Minority stress" refers to the social stress faced specifically by LGBTQ+ individuals due to discrimination and stigmatized social status (relative to non-LGBTQ+ populations).[10] These factors contribute to a stress response in the body that drives both physical and mental health disparities. LGBTQ+ individuals are much more likely to experience discrimination and report mistreatment when seeking medical care compared to non-LGBTQ+ individuals. For example, LGBTQ+ adults are twice as likely as non-LGBTQ+ adults to report negative experiences while receiving health care in the last three years, including being treated unfairly or with disrespect (33% versus 15%) and having at least one of several other negative experiences with a medical provider (61% versus 31%), including a provider assuming something about them without asking, suggesting they were personally to blame for a health problem, ignoring a direct request or question, or refusing to prescribe needed pain medication.[11] LGBTQ+ individuals are more likely to be socially isolated and have fewer economic and legal supports, which can also lead to reduced healthcare access and higher rates of disparities. In general, LGBTQ+ individuals are more likely to lack healthcare access, delay medical care, and be nonadherent to medications.[6]

Improving the health and wellness of LGBTQ+ communities requires interventions at multiple levels.[12] At the clinic-level, healthcare staff and organizations need to be welcoming and affirming. Staff should ask about, document, and try to use correct pronouns. Medical records should systematically document sexual orientation and gender identity to ensure patient's identities are respected and to help guide clinical decision-making. Healthcare staff should be aware of disparities as well as important health topics related to LGBTQ+ communities. For example, medical providers who care for sexually active MSM should discuss pre-exposure prophylaxis (PrEP) to prevent HIV, and also doxycycline post-exposure prophylaxis (DoxyPEP) to prevent bacterial STIs. LGBTQ+ individuals should be screened for mental health illness and substance use. Healthcare staff should also be aware of other social determinants of health (e.g., higher rates of unemployment, unstable housing, sexual assault, etc.) that may also contribute to delays in seeking healthcare.

In addition to clinic- and organization-level approaches, policy-level interventions are an important consideration to address LGBTQ+ health. Importantly, there were more than 500 anti-LGBTQ+ bills across 42 states in 2024, many of which increase stigma and discrimination related to LGBTQ+ health.[13] On January 20, 2025, the White House released an executive order entitled, "Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government." This executive order has been part of a broader government approach to target transgender people and limit funding (including healthcare payments) to organizations which recognize and study gender identity as a legitimate demographic descriptor. This and other attacks on LGBTQ+ individuals only serve to further marginalize and stigmatize these groups which already experience significant disparities in health. By contrast, legislation is also being passed in some states to facilitate LGBTQ+ care. For example, "Shield Laws" including here in Rhode Island seek to protect medical providers who provide LGBTQ+ care from civil or criminal suits from other states.[14]

Rhode Island has been fortunate to have many state and community-based organizations lead efforts to advance the health and safety of LGBTQ+ communities through a mix of policy, programmatic, and clinical initiatives. Blue Cross Blue Shield of Rhode Island has a "Safe Zone" designation which indicates clinics that provide a safe, affirming, and welcoming environment for all people (www.bcbsri.com/safezones). Several clinics in Rhode Island are known to provide culturally-competent LGBTQ+ health programs in the state, including Thundermist Health Center, Open Door Health, Planned Parenthood and Brown University Health. Other community-based organizations such as the Rhode Island Health Schools Coalition have developed a sexual and reproductive health app (www.righttoknowapp.com) for teens that includes special topics for LGTBQ+ adolescents. Numerous other community-based organizations in the state work to provide services and programs related to LGBTQ+ health. In addition, the Rhode Island Department of Health and other state agencies have supported LGBTQ+ health equity and partner with numerous organizations, including healthcare clinics to provide services to support LGBTQ+ health. One example is the creation of the "PrEP Champions Network" at the health department to increase access to PrEP services for LGBTQ+ individuals. By tapping into the strong infrastructure of clinical and community partnerships to address LGBTQ+ health, Rhode Island ranked first in the nation for two-dose Mpox vaccinations during 2022. Although more needs to be done, these and other examples highlight the dedicated efforts to date to improve LGBTQ+ health in our state.

In conclusion, LGBTQ+ individuals face numerous disparities related to mental health, substance use, sexual health, and chronic diseases. Healthcare professionals in Rhode Island should be aware of these disparities and strive to provide welcoming, culturally-competent care to individuals who identify as part of the LGBTQ+ community. Medical providers should be aware of evidence-based health interventions which are specifically recommended for LGBTQ+ individuals. Systems-level approaches, including legislation, should focus on facilitating the health and wellness of LGBTQ+ individuals, and not promulgating laws and regulations which only serve to further marginalize and stigmatize these populations.

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Disclosures

Acknowledgment: We thank all authors for their assistance with the manuscript.

Sources of support: The current study was unfunded.

Competing interests: The authors declare no competing interests.

Ethics statement: Not applicable.

Data availability statement: Not applicable.

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Implementing Behavioral Health Services at a Community-Based LGBTQ+ Clinic

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ABSTRACT

INTRODUCTION: Lesbian, gay, bisexual, transgender, and queer (LGBTQ+) individuals face significantly more behavioral health disease burden than their heterosexual counterparts. Improved access to behavioral health services is urgently needed. We describe developing and implementing a comprehensive integrated behavioral health (IBH) program at a community-based clinic in Rhode Island, where primary care, behavioral health, and psychiatric providers work in a coordinated setting to support patients' whole health.

METHODS: We reviewed demographic and clinic data from 2023 to 2025 of an IBH program at Open Door Health in Providence, Rhode Island. We compared implementation outcomes between Year 1 and Year 2 of the program.

RESULTS: During the two-year study period, N=2,914 behavioral health visits were conducted among N=684 unique adult patients (N=212 in Year 1; N=548 in Year 2). The average patient age was 34.8 years (range: 18-77 years). Among these patients, 70.2% identified as White, 13.7% as Black/African American, 15.9% as Hispanic/Latino, 41.81% as transgender/gender diverse/nonbinary, and 81.4% as LGBTQ+. Patient volume increased 200% in Year 2 compared to Year 1 (723 versus 2,191 visits). LGBTQ+ patients utilized a greater volume of IBH services, with 20.11% having five or more visits compared to 10.2% of non-LGBTQ+ patients.

CONCLUSION: IBH services increased dramatically year over year. Offering behavioral health services during primary care visits at a community-based LGBTQ+ clinic resulted in significant uptake of behavioral health services for patients who might not otherwise have access to these services.

KEYWORDS: LGBTQ+ Health; Integrated Behavioral Health; Mental Health; Primary Care; Implementation

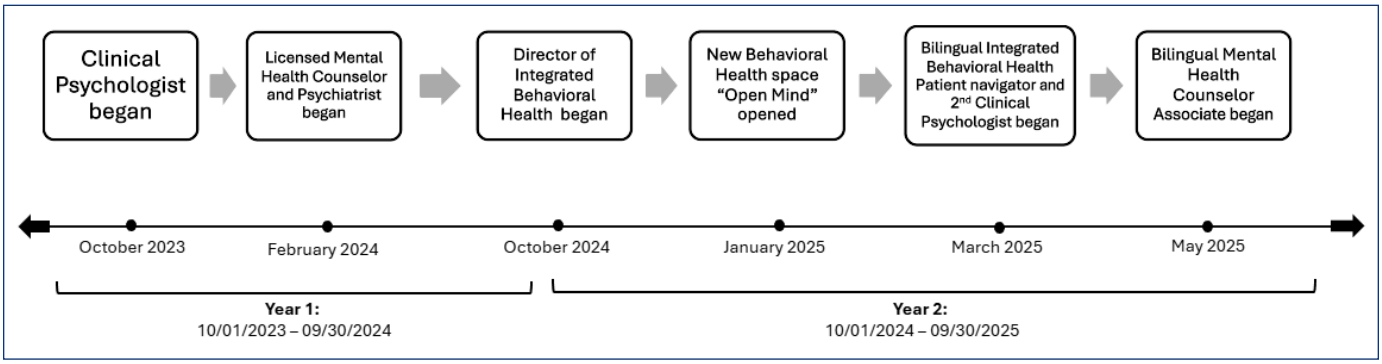
INTRODUCTION

In the United States, lesbian, gay, bisexual, transgender, and queer (LGBTQ+) individuals are disproportionately affected by mental health conditions compared to their non-LGBTQ+ counterparts. A 2025 national study of more than 430,000 adults found that cisgender sexual minority men had significantly higher odds of being diagnosed with multiple psychiatric diagnoses compared to cisgender heterosexual men, including elevated odds of anxiety (adjusted odds ratio [AOR] 1.64), depression (AOR 1.86), bipolar disorder (AOR 1.87), obsessive-compulsive disorder (AOR 1.56), and five other major mental health conditions.[1] Another cross-sectional analysis of adults in the United States found that sexual minority respondents screened positive for depression and anxiety at approximately four times the rate of heterosexual respondents, with roughly half of sexual minority adults meeting GAD-7 or PHQ-9 criteria for depression or anxiety.[2] The mental health burden is particularly acute among transgender and gender non-conforming individuals. One study found that transgender individuals were at 19-fold greater risk of dying by suicide than the general population,[3] and more recent data suggest that 82% of transgender individuals have considered suicide and 40% have made at least one lifetime attempt.[4]

The elevated mental health burden in LGBTQ+ populations is further exacerbated by increased substance use. LGBTQ+ adults in the United States report substantially higher prevalence of tobacco use (27.4% vs. 18.4% among heterosexual adults) and cannabis use (40.8–42.9% among gay and bisexual men vs. 23.9% among heterosexual men).[5,6] Illicit stimulant use, including methamphetamine, is also more prevalent among men who have sex with men (MSM) compared to non-MSM populations,[7] with important public health implications given methamphetamine's role as a risk factor for HIV acquisition. Persistent methamphetamine use among gay and bisexual men has been associated with a 14% incidence of HIV seroconversion over 12 months, corresponding to a four- to seven-fold increase in HIV acquisition odds compared to men without persistent use.[8] Sexual minority women also use alcohol at higher rates than their heterosexual counterparts; one study found that lesbian women were approximately seven times more likely, and bisexual women nearly 6.5 times more likely, than heterosexual women to meet clinical criteria for alcohol dependence.[9]

Access to affirming, culturally tailored behavioral health services is challenging for many LGBTQ+ individuals. Although 67% report needing mental health care compared

Figure 1. Integrated Behavioral Health Program Expansion Timeline (October 2023–May 2025)



Timeline depicts key programmatic milestones across a two-year implementation period from October 2023 to May 2025.

to 39% of non-LGBTQ+ individuals, fewer than half of LGBTQ+ individuals actually receive it.[10] Some of the most commonly cited structural barriers for accessing behavioral health services include long wait times, insurance limitations, and fear of discrimination or stigma. Forty-two percent of individuals report delays exceeding a month for appointments and 8% of LGBTQ+ individuals and 22% of transgender individuals avoid care altogether.[10] These challenges reveal the growing demand for novel approaches to address barriers to accessing behavioral health care among LGBTQ+ populations.

One effective approach to addressing this burden is offering integrated behavioral health (IBH) services in primary care settings. IBH refers to a healthcare model in which primary care, behavioral health, and psychiatric providers work together in a coordinated and integrated setting.[11] The model incorporates universal behavioral health screening, in which all patients are systematically assessed for mental and behavioral health conditions and substance use disorders at each visit using validated, standardized tools. Patients who screen positive are then offered a referral to behavioral health providers for further evaluation and treatment. Additionally, the IBH model enables primary care providers to directly refer patients internally to IBH services, enabling "warm handoffs," which refer to internal referrals within a care team for same day access to consultations, therapy, or psychiatric support without external referrals. The goal is to provide comprehensive and cohesive care through seamless internal referrals, shared communication between care teams, and recurring measurement-based assessments to monitor and manage behavioral health conditions.

Previous studies demonstrate that IBH services can significantly improve behavioral health outcomes. For example, one IBH program in Louisiana reported significant improvements in depression and anxiety.[12] Another large healthcare system in North Carolina found that after implementing an IBH model, approximately half of the patients with mood disorders achieved a 50% reduction in depression and anxiety symptoms, and an 82% reduction or elimination of suicidal thoughts.[13] Similarly, the American Medical Association depicted a medical practice where 60% of PHQ-9 scores and 63% of GAD-7 scores decreased by half within six months.[14] Given these demonstrated benefits, primary care clinics serving populations with higher behavioral health needs, such as LGBTQ+ communities, are well-positioned to implement such evidence-based IBH models.

Open Door Health is a community-based LGBTQ+ clinic in Providence, Rhode Island, established in 2020 as an initiative of the Rhode Island Public Health Institute (RIPHI). Open Door Health is a non-profit clinic that provides affirming and accessible primary care to all persons, and offers specialty services for LGBTQ+ individuals. The clinic provides comprehensive primary care, sexual health services, gender-affirming medical care, HIV prevention and treatment, and behavioral health services. In response to overwhelming demand for behavioral health services among its LGBTQ+ patient population, Open Door Health launched an IBH program in 2023 [**Figure 1**]. This analysis describes outcomes from the first two years of the program's implementation.

METHODS

This study was a descriptive, retrospective analysis of IBH services implemented at Open Door Health, a community-based LGBTQ+ primary care and sexual health clinic in Providence, Rhode Island. We reviewed electronic medical records across two time periods: Year 1 (October 1, 2023 to September 30, 2024) and Year 2 (October 1, 2024 to September 30, 2025). We assessed demographic information and service utilization for all patients accessing IBH services during the study period, including the frequency and types of behavioral health visits provided by various providers. Behavioral health visits were categorized as triage visits (initial assessment visits) or other behavioral health visits (follow-up and treatment visits for psychotherapy or psychiatry). Visit frequency was compared between LGBTQ+ and non-LGBTQ+ individuals, categorizing visits as 1, 2, 3, 4, or 5 or more visits per patient during the evaluation period. Finally, frequencies and percentages were used to assess changes in behavioral health service utilization across Year 1 and Year 2. Retrospective review of medical records was approved by the Brown University Institutional Review Board.

RESULTS

During the two-year study period (Year 1 and Year 2), a total of N=2,914 behavioral health visits were conducted among N=684 unique adult patients (N=212 in Year 1 and N=548 in Year 2). The average patient age was 34.8 years (range: 18–77 years). Demographic characteristics of the population included: N=480 patients (70.2%) identified as White, N=94 (13.7%) as Black or African American, N=109 (15.9%) as Hispanic or Latino, N=286 (41.8%) as transgender, gender diverse, or nonbinary, and N=557 (81.4%) as LGBTQ+. Approximately half the sample (326, 47.66%) had private insurance. Detailed demographic characteristics of all unique patients receiving integrated behavioral health services are presented in **Table 1**.

Table 1. Demographic Characteristics of Patients Receiving Integrated Behavioral Health Services (N=687)

Age group: Mean: 34.8 (Range: 18–77)	N	%
Race		
White	480	70.18%
Black/African American	94	13.74%
Other race	52	7.60%
Asian	30	4.39%
Patient Declined	17	2.49%
American Indian/Alaska Native	11	1.61%
Ethnicity		
Not Hispanic or Latino	553	80.85%
Hispanic/Latino	109	15.94%
Patient Declined	21	3.07%
Not recorded	1	0.15%
Gender Category		
Cisgender Man	245	35.82%
Cisgender Woman	115	16.81%
Genderqueer/Gender non-conforming	126	18.42%
Transgender Woman	85	12.43%
Transgender Man	75	10.96%
Choose not to disclose	28	4.09%
Unable to determine	10	1.46%
LGBTQ+ Identity		
LGBTQ	557	81.43%
Not LGBTQ	127	18.57%
Sexual Orientation		
Lesbian, gay, or homosexual	242	35.38%
Something else	156	22.81%
Bisexual	104	15.20%
Straight or heterosexual	101	14.77%
Choose not to disclose	65	9.50%
Don't know	16	2.34%
Insurance Type		
Private	326	47.66%
Medicaid (MMP)	267	39.04%
Self-pay	54	7.89%
Medicare	30	4.39%
Other	7	1.02%

Demographic characteristics of 687 unique adult patients receiving integrated behavioral health services at Open Door Health (2023–2025). Values are N (% of total, N+684)

Year 1 included a total of N=723 behavioral health visits, comprising 91 triage visits and 632 other behavioral health visits. Year 2 demonstrated substantial growth to N=2,191 total visits, including 423 triage visits and 1,768 other behavioral health visits, representing a 200% increase in visit volume from Year 1 to Year 2. The increase in visit volume reflected programmatic expansion during the study period [**Figure 1**]. Year 1 included the addition of one clinical psychologist, one licensed mental health counselor (LMHC), and one psychiatrist. Year 2 expansion included the appointment of a Director of Integrated Behavioral Health Services, a new clinical venue for service provision called "Open Mind," which refers to a dedicated space for LGBTQ+-competent mental health care in a private and secure setting connected to the main Open Door Health facility. We also added bilingual patient navigation services, a second clinical psychologist, and a bilingual mental health counselor associate (MHCa).

LGBTQ+ patients demonstrated higher engagement in IBH services with repeat visits compared to non-LGBTQ+ patients. Among LGBTQ+ patients, 44.7% had one visit, 21.18% had two visits, and 20.11% had five or more visits during the study period. In contrast, non-LGBTQ+ patients more frequently had single visits (59.84%), with only 10.24% having five or more visits, indicating greater treatment engagement among LGBTQ+ patients receiving IBH services [**Table 2**].

Table 2. Behavioral Health Visit Frequency by LGBTQ+ Status (N=684)

Number of Barriers	LGBTQ		Non-LGBTQ	
	N	%	N	%
1	249	44.70%	76	59.84%
2	118	21.18%	30	23.62%
3	51	9.16%	4	3.15%
4	27	4.85%	4	3.15%
5+	112	20.11%	13	10.24%
Total	**557**	**100.00%**	**127**	**100.00%**

Number and percentage of unique patients by number of visits during two-year IBH program (2023-2025). LGBTQ+ patients: n=557; non-LGBTQ+ patients: n=127. Percentages sum to 100% within groups.

DISCUSSION

This analysis represents among the first descriptions of implementation of IBH services at a community-based LGBTQ+ primary care clinic in Rhode Island. Previous studies have documented the effectiveness of the IBH model in improving key behavioral health indicators, such as anxiety, depression, and substance use. This study adds to the literature by demonstrating the feasibility and success of IBH implementation in a community clinic setting.

Over the two-year study period, our IBH program showed significant growth, evidenced by increased patient visits, clinical staff expansion, and effective engagement with historically marginalized populations. The program evolved from a primary care service with one licensed mental health psychologist to a comprehensive, culturally tailored IBH program supporting patients at every care stage [**Figure 1**], from patient navigator consultations through long- and short-term psychiatric and psychotherapy services. Year 1 added a clinical psychologist, LMHC, and psychiatrist. Year 2 brought a Director of Integrated Behavioral Health Services, the dedicated "Open Mind" LGBTQ+-competent space, a bilingual patient navigator, a second clinical psychologist, and a bilingual LMHC. The 200% increase in patient volume from Year 1 to Year 2 (723 to 2,191) reflects both demand for behavioral health services among the LGBTQ+ community and the effectiveness of our strategic expansion.

Previous studies have documented the effectiveness of the IBH model in improving key behavioral health indicators, such as anxiety, depression, and substance use.[15-17] This study adds to the literature by demonstrating the feasibility and success of IBH implementation in a community clinic setting. LGBTQ+ individuals experience well-documented mental health challenges and unmet needs due to stigma, economic vulnerabilities, and lack of affirming services.[18-23] Integrating IBH services within primary care removes barriers common among LGBTQ+ individuals and present in traditional siloed systems, where differing EMRs, billing, and care teams lead to lost referrals and poor follow-up. Embedding behavioral health providers facilitates clearer communication with primary care via shared EMRs and enables timely same-team referrals. This aligns with prior literature showing improved screening, diagnosis, and treatment when mental health providers share clinical information and streamlined workflows.

In support of this model, we hired an IBH patient navigator to conduct initial consultations, review screening data, perform intakes for flagged patients, and facilitate warm handoffs to internal or external services. Navigators reduce key barriers, including bridging primary care and behavioral health, managing appointments, and navigating insurance.[24-26] These roles prove especially valuable for LGBTQ+ patients wary of unvetted specialty mental health. Similarly critical was Year 2's appointment of a Director of Integrated Behavioral Health Services [**Figure 1**], whose leadership drove staffing expansion, billing integration, and the "Open Mind" dedicated space, ensuring clinical scalability and the 200% volume growth.

IBH models improve engagement, with 75% of patients achieving diagnosis and treatment initiation within 6 months versus less than 25% in fragmented systems.[27] These effects prove even stronger for stigmatized LGBTQ+ individuals who often delay care.[28,29] Affirming, integrated settings eliminate the need to navigate unknown specialty systems. We intentionally hired bilingual and LGBTQ+-identifying staff to foster patient-provider trust, yielding a diverse cohort: 81.4% LGBTQ+ (41.9% transgender/gender diverse) with substantial Black/African American and Hispanic/Latino representation. These results show that providers who reflect patients' identities help overcome access barriers, advancing equity for marginalized groups. LGBTQ+ patients showed higher repeat visit rates (20.11% with five or more visits) than non-LGBTQ+ patients (10.2%), suggesting affirming integrated care sustains engagement. Evidence confirms culturally competent care boosts retention among LGBTQ+ populations.[30-33] Together, these findings position LGBTQ+-affirming IBH as a promising solution to care disengagement.

This study has several limitations. This study was conducted at a single primary care clinic, which limits the generalizability of these findings to regions of the country that may be more restrictive of LGBTQ+ focused or culturally tailored services. Additionally, although this study included service utilization frequency, it did not include standardized clinical measurements such as GAD-7 or PHQ-9 scores. This limits our ability to determine whether the IBH model improved clinical outcomes compared to traditional healthcare approaches. Finally, our two-year study period during the investment in IBH program development represents an early implementation phase, and as such, longer-term follow-up would be needed to assess program sustainability and success beyond the initial growth period. Despite these limitations, this work provides important preliminary evidence that integrated behavioral health delivery within LGBTQ+-affirming primary care is feasible and effective at reaching and engaging marginalized populations in Rhode Island.

In conclusion, implementing an IBH program at a community-based LGBTQ+ clinic resulted in significant uptake of services over a two year period. There's a public health opportunity to enhance access and uptake of behavioral health services by integrating them with primary care.

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Disclosures

Sources of Support: The current study was unfunded.

Competing Interests: The authors declare no competing interests.

Ethics Statement: Not applicable.

Data Availability Statement: Not applicable.

Authorship: All authors contributed equally to the manuscript, and have read and approved the final manuscript.

Acknowledgments: We thank all authors for their assistance with the manuscript.

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Anal Cancer Screening Rates Among Gay, Bisexual, and Other Men Who Have Sex With Men and Transgender Women Presenting for Services at a Community-Based Clinic

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ABSTRACT

PURPOSE: To evaluate anal cancer screening rates among men who have sex with men (MSM), transgender women (TGW), and people living with HIV (PLWH) at a community-based lesbian, gay, bisexual, transgender, and queer (LGBTQ+) clinic.

METHODS: We reviewed anal cancer screening rates from April 2023 to April 2025 among MSM, TGW and PLWH receiving care at an LGBTQ+ clinic in Providence, Rhode Island. Bivariate analyses and logistic regression were used to explore factors associated with anal cancer screening.

RESULTS: A total of N=302 individuals were eligible for anal cancer screening based on clinical guidelines during the evaluation period. Anal cancer screening was performed in 14.2% of eligible individuals, with 6.3% reporting abnormal results. In the multivariate analysis, after adjusting for age, race, and ethnicity, being a PLWH was associated with anal cancer screening (OR: 2.60; 95% CI: 1.31-5.52). A total of N=17 individuals had a high-resolution anoscopy performed (N=9 with atypical squamous cells of undetermined significance and N=8 with low-grade squamous intraepithelial lesions on cytology). Of those with anoscopy performed, 59% had abnormal pathology (N=4 Anal intraepithelial neoplasia [AIN] stage 1; N=4 AIN2; N=2 AIN3). No individuals were diagnosed with anal cancer.

CONCLUSION: Improved efforts are needed to screen at-risk populations for anal cancer in community settings.

KEYWORDS: Anal cancer screening; Men who have sex with men; Transgender women; HIV and LGBTQ+

INTRODUCTION

In 2023, there were nearly 10,000 anal cancer cases diagnosed in the United States (US).[1] Anal cancer disproportionately impacts select subpopulations in the US, including people living with HIV, particularly gay, bisexual, and other men who have sex with men (MSM), and transgender women (TGW). Although the overall cases in the general population are low, MSM and TGW have a substantially higher risk of developing anal cancer, primarily due to human papillomavirus (HPV) infection and other risk factors associated with sexual behavior.[2] The incidence rate of anal cancer is 85 per 100,000 person-years for HIV-positive MSM and 19 per 100,000 for HIV-negative MSM.[3] Among HIV-negative MSM, anal cancer incidence increases significantly with age, reaching 34 cases per 100,000 men at age 60 years or older. This compares to HIV-negative heterosexual men who have sex with women (MSW), where the incidence is fewer than 3 cases per 100,000 men at all ages.

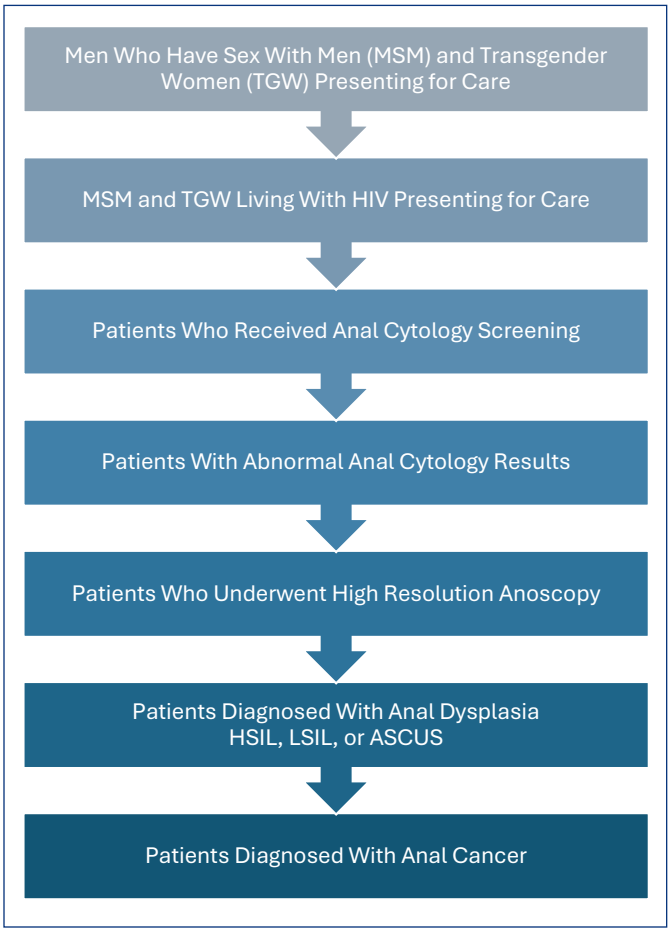
Screening for anal cancer is the first step in addressing the burden of anal cancer among sexual and gender minority populations, including MSM and TGW. The International Anal Neoplasia Society (IANS) released updated clinical guidelines in 2024 regarding anal cancer screening. Guidelines state that screening initiation at age 35 years is recommended for MSM and TGW living with HIV. For other people living with HIV and for men who have sex with men and transgender women without HIV, screening initiation at age 45 years is recommended. Data on screening rates are limited, and existing studies suggest that anal cancer screening among men who have sex with men and transgender women remains low. Less than 50% of MSM have had anal cancer screening, and rates are far lower among Black/African American men. For individuals with anal dysplasia, including high-grade intraepithelial lesions (HSIL), further intervention is warranted with high-resolution anoscopy and targeted interventions to reduce anal cancer.

The goal of this study was to evaluate baseline rates of anal cancer screening and subsequent anoscopy in MSM and TGW with anal dysplasia at a lesbian, gay, bisexual, transgender, and queer (LGBTQ+) clinic, in order to identify gaps in services and guide subsequent efforts to improve anal cancer screening and treatment rates.

METHODS

We reviewed demographic and behavioral data from April 2023 to April 2025 on all patients receiving primary care at Open Door Health, a community-based LGBTQ+ clinic in Providence, Rhode Island. In addition, we reviewed patients who received anal cancer screening and had subsequent high-resolution anoscopy. Open Door Health provides care to over 7,000 patients, the majority of whom identify as LGBTQ+. This clinic provided a unique setting and opportunity to evaluate anal cancer screening among MSM and TGW. We developed a cascade to characterize screening

Figure 1. HSIL indicates high-grade squamous intraepithelial lesions. LSIL indicates low-grade squamous intraepithelial lesions. ASCUS indicates atypical squamous cells of undetermined significance.



opportunities and patient progression through this process. This "Anal Health Cascade" represents key points in patient engagement with anal cancer screening, from initial presentation for care through diagnostic evaluation and detection of anal dysplasia or cancer [**Figure 1**].

Bivariate analyses were conducted to examine differences in characteristics between individuals who received anal cancer screening and those who did not. Chi-square tests were used for categorical variables, and the Kruskal-Wallis test was used for continuous variables. Fisher's exact test was applied to variables with zero-cell counts or small cell sizes (N<5). To assess factors associated with receipt of anal cancer screening, we performed logistic regression analyses. First, bivariate logistic regression models were fitted for each independent variable. Then, a multivariable logistic regression model was constructed, adjusting for age, race, and ethnicity. Adjusted odds ratios (aORs) and 95% confidence intervals (CIs) were reported. Exact logistic regression was used when needed to account for sparse data and zero-cell counts. Review of deidentified data was approved by the local institutional review board.

Table 1. Participant Demographics by Receipt of Anal Cancer Screening

Variable	Receiving anal pap test			p-value
	No (%)	Yes (%)	Total (%)	
Age (Median, Interquartile range)	54 (48, 60)	55 (45, 61)	54 (47, 60)	0.75
Race				
White	188 (74.90%)	34 (82.93%)	222 (76.03%)	0.359
Black	31 (12.35%)	2 (4.88%)	33 (11.30%)	
Other	32 (12.75%)	5 (12.20%)	37 (12.67%)	
Missing	8	2	10	
Assigned Sex at Birth				0.375*
Male	247 (95.74%)	43 (100.00%)	290 (96.35%)	
Female	11 (4.26%)	0 (0.00%)	11 (3.65%)	
Missing	1	0	1	
Ethnicity				
Non-Hispanic	217 (87.85%)	36 (83.72%)	253 (87.24%)	0.453
Hispanic	30 (12.15%)	7 (16.28%)	37 (12.76%)	
Missing	12	0	12	
PLWH				
No	182 (70.27%)	22 (51.16%)	204 (67.55%)	0.013
Yes	77 (29.73%)	21 (48.84%)	98 (32.45%)	
Missing	0	0	0	
MSM				
MSM/TGW	212 (85.83%)	36 (83.72%)	248 (85.52%)	0.717
Heterosexual	35 (14.17%)	7 (16.28%)	42 (14.48%)	
Missing	12	0	12	

*Fisher exact test for p-value

RESULTS

A total of 302 individuals were included. **Table 1** presents the bivariate analyses comparing demographics and anal cancer screening. The median age was 54 years (IQR: 47–60). Most participants were assigned male at birth (96.4%), and 3.6% were female. The majority identified as White (76.0%) and non-Hispanic (87.2%). Nearly one-third (32.5%) were living with HIV. Among participants with complete sexual behavior data (N=290), 85.5% identified as MSM or TGW, and 14.5% as heterosexual.

Anal cancer screening was performed in 14.2% of individuals, with 6.3% reporting abnormal results. A total of N=17 individuals had a high-resolution anoscopy performed (N=9 with ASCUS and N=8 with LSIL on cytology). Of those with high-resolution anoscopy performed, 59% had abnormal pathology (N=4 Anal intraepithelial neoplasia [AIN] stage 1; N=4 AIN2; N=2 AIN3). No individuals were diagnosed with anal cancer.

There were no significant differences in age (p = 0.75), race (p = 0.359), or ethnicity (p = 0.453) by anal cancer screening.

Table 2. Factors Associated with Anal Cancer Screening

Variables	Crude odds ratio (95% confidence interval)	Adjusted odds ratio (95% CI)*
Age	0.98 (0.95, 1.02)	—
Assigned sex at birth		
Male	ref	
Female	0.38 (0, 2.39)#	
Race		
White	ref	
Black	0.36 (0.08, 1.56)	
Other	0.86 (0.31, 2.37)	
Ethnicity		
No	ref	
Yes	1.41 (0.57, 3.44)	
Being MSM/TGW		
MSM/TGW	ref	ref
Heterosexual men	1.18 (0.49, 2.85)	1.17 (0.45, 3.06)
Living with HIV		
No	ref	ref
Yes	2.26 (1.17,4.34)	2.69 (1.31, 5.52)

*Adjusted for age, race, and ethnicity
#exact logistic regression to account for sparse data and zero-cell counts

Although no females received anal cancer screening, statistical significance was not observed due to the small sample size (p = 0.375), while Fisher's exact test was used to account for having no people in the category. Individuals living with HIV were significantly more likely to receive anal cancer screening than those not living with HIV (48.8% vs. 29.7%; p = 0.013). Being MSM/TGW was not associated with a higher likelihood of receiving anal cancer screening (p = 0.717).

In multivariable logistic regression analyses adjusted for age, race, and ethnicity, individuals living with HIV had significantly higher odds of receiving anal cancer screening compared to those not living with HIV (adjusted OR: 2.60; 95% CI: 1.31–5.52). Assigned sex at birth, race, ethnicity, and sexual behavior (MSM/TGW vs. heterosexual men) were not significantly associated with anal cancer screening. Although none of the female participants received screening, this association did not reach statistical significance after adjusting for sparse data using exact logistic regression. [See **Table 2**]

DISCUSSION

Despite important need for anal cancer screening in this LGBTQ+ population, few individuals were screened for services. High-resolution anoscopy was performed in the majority of people with abnormal anal cytology. This is among the few studies to evaluate anal cancer screening rates in populations that are at higher risk of anal cancer, including MSM, TGW, and PLWH. Given accumulating data and release of clinical guidelines in 2024, anal cancer screening in these populations is warranted. Despite this, we found that anal cancer screening rates are low in LGBTQ+ populations. In those that did have anal cancer screening performed, the rates of abnormal results were high. Fortunately, no anal cancer was found in our population, although the overall number of patients was low. These data suggest that significant efforts are needed to implement anal cancer screening in clinical settings focused on LGBTQ+ populations.

Anal cancer screening is an acceptable practice among those at higher risk of anal cancer.[8-10] However, awareness of the importance of anal cancer screening is low.[9-13] Most studies of anal cancer screening have been conducted at academic HIV clinics.[10,14] Consistent with these results and others,[15,16] our study found low anal cancer screening rates despite strong institutional support for the program, likely due to the need to prioritize other timely health issues and the fact that guidelines are more recent.[14] These results suggest that improved efforts are needed to both increase anal cancer screening and subsequent follow-up high-resolution anoscopy in patients with abnormal results. In contrast to other studies among patients with abnormal findings,[15] follow-up anoscopy was high in patients reporting abnormal anal cytology on screening. Onsite high-resolution anoscopy services at our clinic may have facilitated these high rates.

There were several limitations of our study. The study was performed at a single site, which may limit generalizability. Our study focused only on populations aged 35 years and older given clinical recommendations and that existing studies do not recommend screening under this age.[17] All data reviewed was part of clinic medical records. However, patients could have had clinical care outside of the clinic that may have been missed during the review process, which would have underestimated anal cancer screening rates. Despite these limitations, these data characterize gaps in anal cancer screening among higher-risk populations.

In summary, improved efforts are needed to increase anal cancer screening rates among MSM, TGW, and PLWH at this LGBTQ+ clinic. Numerous implementation questions remain related to anal cancer screening, including cost-effectiveness and optimal approaches to screening.[18,19] New screening guidelines present a public health opportunity to expand anal cancer screening at LGBTQ+ clinics. Our experience demonstrates that staff training and institutional commitment is necessary to expand anal cancer and anoscopy at busy community clinics. However, our baseline data suggests this is feasible, and screening policies identify patients at high risk for developing anal cancer.

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Disclosures

Conflicting Interests and Financial Disclosures: The authors declare no conflicting interests or financial disclosures.

Acknowledgments: We thank all authors for their assistance with the manuscript.

Ethical Approval: Review of deidentified data was approved by the local institutional review board.

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Interpersonal Violence Victimization of Sexual and Gender Minority Youth: A Cross-Sectional Study of Risk and Protective Factors

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ABSTRACT

BACKGROUND: Little is known about risk and protective factors associated with distinct forms of violence victimization among lesbian, gay, bisexual, transgender, or questioning youth, or youth who define their sexual identity another way (LGBTQ+). This study sought to examine this in a statewide representative sample of Rhode Island high school students.

STUDY DESIGN AND METHODS: Data were from the 2023 Rhode Island High School Youth Risk Behavior Survey—a biennial, voluntary, and anonymous survey designed to measure health-related behaviors and experiences among high school students. The sample comprised 1,932 high school students (weighted sample n = 46,603), of whom 28% identified as lesbian, gay, bisexual, transgender, questioning, or defined their sexual identity another way ("LGBTQ+" weighted sample n=11,891). The primary outcomes of interest were three types of victimization: bullying/discrimination, intimate partner violence (IPV), and sexual coercion/exploitation. Bivariate analysis explored differences in rates of victimization based on sexual orientation and gender identity. Weighted logistic and multinomial regression models focused on LGBTQ+ youth and examined the role of risk and protective factors in victimization.

RESULTS: LGBTQ+ students who reported always having their basic needs met at home were less likely to experience IPV (Adjusted Odds Ratio [AOR]=0.53, 95% Confidence Interval [CI]= 0.31–0.88), sexual coercion/exploitation (AOR=0.38, 95% CI=0.17-0.85), and multiple types of victimization (AOR=0.32, 95% CI=0.18–0.57). Housing insecurity (AOR=3.36, 95% CI=1.73–6.50), ever living with someone with a drug/alcohol problem (AOR=2.56, 95% CI=1.63–4.04), and ever living with someone with mental illness (AOR=3.97, 95% CI=1.76–8.96) were associated with higher odds of sexual coercion/exploitation.

CONCLUSION: Overall, findings contribute to the understanding of distinct types of victimization that LGBTQ+ youth face. Further research into the relationship between risk factors associated with unstable home environments and victimization would be valuable in identifying opportunities for prevention.

KEYWORDS: interpersonal violence victimization; risk and protective factors; sexual and gender minority youth

INTRODUCTION

Interpersonal violence victimization, including dating violence, sexual violence, and bullying, is a serious public health problem among adolescents that is associated with long-term negative effects on health.[1] In 2023, an estimated 11% U.S. high school students reported experiencing sexual violence during the previous 12 months, and 8% experienced forced sex in their lifetime.[2] Other studies suggest rates of victimization are higher when accounting for psychological forms of abuse. Sexual minority (i.e., individuals who report non-heterosexual identity) and gender minority (i.e., individuals who do not identify with their sex assigned at birth) youth experience disproportionately greater prevalence of all forms of interpersonal violence victimization compared with their cisgender/straight peers.[1,3-12] However, most health surveys have not consistently included questions assessing sexual orientation and gender identity (SOGI) and thus risk factors for victimization are understudied in sexual and gender minority (SGM) youth.[13]

The present study examines risk and protective factors associated with distinct forms of violence victimization, as well as experiences of multiple types of victimization among SGM youth (Aim 1). Three understudied risk and protective factors are explored—the home and school environment and connectedness to others (Aim 2). This is the first Rhode Island study to estimate risk and protective factors in relationship to interpersonal violence victimization in a statewide representative sample of SGM high school students.

METHODS

Data were from the 2023 Rhode Island High School Youth Risk Behavior Survey (RI YRBS), a biennial, voluntary, and anonymous survey conducted by the Rhode Island Department of Health with support from the Centers for Disease Control and Prevention (CDC). The survey uses single-item multiple-choice questions to measure health-related behaviors and experiences among high school students. A total

of 25 Rhode Island schools were selected systematically with probability proportional to enrollment in grades 9 through 12 using a random start. Systematic equal probability sampling with a random start was used to select classes from each school that participated in the survey. No bias was found in nonresponse rates between responding versus nonresponding schools by school enrollment size, poverty measure, geographic location, or student grade. Nineteen of the 25 sampled eligible schools participated. The overall response rate of 56%. Data were weighted to obtain statewide population estimates.[14]

A combined sexual orientation and gender identity (SOGI) variable was created categorizing respondents as "cisgender and straight" or "lesbian, gay, bisexual, transgender, questioning, or described their sexual identify in another way (LGBTQ+)." This study uses cisgender to describe individuals whose gender identity and expression align with the sex they were assigned at birth. LGBTQ+ and sexual and gender minority (SGM) are used interchangeably as umbrella terms for youth with non-majority sexual orientations or gender identities.

The main outcome variables of interest were those related to experiences with violence victimization. Three types of victimization were identified based on factor analysis: bullying/discrimination, intimate partner violence (IPV), and sexual coercion/exploitation. Bullying/discrimination was defined as having experienced bullying on school grounds or electronically in the previous 12 months or having ever been treated badly/unfairly due to one's perceived SOGI status. Intimate partner violence was defined as experiencing physical or sexual dating violence in the past 12 months. Sexual coercion/exploitation was defined as ever being forced to have sex against one's will or having ever been given money, a place to stay, food, or something else of value in exchange for sex. Additionally, a combined victimization variable was created tabulating the types of victimization experienced (0, 1, or 2 or more).

Descriptive analyses were conducted to examine demographic characteristics of both groups (LGBTQ+ and cisgender/straight students) and the prevalence of all victimization outcomes and risk and protective factors of interest. Because victimization rates are higher among LGBTQ+ youth, regression analyses examining the relationship between risk and protective factors and victimization focused on LGBTQ+ high school students. Separate multivariable logistic regressions were computed to examine the role of risk and protective factors in each of the three types of victimization experienced (bullying/discrimination, IPV, and sexual exploitation/coercion). A multinomial logistic regression model was then computed modeling the relationship between risk and protective factors and the number of types of victimization experienced (0, 1, or 2 or more). All models adjusted for participants' sex.

Protective factors of interest included having an adult at school to talk to if you have a problem, always having basic needs met at home (safety, clean clothes, food), and getting the help needed when feeling sad/angry/anxious. Risk factors of interest included food insecurity (ever going hungry in the past 30 days because there was not enough food in the home), housing insecurity (ever getting kicked out of the home or not usually sleeping at home due to parents not being able to afford housing in the past 30 days), student substance use (current alcohol/ marijuana use or ever abusing pain medications), or ever living with someone with a drug or alcohol problem or who was depressed, mentally ill or suicidal.

RESULTS

In 2023, 1,932 Rhode Island high school students completed the YRBS—representing a statewide weighted sample of 46,603 students, of whom 28% identified as LGBTQ+ (weighted sample n =11,891). Among those who identified as LGBTQ+, the most common sexual orientation was bisexual (46.2%) and 14.4% identified as transgender [**Table 1**].

Analysis of victimization outcomes revealed LGBTQ+ high school students were more likely than cisgender/straight students to experience nearly all types of victimization assessed [**Table 2**]. Two-thirds (66.6%) of LGBTQ+ students were a victim of bullying and/or discrimination, 17.2% experienced dating violence in the past year, and 15.6% have been a victim of sexual coercion/exploitation in their lifetime. Rates among cisgender/straight students were significantly lower, with 21.9% experiencing bullying/discrimination (p<.0001), 7.3% experiencing dating violence (p<.0001), and 5.4% experiencing sexual coercion/exploitation (p<.0001).

Analysis of risk and protective factors found that among LGBTQ+ high school students, 59.3% have ever lived with someone who was depressed, mentally ill, or suicidal, which was two times higher than for cisgender high school students [26.5%; p<.0001; **Table 3**]. A higher percentage of LGBTQ+ students than cisgender students had ever lived with someone with a drug or alcohol problem (44.7% vs. 23.0%; p<.0001). Additionally, LGBTQ+ students were more likely than cisgender students to report substance use. (43.5% vs. 30.7%; p=.0004). Among high school students who reported having felt sad, empty, hopeless, angry, or anxious in the 12 months before the survey, cisgender students were about five times as likely to get the help needed than LGBTQ+ students (82.4% vs. 17.6%; p<.0001; data not shown).

Multivariable logistic regression models examined risk and protective factors associated with interpersonal violence victimization in the LGBTQ+ high school student sample. Ever living with someone who was depressed, mentally ill or suicidal emerged as a significant risk factor for experiencing bullying/discrimination (Adjusted Odds Ratio [AOR]=1.92,

95% Confidence Interval [CI]=1.22–3.03) [**Table 4**]. A second multivariable logistic regression model found that student substance use was a significant risk factor for IPV (AOR=2.35, 95% CI=1.17–4.68). Having one's basic needs met at home also emerged as a significant protective factor. Students who reported always having their needs met were less likely than those who do not always have their needs met to experience IPV (AOR=0.53, 95% CI=0.31–0.88).

Table 1. Demographic characteristics of Rhode Island high school students by sexual orientation and gender identity

	LGBTQ+ n=11,891, (28.0%)	Cisgender/ straight n=30,512 (72.0%)	*p*-value *
Age			0.27
≤14 years	1,139 (9.6%)	3,529 (11.6%)	
15 years	3,018 (25.4%)	7,741 (25.4%)	
16 years	2,761 (23.2%)	6,646 (25.4%)	
17 years	3,203 (26.9%)	6,914 (22.7%)	
18+ years	1,770 (14.9%)	4,558 (15.0%)	
Sex			<.0001
Female	8,655 (74.8%)	14,174 (46.6%)	
Male	2,923 (25.2%)	16,264 (53.4%)	
Race/ethnicity			0.04
White, Non-Hispanic	6,093 (51.9%)	15,749 (51.9%)	
Black, Non-Hispanic	1,062 (9.0%)	2,986 (9.8%)	
Hispanic	3,237 (27.6%)	9,418 (31.0%)	
Other, Non-Hispanic	1,351 (11.5%)	2,220 (7.3%)	
Sexual orientation			
Heterosexual	129 (1.1%)	30,512 (100%)	
Gay or lesbian	1,993 (16.8%)		
Bisexual	5,488 (46.2%)		
Other	2,206 (18.6%)		
Questioning	2,075 (17.4%)		
Gender identity			
Cisgender	8,996 (76.6%)	30,512 (100%)	
Transgender	1,695 (14.4%)		
Unsure	8,12 (6.9%)		
Don't know what this means	2,45 (2.1%)		

Source: 2023 Rhode Island Youth Risk Behavior Survey, weighted data
* *P* <=0.05 indicates the groups being compared are significantly different from one another.
LGBTQ+ = lesbian, gay, bisexual, transgender, questioning, or described their sexual identity in other way..

Table 2. Percentage of high school students who experienced victimization by sexual orientation and gender identity

	LGBTQ+ Percentage (95% CI)	Cisgender/ straight Percentage (95% CI)	*p*-value*
BULLYING/STIGMA			
Bullied at school[1]	27.1% (20.4–33.7%)	11.9% (8.4–15.3%)	<.0001
Bullied electronically[1]	21.7% (17.3–26.1%)	10.5% (8.3–12.6%)	<.0001
Any type of bullying[1]	33.4% (26.7–40.2%)	16.2% (12.6–19.8%)	<.0001
Discriminated against due to SOGI[2]	60.0% (53.9–66.0%)	7.8% (5.1–10.5%)	<.0001
Any bullying/stigma	66.6% (60.5–72.8%)	21.9% (17.4–26.4%)	<.0001
INTIMATE PARTNER VIOLENCE			
Sexual dating violence[1]	15.0% (11.9–18.1%)	5.3% (3.5–7.1%)	<.0001
Physical dating violence[1]	6.1% (3.8–8.5%)	3.6% (2.2–4.9%)	.05
Any dating violence	17.2% (14.4–20.0%)	7.3% (5.1–9.5%)	<.0001
SEXUAL COERCION/ EXPLOITATION			
Ever forced to have sex against will	14.4% (9.3–19.4%)	4.8% (2.9–6.7%)	<.0001
Ever given goods in exchange for sex[3]	5.3% (3.4–7.2%)	0.8% (0.1–1.6%)	.0002
Any sexual coercion/ exploitation	15.6% (11.0–20.2%)	5.4% (3.5–7.3%)	<.0001
TOTAL VICTIMIZATION			<.0001
0 types victimization	29.3% (24.3–34.3%)	73.1% (68.0–78.2%)	
1 types victimization	48.8% (44.4–53.2%)	21.32 (17.3–25.0%)	
2 types victimization	16.0% (12.7–19.4%)	4.2% (2.4–6.1%)	
3 types victimization	5.8% (3.7–7.9%)	1.5% (0.5–2.5%)	

Source: 2023 Rhode Island Youth Risk Behavior Survey, weighted data
SOGI = sexual orientation and gender identity
* P <=0.05 indicates the groups being compared are significantly different from one another.
1 Experienced victimization during the past 12 months.
2 "During your life, how often have you felt that you were treated badly or unfairly because you are or people think you are lesbian, gay bisexual, transgender, or questioning? This could include being treated badly of who you are sexually attracted to or because you express your gender in a way that is different from what people expect?"
3 "Ever been given money, a place to stay, food, or something else of value in exchange for sex?"

Table 3. Prevalence rates (%, n) of risk and protective factors for interpersonal violence victimization by sexual orientation and gender identity

	LGBTQ+ Percentage (95% CI)	Cisgender/ straight Percentage (95% CI)	*p*-value*
Risk Factors			
Food insecurity (past 30 days)[1]			.02
Ever food insecure	3,850 (32.6%)	8,230 (27.1%)	
Never food insecure	7,959 (67.4%)	22,175 (72.9%)	
Housing insecurity (past 30 days)[2]			.06
Any housing insecurity	898 (7.8%)	1,455 (4.9%)	
No housing insecurity	10,522 (92.2%)	28,404 (95.1%)	
Ever lived with someone with drug or alcohol problem			<.0001
Yes	5,127 (44.7%)	6,564 (23.0%)	
No	6,352 (55.3%)	23,286 (78.0%)	
Ever lived with someone depressed, mentally ill, or suicidal			<.0001
Yes	6,826 (59.3%)	7,853 (26.5%)	
No	4,683 (40.7%)	21,815 (73.5%)	
Substance use[3]			
Yes	4,896 (43.5%)	8,957 (30.7%)	.0004
No	6,352 (56.5%)	20,264 (69.3%)	
Protective Factors			
Basic needs met at home[4]			.09
Always	8,621 (71.3%)	23,110 (77.8%)	
Not Always	3,333 (28.7%)	6,589 (22.2%)	
Adult at school to talk to if having problems[5]			.09
Yes	6,525 (56.2%)	18,978 (63.2%)	
No	5,077 (43.8%)	11,054 (36.8%)	
Get help when sad/anxious[6]			<.0001
Don't feel sad/anxious	1,116 (9.6%)	9,880 (33.1%)	
Usually get help	1,861 (16.0%)	5,329 (17.8%)	
Don't usually get help	8,960 (74.5%)	14,679 (49.1%)	

Source: 2023 Rhode Island Youth Risk Behavior Survey, weighted data

p < = .05 indicates significant differences between LGBTQ+ Rhode Island high school students compared with their cisgender /straight peers.

1 "During the past 30 days, how often did you go hungry because there was not enough food in your home?"

2 "During the past 30 days, where did you usually sleep? " (other than parents/ guardian home) and "During the past 30 days, did you ever sleep away from your parents or guardians' home because you were kicked out, ran away, or were abandoned?"

3 Current (past 30 days) alcohol or marijuana use, or any lifetime misuse of pain medications

4 "During your life, how often has there been an adult in your household who tried hard to make sure your basic needs were met, such as looking after your safety and making sure you had clean clothes and enough to eat?"

5 "Is there at least one teacher or other adult in your school that you can talk to if you have a problem?"

6 "When you feel sad, empty, hopeless, angry, or anxious, how often do you get the kind of help you need?" (reference group: don't usually get help)

Table 4. Risk and protective factors associated with violence victimization experienced by LGBTQ+ high school students

	Type of victimization[1]		
	Any Bullying/ Discrimination AOR (95% CI)	Any IPV AOR (95% CI)	Any sexual coercion/ exploitation AOR (95% CI)
Demographics			
Female	0.89 (0.52–1.51)	1.33 (0.70–2.56)	1.22 (0.52–2.86)
Risk Factors			
Ever food insecure (past 30 days) [2]	1.16 (0.59–2.27)	1.22 (0.68–2.19)	1.31 (0.71–2.43)
Ever housing insecure (past 30 days) [3]	0.75 (0.26–2.13)	2.55 (0.91–7.16)	**3.36 (1.73–6.50)**
Ever lived with someone with drug or alcohol problem	1.40 (0.82–2.38)	1.05 (0.62–1.78)	**2.56 (1.63–4.04)**
Ever lived with someone depressed, mentally ill, or suicidal	**1.92 (1.22–3.03)**	1.71 (0.67–4.36)	**3.97 (1.76–8.96)**
Any substance use [4]	1.30 (0.82–2.07)	**2.35** (1.17–4.68)	**3.00** (1.66–5.44)
Protective Factors			
Basic needs always met at home[5]	0.62 (0.38–1.00)	**0.53 (0.31–0.88)**	**0.38 (0.17–0.85)**
Adult at school to talk to if having problems [6]	1.25 (0.93–1.67)	1.05 (0.62–1.78)	0.76 (0.41–1.40)
Help when sad/anxious [7]			
Don't feel sad/anxious	0.52 (0.32–1.04)	0.59 (0.21–1.70)	1.14 (0.39–3.35)
Most of the time get help	1.13 (0.57–2.35)	0.65 (0.24–1.78)	1.35 (0.52–3.53)

Source: 2023 Rhode Island Youth Risk Behavior Survey, weighted data

AOR = adjusted odds ratio

CI= confidence intervals

IPV= Intimate Partner Violence

1 Three outcomes were modeled in separate logistic regressions. Adjusted odds ratios and 95% confidence intervals shown in bold indicate that the risk or protective factor is significantly associated with victimization, controlling for other factors. All models controlled for participant's sex.

2 "During the past 30 days, how often did you go hungry because there was not enough food in your home?"

3 "During the past 30 days, where did you usually sleep? " (other than parents/guardian home) and "During the past 30 days, did you ever sleep away from your parents or guardians' home because you were kicked out, ran away, or were abandoned?"

4 Current (past 30 days) alcohol or marijuana use, or any lifetime misuse of pain medications

5 "During your life, how often has there been an adult in your household who tried hard to make sure your basic needs were met, such as looking after your safety and making sure you had clean clothes and enough to eat?"

6 "Is there at least one teacher or other adult in your school that you can talk to if you have a problem?"

7 "When you feel sad, empty, hopeless, angry, or anxious, how often do you get the kind of help you need?" (reference group: don't usually get help)

In the third outcome assessed—sexual coercion/exploitation among LGBTQ+ students, five factors assessed emerged as significant. Students who faced housing insecurity had more than three times the odds of sexual exploitation/victimization (AOR=3.36, 95% CI = 1.73–6.50) than those who did not face housing insecurity. Additionally, ever living with someone with a drug or alcohol problem (AOR=2.56, 95% CI=1.63–4.04), ever living with someone depressed, mentally ill, or suicidal (AOR=3.97, 95% CI=1.76–8.96), and student substance use (AOR=3.00, 95% CI=1.66–5.44) were associated with greater risks of sexual exploitation/victimization.

Lastly, like IPV, always having one's basic needs met at home emerged as a significant protective factor (AOR=0.38, 95% CI=0.17–0.85).

Results of a multinomial regression model found that among LGBTQ+ students, those who ever lived with someone who was depressed, mentally, ill, or suicidal had nearly four times the odds of experiencing multiple types of victimization [AOR=3.94, 95% CI=1.66–9.35; **Table 5**]. Having lived with someone who had an alcohol or drug problem (AOR=1.86, 95% CI=1.01–3.44) and student substance use (AOR=2.93, 95% CI=1.39–6.10) also were associated with increased risk of multiple victimization. Those who always have their basic needs met at home were significantly less likely to report multiple types of victimization (AOR=0.32, 95% CI=0.18–0.57).

Table 5. Multinomial regression models examining risk and protective factors associated with number of types of victimization experienced by LGBTQ+ high school students

	Number of types of victimization[1]	
	1 type AOR (95% CI)	2 or more AOR (95% CI)
Demographics		
Female	1.05 (0.55–1.88)	1.18 (0.47–2.98)
Risk Factors		
Ever food insecure (past 30 days) [2]	1.31 (0.69–2.49)	1.57 (0.75–3.30)
Ever housing insecure (past 30 days) [3]	0.72 (0.14–3.75)	1.81 (0.38–8.64)
Lived with someone with drug or alcohol problem	**1.71** (1.14–2.55)	**1.86** (1.01–3.44)
Lived with someone depressed, mentally ill, or suicidal	1.71 (0.91–3.23)	**3.94 (1.66–9.35)**
Any substance use [4]	1.00 (0.55–1.79)	**2.93 (1.39–6.10)**
Protective Factors		
Basic needs always met at home [5]	0.71 (0.38–1.33)	**0.32 (0.18–0.57)**
Adult at school to talk to if having problems[6]	1.38 (0.85–2.25)	1.18 (0.71–1.97)
Help when sad/anxious[7]		
Don't feel sad/anxious	0.62 (0.34–1.12)	0.51 (0.16–1.65)
Most of the time get help	0.93 (0.37–2.34)	0.86 (0.28–2.62)

Source: 2023 Rhode Island Youth Risk Behavior Survey, weighted data
AOR = adjusted odds ratio
CI= confidence intervals

1 The reference group is experiencing 0 types of violence victimization versus experiencing 1 type or 2 or more types of victimization. Adjusted odds ratios and 95% confidence intervals shown in bold indicate that the risk or protective factor is significantly associated with victimization. All models controlled for participant's sex.

2 "During the past 30 days, how often did you go hungry because there was not enough food in your home?"

3 "During the past 30 days, where did you usually sleep? " (other than parents/guardian home) and "During the past 30 days, did you ever sleep away from your parents or guardians' home because you were kicked out, ran away, or were abandoned?"

4 Current (past 30 days) alcohol or marijuana use, or any lifetime misuse of pain medications

5 "During your life, how often has there been an adult in your household who tried hard to make sure your basic needs were met, such as looking after your safety and making sure you had clean clothes and enough to eat?"

6 "Is there at least one teacher or other adult in your school that you can talk to if you have a problem?"

7 "When you feel sad, empty, hopeless, angry, or anxious, how often do you get the kind of help you need?" (reference group: don't usually get help)

DISCUSSION

This is the first study to use data from a statewide representative survey of Rhode Island high school students to estimate risk and protective factors for multiple measures of interpersonal violence victimization among LGBTQ+ youth. The findings add to a growing body of research that LGBTQ+ youth face disproportionately higher rates of victimization, often experiencing multiple, concurrent forms of intimate partner violence and sexual coercion, compared to non-sexual and gender minority youth.[5,15]

Regression models focused solely on LGBTQ+ high school students. Seventy percent of LGBTQ+ students in this study experienced one or more forms of interpersonal violence victimization. Three important risk factors included in the regression models were students' home and school environments and school connectedness. LGBTQ+ students who reported always having their basic needs met at home were less likely to experience IPV, sexual coercion/exploitation, and multiple forms of violence victimization. Housing insecurity was associated with higher odds of sexual coercion and exploitation. Although the exact number is unknown, unhoused LGBTQ+ youth who engage in "survival sex" (exchanging sex for food, shelter, or basic needs) are highly vulnerable to assault, trauma, and trafficking.[16,17] Another key finding was that LGBTQ+ youth who ever lived with someone who was mentally ill or had a problem with drugs or alcohol had increased odds of being the victim of sexual coercion/exploitation and multiple forms of victimization. The relationship between a young person's home environment and interpersonal violence victimization is undoubtedly complex. Improved data collection on risk factors that

contribute to LGBTQ+ youth being unhoused would be valuable in identifying opportunities for prevention.[18] Such efforts would benefit from including standard questions for adverse childhood experiences (ACEs) with an LGBTQ+ identifier, as LGBTQ+ youth experience significantly higher rates of ACEs compared to their cisgender peers (e.g., sexual, physical, and/or emotional abuse, household instability).[19] One example would be the ACE question, "Have you ever experienced sexual abuse because of your LGBTQ+ identify?"

Connectedness to others was not a significant protective factor in any regression models, whether measured as having a trusted adult at school to talk to when there was a problem, or getting the kind of help needed when feeling sad, hopeless, angry, or anxious. There is limited research on having an important adult to turn to as a protective factor for reducing risk of youth violence victimization.[20] Having a trusted adult in one's school can be challenging for LGBTQ+ students. Stigma, discrimination, and prejudice directed toward LGBTQ+ youth function as powerful mechanisms of gender policing, decreasing opportunities for LGBTQ+ youth to feel connected to and accepted by teachers and other adults in their school. High school students who are perceived by others to express their gender in ways that do not conform to their self-reported sex are at greater risk of rejection from teachers and their peers, especially gender-nonbinary youth assigned male at birth.[21]

Creating a safe and affirming school environment for LGBTQ+ youth requires a multipronged approach. Several research studies have created evidence-based frameworks to better protect and support LGBTQ+ youth in schools.[22-24] Key strategies include: 1) explicit anti-bullying school policies that are inclusive of sexual orientation and gender identity; 2) cultural sensitivity training for teachers and other school staff to support young people who identify as LGBTQ+; 3) empowering and supporting LGBTQ+ students to create their own safe spaces (e.g., clubs, teams, school-based gender and sexuality alliances); 4) Implementing LGBTQ-inclusive curricula.

Schools can make a positive difference in implementing policies and practices to create environments for LGBTQ+ youth to thrive. But schools alone cannot prevent violence against LGBTQ+ youth. Two public health approaches for those working with and on behalf of LGBTQ youth to consider are offered here.

Systems-level

Systems that interact with SGM youth, such as child welfare agencies, should consider screening for commercial sexual exploitation and survival sex when a child or adolescent is removed from the home based on lack of housing or significant substance use by members of the household. Currently, there is no consensus screening tool to identify trafficking experiences among runaway and unhoused LGBTQ+ youth. The Commercial Sexual Exploitation-Identification Tool[25] and the Human Trafficking Screening Tool[26] are two validated screening tools for youth involved with the child welfare system or receiving services from anti-trafficking agencies to better identify exploitation of vulnerable youth, including unhoused LGBTQ+ youth engaged in commercial sex to meet their basic needs.

Individual-level

Social workers and other healthcare professionals caring for LGBTQ+ youth should implement gender-affirming care for LGBTQ+ youth whose experiences of discrimination, physical threats, and stigma contribute to disproportionately high rates of anxiety, depression, and suicide risk.[27] Key practices include:1) using inclusive language; 2) respecting pronouns; 3) creating safety for young patients to disclose their concerns without fear of parental involvement (subject to state laws and the federal Health Insurance Portability and Accountability Act (HIPAA) to protect sensitive patient health information from being disclosed without consent); 4) implementing trauma-informed care; 5) understanding the societal causes of anxiety and depression (stigma, discrimination) that put LGBTQ+ youth at increased risk for negative health and life outcomes; and 6) connecting youth with LGBTQ+ youth-affirming organizations and, when needed, referring youth to healthcare practices that specialize in LGBTQ+ care.

Limitations

Due to sample size, we could not compare risk and protective factors for interpersonal violence victimization by SGM subgroups. Additionally, the temporality of risk/protective factors and victimization cannot be fully ascertained in cross-sectional data.

IMPLICATIONS AND CONCLUSION

The current study provides an important foundation for researchers, educators, and healthcare professionals working to prevent interpersonal violence victimization among LGBTQ+ youth. Although other studies have examined violence victimization among youth, our findings demonstrate a need for continued assessment of interpersonal violence victimization and sexual exploitation of LGBTQ+ youth without comparison to their cisgender peers.

Decades of research have shown that systems-level changes are needed to reverse policies, laws and social norms that make perpetration of violence against LGBTQ+ youth acceptable. LGBTQ+ youth experience elevated rates of violence victimization driven by minority stress, structural inequalities, and exposure to risk factors across the social ecology.

Longitudinal trajectories of interpersonal violence victimization onset, continuation, and escalation from early

adolescence to young adulthood that account for co-occurring social identities based on race, ethnicity, sexual orientation, and gender identity are needed due to intersecting systems of oppression, such as racism, homophobia, and transphobia.[3] Efforts to reduce and prevent violence victimization must be comprehensive, addressing legislative and policy actions to uphold protections for LGBTQ+ youth. Such efforts should be implemented concurrently with school, healthcare, and community-based interventions informed by research and data that support the health and well-being of LGBTQ+ youth.

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Disclosures

The authors received no specific grant or financial support for the research, authorship, and/or publication of this article. The Rhode Island Youth Risk Behavior Survey is conducted as a public health surveillance activity following Centers for Disease Control and Prevention protocols and is not considered human subjects' research. The present analysis used de-identified data and did not require additional Institutional Review Board review.

Acknowledgments: Drs. Pearlman and Jackson conceptualized the study and co-wrote the paper. They are co-first authors. Angela Kemp, MSW, and Karine Monteiro, MPH, provided substantive input on the conceptualization and writing of the paper.

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Restrictive Masculinity Norms and Behavioral Health Outcomes Among Rhode Island Sexual and Gender Minority Young Adults

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ABSTRACT

INTRODUCTION: Restrictive masculinity norms (RMNs), characterized by emotional suppression, dominance, and risk-taking, have been linked to adverse health among cisgender heterosexual men. Little is known about how RMNs operate among sexual and gender minority (SGM) populations, particularly transgender young adults.

METHODS: Data were from the 2024 Rhode Island Young Adult Survey, a cross-sectional, web-based survey of adults aged 18–25 years. Analyses were restricted to SGM participants (n=438), with sub-analyses among transgender young adults (n=100). RMNs were measured using a 12-item questionnaire. Outcomes include alcohol use disorder (AUD), cannabis use disorder (CUD), heroin use, intimate partner violence (IPV), problematic pornography use, and problem gambling. Modified Poisson regressions with robust standard errors were used to assess main effects after adjusting for sex assigned at birth, transgender identity, age, race/ethnicity, and social status.

RESULTS: Among SGM young adults, a one-unit increase in RMNs score was associated with increased risk of all outcomes [AUD: 1.13 (95%CI 1.08, 1.18); CUD: 1.03 (95%CI 1.01, 1.06); heroin use: 1.22 (95%CI 1.13, 1.31); IPV: 1.04 (95%CI 1.02, 1.06); problematic pornography use: 1.05 (95%CI 1.02, 1.09); problem gambling: 1.11 (95%CI 1.07, 1.15)]. Associations were consistently stronger among transgender young adults, including a markedly elevated risk for heroin use [4.91 (95%CI 3.30, 7.31)], while the association with CUD was not statistically significant.

CONCLUSIONS: RMNs are associated with adverse behavioral health among SGM young adults and exert a disproportionate impact on transgender individuals. Addressing RMNs may represent an important, modifiable pathway for reducing behavioral health inequities during young adulthood.

KEYWORDS: restrictive masculinity; young adults; sexual and gender minorities; transgender

INTRODUCTION

Restrictive Masculinity Norms (RMNs) are rigid societal standards rooted in traditional cisgender male ideals that define expectations of masculinity, including risk-taking, emotional toughness, self-reliance, dominance, aggression and anti-femininity.[1,2] They are often highly reinforced and celebrated culturally, including in widespread media portrayals and through everyday social norms.[3] At a structural level, these norms organize financial, sexual, and social power in ways that maintain and reinforce male dominance.[4]

Adherence to RMNs has been associated with poorer health and well-being, particularly through avoidance of vulnerability and help-seeking, as well as increased engagement in risky behaviors such as: substance use, aggression, and sexual behaviors.[5,6] However, existing research largely focuses on cisgender heterosexual men,[7] leaving limited understanding of how these norms affect sexual and gender minority (SGM) health, and particularly transgender individuals.

For SGMs, RMNs are considered within a heteronormative social context that privileges cisgender heterosexuality and traditional gender roles.[8] For transgender and gender-diverse individuals, these norms may be especially salient, due to heightened gender policing and pressures related to gender legitimacy.[9] As a result, RMNs may differentially shape stress exposure, identity development, and coping behaviors, warranting examination by transgender status rather than treating SGM populations as homogenous.

From the perspective of Minority Stress Theory, RMNs may function as chronic stressors by reinforcing stigma, discrimination, and pressures to conform to dominant gender expectations, with transgender individuals potentially experiencing compounded stress, due to the intersection of gender-identity stigma and rigid gender-norm enforcement.[8] These norms are often internalized at a young age and may contribute to psychological distress and mental health disparities.[10] Chronic exposure to such stressors has been associated with poorer mental health outcomes and maladaptive coping strategies, which may manifest in risky or compulsive behaviors similar to those observed among cisgender heterosexual men due to RMNs.[11]

Young adulthood represents a critical developmental period characterized by identity exploration, risk-taking, and the highest rates of anxiety and depression.[12-14] SGM

young adults experience disproportionate mental health burdens during this stage, yet the role of RMNs in this disparity remains unexamined.[15] Accordingly, this study aims to assess associations between RMNs and multiple behavioral outcomes—including alcohol use disorder (AUD), cannabis use disorder (CUD), heroin use, intimate partner violence (IPV), problematic pornography use, and gambling problems—among SGM young adults, with separate analyses by transgender status to identify distinct risk pathways.

METHODS

Sample

This study utilized data from the 2024 administration of the Rhode Island Young Adult Survey (RIYAS). This survey is web-based in Qualtrics and is implemented by the Rhode Island Department of Behavioral Health, Developmental Disabilities & Hospitals (BHDDH). Eligible participants included young adults aged 18–25 years old who reside in Rhode Island for at least part of the year. Data collection occurred from May through August of 2024. Recruitment was conducted via targeted paid ads on Instagram and Spotify, as well as informal emails to multiple institutions of higher education across the state. This was a self-report survey that took an average of 20 minutes to complete. All participants received a $10 electronic gift card. All respondents provided electronic informed consent. This study was approved by the local institutional review board. Among the total sample (n=1,008), those who identified as sexual and/or gender minority individuals were included in this study. This includes those who responded that their sexual orientation was anything other than heterosexual (e.g., gay/lesbian, bisexual, pansexual, etc.) or that their self-reported gender identity did not align with their sex assigned at birth, or they reported themselves to be transgender (n=442). Those who reported their sex assigned at birth as intersex (n=4) were excluded due to a small sample size when controlling for sex assigned at birth. This yielded a final analytic sample of n=438. Sub-analyses were also restricted to those SGMs who responded *yes* to "Do you identify as transgender?" (n=100).

Measures

The primary exposure of interest in this study is RMNs. This was assessed by a 12-item measure known as the Restrictive Masculinity Scale, which evaluates the extent to which individuals endorse rigid or traditional masculine norms. The scale includes statements such as, "Men should be able to cry openly when they feel emotional," and, "If a woman declines sex, men should respect that choice." Responses were recorded on a 5-point scale, ranging from 0 (strongly disagree) to 4 (strongly agree). After scoring, possible total values ranged from 0, representing the lowest endorsement of restrictive masculinity norms, to 48, representing the highest endorsement.[16]

Alcohol use disorder was measured using the Alcohol Use Disorders Identification Test (AUDIT), a valid and reliable 10-item screening tool.[17] Scores were calculated using standard scoring procedures, and participants with scores ≥15 were categorized as having AUD (α=0.82). Cannabis use disorder was evaluated using the Cannabis Use Disorders Identification Test-Revised (CUDIT-R), a valid and reliable 8-item screening instrument.[18] Items were scored following standard scoring procedures, and participants with scores of ≥12 were categorized as having CUD (α=0.83). Heroin use was assessed by the question, "Have you ever used heroin?" Those with response options "yes, in the past month" or "yes, more than a month ago" were considered to have used heroin. Intimate partner violence was measured in response to the question, "Have you ever experienced verbal or physical abuse or threats from a romantic partner?" Those responding "yes, in childhood" or "yes, in adulthood" were considered to have experienced IPV. Problematic pornography use was measured using the valid and reliable 6-item Problematic Pornography Consumption Scale (PPCS-6).[19] Item scores were summed in accordance with scoring instructions (α=0.87), and those with scores of ≥20 were categorized as having problematic pornography consumption. Problem gambling was measured using the valid and reliable 3-item Brief Biosocial Gambling Screen (BBGS), an instrument designed to identify behaviors associated with gambling-related harm.[20] Each item had a Yes/No response format, and endorsement of at least one item was defined as problem gambling. The items asked respondents whether, in the past 12 months, they: (1) felt restless, irritable, or anxious when attempting to reduce or stop gambling; (2) tried to hide the extent of their gambling from family or friends; or (3) experienced financial difficulties severe enough to require assistance with basic expenses.

Other covariates were included because they are considered potential confounders in the relationship between RMNs and the various outcomes.[21] These include sex assigned at birth (female, male), transgender identity (yes/no), age (in years), race/ethnicity (White, Black, Hispanic, Asian, something else), and social status. Perceived social status was assessed using the MacArthur Social Ladder. Participants indicated where they believed they ranked within their community on a scale from 1 (worst off) to 10 (best off).[22]

Statistical Analysis

The analytic sample of sexual and gender minorities (n=438) was first described by all study variables using frequencies and percents. Two-sample t-tests were used to compare mean RMN scores by transgender identity and each of the study outcomes. Crude and multivariable modified Poisson regression with robust standard errors was used to examine the relationship between RMNs and each of the study outcomes among the full SGM sample, as well as transgender young adults specifically. Because odds ratios from logistic

regression can substantially overestimate risk ratios, even for relatively rare outcomes, modified Poisson regression with robust standard errors were used to directly estimate risk ratios. This approach provides more interpretable effect estimates and avoids convergence issues associated with log-binomial models.[23] Adjusted models controlled for sex assigned at birth, transgender identity, age, race/ethnicity, and social status. Model coefficient estimates were exponentiated to report risk ratios (RRs) and adjusted RRs (aRRs) along with their corresponding 95% confidence intervals. Statistical significance was determined using a threshold of α=0.05. All statistical analyses were conducted in Stata, version 15.[24]

RESULTS

The sample of sexual and gender minority young adults in Rhode Island was predominantly female (82.4%) and White (60.7%). The young adults had a mean age of 21.06 years (SD: 0.11) and mean social status of 5.39 (SD: 0.09). The poor health outcomes among SGM young adults ranged in prevalence from 29.0% experiencing IPV, 18.3% meeting the definition for CUD, 9.4% with problematic pornography use, 5.3% with problem gambling, 3.4% meeting the definition of AUD, to 1.1% reporting heroin use. The mean RMNs score, which can range from 0 to 48, with higher scores showing greater endorsement of restrictive norms, was 24.01 (SD: 0.31) in this sample [**Table 1**]. Transgender young adults had lower mean RMNs score [22.0 (SE: 0.61)] than those who did not identify as transgender [24.6 (SE:0.35); p<0.001], while those with AUD (p<0.001), heroin use (p<0.001), IPV (p=0.002), problematic pornography use (p<0.001), and problem gambling (p<0.001) had higher RMNs scores than their non-outcome counterparts [**Figure 1**]. Only those with CUD relative to those without had insignificant differences in mean RMNs scores (p=0.075).

In crude and adjusted models, RMNs were positively associated with all outcomes among SGM young adults [**Table 2**]. Similarly, among transgender young adults specifically, all crude relationships, except between RMNs and CUD, were significant and positive. After controlling for all covariates, these findings remained [**Table 2**].

Table 1. Sexual and Gender Minorities Sample (N = 438), RIYAS 2024

Variable	N	%
Sex Assigned at Birth		
Female	361	82.4
Male	77	17.6
Transgender		
Yes	100	22.8
No	338	77.2
Age [Mean (SD)]	21.06	0.11
Race/Ethnicity		
White	266	60.7
Black	23	5.3
Hispanic	82	18.7
Asian	31	7.1
Something Else	36	8.2
Social Status [Mean (SD)]	5.39	0.09
Alcohol Use Disorder	15	3.4
Cannabis Use Disorder	80	18.3
Heroin Use	5	1.1
Intimate Partner Violence	127	29.0
Problematic Pornography Use	41	9.4
Problem Gambling	23	5.3
Restrictive Masculinity Norms [Mean (SD)]	24.01	0.31

Figure 1. Mean Restrictive Masculinity Scale by Behavioral Health Outcomes among Sexual and Gender Minority Young Adults

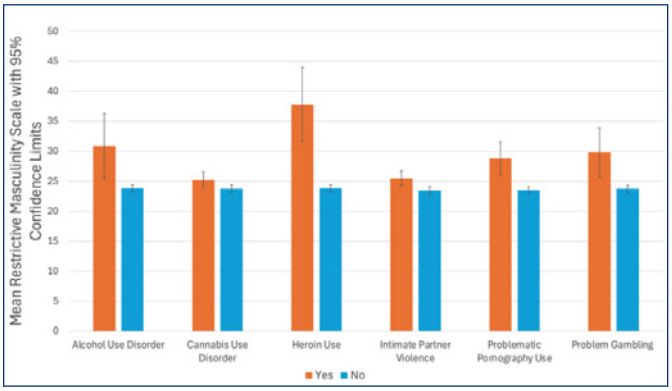

Table 2. Adjusted Risk Ratios for Outcomes Associated with a One-Unit Increase in Restrictive Masculinity Norms Score among SGM and Transgender Young Adults

	SGM Young Adults (n=438)		Transgender Young Adults (n=100)	
Outcome	**aRR**	**95% CI**	**aRR**	**95% CI**
Alcohol Use Disorder	1.13	1.08–1.18	1.16	1.10–1.24
Cannabis Use Disorder	1.03	1.01–1.06	1.03	0.97–1.08
Heroin Use	1.22	1.13–1.31	4.91	3.30–7.31
Intimate Partner Violence	1.04	1.02–1.06	1.05	1.02–1.08
Problematic Pornography Use	1.05	1.02–1.09	1.11	1.01–1.21
Problem Gambling	1.11	1.07–1.15	1.16	1.08–1.24

NOTE: Modified Poisson regression with robust standard errors was used and coefficients were exponentiated. Adjusted models among SGMs controlled for sex assigned at birth, transgender identity, age, race/ethnicity, and social status. Adjusted models among transgender individuals controlled for the same except for transgender identity. All models were statistically significant.

DISCUSSION

Higher endorsement of RMNs among SGM young adults is associated with an increased risk of multiple, adverse, behavioral health outcomes, AUD, CUD, heroin use, IPV, problematic pornography use, and problem gambling. These findings extend previous research conducted largely among cisgender heterosexual men, by demonstrating that RMNs remain harmful even within populations that, on average, endorse more flexible gender norms.[7,25] Notably, associations were often stronger among transgender young adults, identifying RMNs as a particularly salient and underrecognized contributor to behavioral health inequities within this population.

Although SGM young adults tend to endorse less restrictive gender norms than cisgender heterosexual individuals, these findings demonstrate that when RMNs are internalized, they are associated with harm. Within the context of minority stress, pressures to conform to dominant gender expectations may compound experiences of stigma and marginalization, reinforcing self-reliance, emotional suppression, and avoidance of help-seeking. These dynamics may increase vulnerability to maladaptive coping behaviors.[26]

Among transgender young adults, RMNs appear to exert a disproportionately strong influence on behavioral health outcomes. Despite lower average RMNs endorsement, transgender participants demonstrated larger effect sizes across nearly all outcomes, suggesting that even modest internalization of RMNs may carry increased risk. This pattern highlights the importance of examining RMNs by transgender status, as analyses that aggregate SGMs may obscure greater vulnerability among transgender young adults.

INTIMATE PARTNER VIOLENCE

The association between RMNs and IPV observed in this study is consistent with findings from cisgender heterosexual samples, while extending this literature to SGM and transgender young adults.[27] From a gender role strain perspective, rigid masculine expectations emphasizing dominance, aggression, and emotional suppression may generate chronic psychological strain when these ideals conflict with an identity.[28] In SGM relationships, gendered power expectations may be negotiated differently across partners, potentially increasing vulnerability to IPV when masculinity is asserted to validate identity or avoid perceived loss of power.[29] Together, these findings suggest that RMNs may compound minority stress, exacerbating risk for IPV.

SUBSTANCE-RELATED OUTCOMES

Restrictive masculinity norms were also significantly associated with substance-related outcomes, including AUD, CUD, and heroin use. Substance use may serve as an avoidance-based coping strategy for managing emotional distress, or identity strain when vulnerability and help-seeking are discouraged.[30] Associations were particularly pronounced among transgender young adults, including a markedly elevated risk ratio for heroin use, suggesting that RMNs may contribute to escalation toward higher-risk substances when access to adaptive coping and care is limited. The absence of a statistically significant association between RMNs and CUD among transgender participants may reflect limited statistical power.

PROBLEMATIC PORNOGRAPHY USE AND PROBLEM GAMBLING

Restrictive masculinity norms were additionally associated with problematic pornography use and problem gambling—behaviors linked to impulsivity, sensation-seeking, and emotional disengagement.[31] Avoidance of vulnerability and emotional intimacy, central features of RMNs, may increase reliance on solitary or compulsive coping behaviors among SGM young adults. The stronger associations observed among transgender young adults in this study indicate that RMNs may partially explain these disparities by reinforcing risk-oriented coping strategies in the context of chronic stress.

Overall, these findings suggest that RMNs contribute to behavioral health risks among SGM young adults through mechanisms of gender role strain shaped by heteronormativity and stigma. Addressing rigid gender norms may therefore represent a meaningful opportunity to intervene in these health outcomes at a societal level.

Limitations

This study is subject to several limitations. The cross-sectional design precludes causal inference, and self-reported data may introduce selection and reporting bias. Findings may not be fully generalizable to all SGM young adults in Rhode Island. Additionally, males were underrepresented in the sample, which may have resulted in conservative estimates of RMN endorsement and associated risks.

IMPLICATIONS

These findings highlight RMNs as a public health concern among SGM young adults, particularly transgender individuals. RMNs may function as modifiable, upstream social determinants of behavioral health risk and should be considered within SGM-affirming healthcare, prevention, and intervention frameworks. Routine assessment of RMNs in clinical and community settings such as primary care, campus health services, and behavioral health screening programs may help identify individuals at increased risk and inform more tailored, upstream interventions.

Practitioners should adopt strength-based approaches that reframe the disclosure of poor health outcomes as acts of

resilience and courage.[32] By using affirming, supportive language, such as recognizing a patient's strength in navigating the pressures of RMNs, clinicians can foster a safer, more trusting environment that encourages help-seeking among young adults. Centering validation of SGM young adults' experiences and promoting a sense of wholeness are essential to supporting mental wellbeing and preventing adverse behavioral health outcomes.[33]

Interventions that promote emotional regulation, adaptive communication, and critical reflection on gender norms may enhance engagement and safety when implemented alongside efforts to address stigma, discrimination, and barriers to care. Addressing RMNs within broader structural contexts may strengthen public health efforts to improve behavioral health and reduce disparities among SGM young adults.

CONCLUSIONS

Greater endorsement of RMNs was associated with increased risk of multiple, adverse, behavioral health outcomes among SGM young adults, with particularly strong effects among transgender individuals. These findings extend existing research on RMNs beyond cisgender heterosexual populations and underscore the importance of addressing rigid gender norms as part of efforts to reduce behavioral health inequities.

Promoting more expansive and inclusive understandings of gender may improve health outcomes not only for SGM communities, but for society as a whole. Young adulthood represents a critical window for this work, as norms established during this period shape long-term health trajectories. Addressing RMNs early may therefore yield lasting benefits for individual wellbeing, community health, and social equity.

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Disclosures

Funding: This work was supported by the Substance Abuse and Mental Health Services Administration Award number 1H79SP080979. The funders had no role in the design, implementation, analysis, or writing of this study. The views and opinions contained in the publication do not necessarily reflect those of SAMHSA or the U.S. Department of Health and Human Services.

Acknowledgments: The authors would like to acknowledge Karen Flora, the project director of the Partnerships for Success II grant which supported this work, as well as the support of the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals.

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Evaluating the Health of Transgender Adults in Rhode Island: A Five-Year Population-Based Analysis

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ABSTRACT

OBJECTIVE: Transgender individuals experience social and structural marginalization that can have a significant impact on physical and mental health. While prior studies have explored health disparities across various settings in the United States, not much is known about the health of the transgender population in Rhode Island. The purpose of this analysis was to understand the health issues faced by transgender adults in RI.

STUDY DESIGN AND METHODS: Data are from the 2020-2024 Rhode Island Behavioral Risk Factor Surveillance System (RI BRFSS), an annual telephone survey of non-institutionalized adults. Five years of data were pooled and weighted to provide average yearly population estimates. Multivariable logistic regression analyses were conducted to estimate the prevalence of various health outcomes among transgender adults compared to cisgender adults.

PRIMARY RESULTS: Overall, 1.0% of Rhode Island adults identified as transgender. After adjusting for age and race/ethnicity, transgender adults had more than three times the odds of reporting fair/poor overall health and frequent mental distress, nearly three times the odds of reporting a history of depression, and more than four times the odds of having any disability. Transgender and cisgender adults had similar rates of health insurance coverage, having a primary care provider, and having a medical checkup in the past year.

PRINCIPAL CONCLUSIONS: This analysis demonstrates persistent health disparities among transgender adults in RI. Continued surveillance, affirming clinical practices, intentional screening, improved access to behavioral and gender-affirming care, and supportive policies are necessary to improve the health of transgender adults in RI.

KEYWORDS: Transgender health; health disparities; mental health, disability; healthcare access

INTRODUCTION

Transgender individuals include a group of people whose gender identity or expression differs from their sex at birth. In the United States, about 2.8 million individuals identify as transgender, comprising approximately 0.8% of the population.[1] Importantly, transgender individuals experience social and structural marginalization that can have a significant impact on physical and mental health. A number of studies have found that compared to cisgender peers (people with the same gender as their birth sex), transgender individuals are more likely to experience poorer overall health, more frequent mental distress, depression, and disability.[2-6] Specifically, recent reports indicate transgender individuals have approximately two to three times the odds of being diagnosed with depression compared to cisgender individuals, and substantially higher prevalence of suicidal ideation and suicide attempts, with lifetime suicide attempt rates estimated to be more than four times higher than those in the general population.[7,8] These disparities persist across many other health diseases and conditions, including chronic diseases, HIV, and other sexually transmitted infections (STIs).[6,9,10] Previous research has also documented disparities in healthcare access and certain health behaviors among transgender adults.[3,4,11]

The reasons for these health disparities are multifactorial. They include intersecting identities as well as "minority stress", which refers to the growing body of evidence that demonstrates that external factors such as stigma, discrimination, and systemic inequalities lead to chronic stress and significant health issues. Studies have shown that experiences of discrimination and structural inequalities are associated with increased psychosocial distress, poorer health, and reduced access to care among transgender individuals.[2,7,9]

While prior studies have explored health disparities across various settings in the United States, not much is known about the health of the transgender population in Rhode Island. Thus, the purpose of this analysis was to understand the health issues faced by transgender adults in Rhode Island.

METHODS

Data are from the 2020–2024 Rhode Island Behavioral Risk Factor Surveillance System (RI BRFSS). The RI BRFSS is an annual telephone survey of non-institutionalized adults aged 18 and older administered by the Rhode Island Department of Health (RIDOH) with support from the Centers for Disease Control and Prevention (CDC), and is used to measure

risk behaviors and health. Data from the survey sample are weighted to obtain statewide population estimates. Five years of data were pooled to obtain an adequate sample size, and sample weights were then proportionally adjusted accounting for the number of respondents each survey year to provide average yearly population estimates. Gender identity was measured using the question "*Do you consider yourself to be transgender?*" Individuals who responded "*Yes*" were categorized as "transgender" and those who said "*No*" were categorized as "cisgender." Those who said they didn't know, were unsure, or refused to answer the question were excluded from analyses.

The demographic characteristics of transgender and cisgender adults were compared using chi-square to test for statistical significance. Chi-square tests were then used to compare the prevalence of health outcomes between the two groups. Health outcomes evaluated included general health, chronic disease, disability, mental health and health behaviors. Because the demographic characteristics of cisgender and transgender adults differ, additional multivariable logistic regression analyses were conducted adjusting for age and race/ethnicity. Sociodemographic variables (e.g., education, household income) were not included in the adjusted analysis since they may be part of the causal pathway between gender identity and health. Health outcomes of interest included measures of overall health, chronic disease, disability, mental health, health behaviors, and healthcare access. All outcomes were binary and those with missing responses or responses of "don't know" or "refused" were excluded from the analyses. For all analyses statistical significance was defined as p<0.05.

Table 1. Demographics and gender identity among RI adults (BRFSS 2020–2024)

	Gender Identity		P
	Transgender (N=8,733 1.0%)	Cisgender (N=843,752 99.0%)	
Sex			0.21
Male	41.7%	48.1%	
Female	58.3%	51.9%	
Age Group			**<.0001**
18–29 years	64.1%	18.7%	
30–44 years	21.2%	25.2%	
45–64 years	10.3%	31.6%	
65+ years	4.3%	24.5%	
Race/Ethnicity			**0.004**
Person of color	42.8%	28.6%	
Non-Hispanic, White	57.2%	71.4%	
Incomes			**<.0001**
Less than $25,000	30.3%	16.5%	
$25,000–49,999	33.2%	22.5%	
$50,000–74,999	15.3%	15.6%	
$75,000+	21.2%	45.5%	
Educational Attainment			**0.002**
Did not graduate high school	20.3%	10.6%	
Graduated high school	38.2%	28.6%	
Some college	24.2%	28.4%	
Graduated college	17.4%	32.3%	

Notes: p-values based on chi-square test, significant difference defined as p<.05; Total N reflects average yearly population estimate from 2020–2024

RESULTS

From 2020–2024 a total of 28,128 adults completed the BRFSS. Those who did not know or did not respond to the question about gender identity were excluded from all analyses (unweighted n=1068). The annual prevalence of individuals identifying as transgender ranged from 0.6% in 2020 to 1.7% in 2024. Overall, from 2020-2024, on average 1.0% of RI adults (unweighted n=170, equivalent to an annual population estimate of 8,733 individuals) identified as transgender. Analysis of demographic characteristics revealed that transgender adults were significantly younger than cisgender adults (e.g., 64% of transgender adults are aged 18–29 years, compared to 19% of cisgender adults; **Table 1**). Transgender adults were also less likely to identify as White and reported lower educational attainment and household income (p<0.05).

Bivariate analysis of gender identity and general health found that transgender adults were significantly more likely than cisgender adults to rate their overall health as fair/poor (32.6% vs. 15.5%, p<.0001), and to have a disability (54.4% vs. 27.4%, p<.0001). These differences remained significant after adjusting for age and race/ethnicity, as transgender individuals had more than three times the odds of reporting fair or poor overall health (adjusted odds ratio [AOR]=3.25, 95% Confidence Interval [95% CI]:1.94-5.46), and more than four times the odds of having a disability (AOR=4.09, 95% CI: 2.63–6.38) [**Table 2**]. Unadjusted analysis of specific disability indicators showed that transgender adults were more likely to report vision problems and difficulty concentrating/making decisions, doing errands alone, and dressing/bathing themselves due to a physical, mental, or emotional condition. After adjusting for age and race/ethnicity, these results remained significant, and differences in difficulty walking and hearing emerged as significant.

Unadjusted analysis indicated that transgender adults were at lower risk of chronic disease. However, after adjusting for differences in age and race/ethnicity, the odds of having a chronic disease was significantly higher among transgender individuals than among cisgender individuals (AOR=1.72, 95% CI: 1.13–2.61). Adjusted analysis of specific, chronic-disease indicators found that rates of diabetes, arthritis,

and cardiovascular disease were similar between groups, but that transgender adults were significantly more likely to have asthma. There were no differences between groups in rates of obesity in either unadjusted or adjusted analysis. Analysis of health behaviors found that even after adjusting for differences in age and race/ethnicity transgender adults were significantly more likely than cisgender adults to report no exercise in the past 30 days and to use marijuana. There were no differences between the two groups in the prevalence of cigarette smoking [**Table 2**].

Analysis of mental health indicated that transgender adults were significantly more likely than cisgender adults to report a history of depression and current frequent mental distress and were less likely to report receiving the social support they need [**Table 2**]. These significant differences were present both in unadjusted analysis of gender identity and health and in multivariable models adjusting for age and race/ethnicity. Even after accounting for differences in age and race/ethnicity, transgender individuals were more than three times as likely as cisgender individuals to report frequent mental distress (AOR=3.60, 95% CI: 2.38–5.45), and nearly three times as likely to report history of depression (AOR=2.98, 95% CI: 1.97–4.49).

Bivariate analysis of gender identity and healthcare access indicated that transgender adults were significantly less likely to have a primary care provider, have had a checkup in the past year, and to have had a dental visit in the past year. However, these differences appear to be largely explained by age and race/ethnicity, as after adjusting for these factors, differences in rates of health insurance, primary care provider, and having had a yearly checkup were no longer statistically significant. Difference in rates of dental visits in the past year remained statistically significant, with transgender adults about half as likely as cisgender adults to have had a dental visit in the past year (AOR=0.55, 95% CI: 0.33–0.79) [**Table 2**].

Table 2. Gender identity and health among RI adults 2020–2024 (RI BRFSS)

	Unadjusted Prevalence			Adjusted Odds Ratio [AOR] (95% Confidence Interval [CI]) Model 1
	Transgender (N=8,733, 1.0%)	Cisgender (N=843,752, 99.0%)	P	
General Health				
Fair/Poor Overall Health	**32.6%**	**15.5%**	**<.0001**	**3.25 (1.94–5.46)**
Obese	33.8%	30.8%	.51	1.15 (0.75–1.76)
Disability				
Hearing	7.7%	6.4%	0.61	**3.80 (1.60–9.01)**
Vision	**11.9%**	**5.0%**	**.01**	**3.30 (1.49–7.32)**
Cognition (concentrating/ decision–making)	**38.6%**	**12.3%**	**<.0001**	**3.14 (2.01–4.93)**
Mobility (difficulty walking)	17.9%	12.1%	.12	**3.26 (1.81–5.86)**
Self–care (difficulty bathing/ dressing)	**8.6%**	**3.4%**	**.03**	**2.48 (1.31–4.69)**
Independent living (running errands)	**25.4%**	**7.1%**	**<.0001**	**3.14 (2.01–4.93)**
Any disability[a]	**54.4%**	**27.4%**	**<.0001**	**4.09 (2.63–6.38)**
Chronic disease				
Diabetes	**6.3%**	**11.3%**	**.03**	1.29 (0.79–2.39)
Asthma	**19.8%**	**12.5%**	**.02**	**1.73 (1.10–2.73)**
Cardiovascular disease	**5.1%**	**8.5%**	**.05**	1.78 (0.97–3.22)
Arthritis	**13.5%**	**26.9%**	**.0002**	1.29 (0.79–2.10)
Any chronic disease[b]	**35.8%**	**48.6%**	**.007**	**1.72 (1.13–2.61)**
Mental Health				
Frequent mental distress[c]	**44.5%**	**14.3%**	**<.0001**	**3.60 (2.38–5.45)**
Depression	**50.6%**	**22.3%**	**<.0001**	**2.98 (1.97–4.49)**
Often gets social/emotional support[d]	**58.0%**	**76.6%**	**.0001**	**2.06 (1.26–2.36)**
Health Behaviors				
Did not get any exercise	**39.4%**	**24.1%**	**.001**	**2.51 (1.53–4.12)**
Current cigarette smoker	9.7%	11.4%	.59	0.84 (0.43–1.63)
Binge drink (past 30 days)	14.0%	16.4%	.50	**0.55 (0.31–0.94)**
Current marijuana user	**33.8%**	**17.1%**	**<.0001**	**1.57 (1.01–2.45)**
Healthcare access				
Have insurance	90.8%	94.6%	.06	0.98 (0.51–1.89)
Had medical checkup in past year	**73.2%**	**84.0%**	**.003**	1.16 (0.66–2.03)
Have primary care provider	**82.2%**	**88.8%**	**.03**	0.76 (0.33–1.76)
Had dental checkup in past year	**55.2%**	**72.6%**	**.0003**	**0.55 (0.33–0.79)**

Notes: unadjusted p-values based on chi-square test - significant difference defined as p<.05 (indicated in bold red or green font). AOR from logistic regression adjusted for age and race/ethnicity

[a] Disability = any problems with hearing, vision, cognition or mental, mobility, self-care, or independent living. [b] Any chronic disease = history of cardiovascular disease, cancer, COPD, asthma, kidney disease, arthritis or diabetes. [c] Frequent Mental Distress = mental health not good for 14 or more days in the past 30 days, [d] Social/emotional support was not assessed in 2021

DISCUSSION

This study is among the first to evaluate disparities in health based on gender identity across the state of Rhode Island. The analysis used data from the RI BRFSS to obtain population-level measures of health and found that compared to cisgender adults, transgender adults were more likely to report poorer overall health, disability, poorer mental health, and some but not all types of chronic disease. These results were similar to those of other studies.[4-6,11,12]

Transgender adults in our study had more than three times the odds of reporting fair/poor overall health and more than four times the odds of having any disability compared with cisgender adults. They were also more than three times as likely to report frequent mental distress and nearly three times as likely to report a history of depression. The extent of these disparities is consistent with, and in some cases higher than, estimates reported in national analyses, which have shown approximately two times the odds of poor mental health, depression, and poor general health among transgender adults.[2,13]

Transgender adults were also more likely to report physical inactivity and marijuana use, with more than twice the odds of reporting no exercise in the past 30 days and nearly twice the odds of current marijuana use compared with cisgender adults. Prior national analyses have similarly documented disparities in physical activity, poorer health related quality of life, and higher prevalence of substance use among transgender adults.[4,7,13] These findings suggest that behavioral health disparities observed in Rhode Island are consistent with patterns reported in national analyses.

Encouragingly, after adjusting for confounders, transgender and cisgender adults had similar rates of health insurance, having a primary care provider, and having a medical checkup in the past year. These results differed from that of some other studies that had found transgender adults were at increased risk of poor healthcare access.[3,11] A recent multistate study found that transgender adults living in gender-affirming states were more likely to access preventive health care services and had fewer disparities than those living in gender non-affirming states.[14] Rhode Island is a gender-affirming state with laws protecting the LGBTQ+ community against discrimination and mandating equal access to health care; these factors may help the transgender community feel comfortable in seeking care.

These results demonstrate persistent and ongoing health disparities related to a wide range of health diseases and conditions in transgender individuals. There are several steps that clinics and healthcare professionals can take to improve access and help address these disparities.[15] Clinics should create welcoming and affirming settings. This includes correct use of pronouns and names, using gender-neutral language, and validating and affirming patients. Staff should be trained appropriately and in a culturally competent manner. Healthcare professionals should be aware of these disparities and intentionally screen individuals for health conditions that disproportionately impact these groups (i.e., HIV/STI testing in transgender women, mental health and suicidality screening for all transgender individuals). Patients should have access to gender-affirming care in their area. Access to behavioral health services is important. On a policy level, laws which support access to care for transgender individuals should be promoted. Safety-net programs, including access to healthcare, are critical for preventative care services.

This study has some limitations. First, the BRFSS is a self-reported survey and thus may be prone to recall, social desirability, and response bias. Some individuals may not feel comfortable disclosing their gender identity, leading to misclassification or an underestimate of the transgender population. Despite these limitations, this analysis provides valuable multi-year, population-based estimates of the health of transgender adults in the state. More research is needed to better understand health needs and improve the health of transgender adults in the state.

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Disclosures

The author(s) declare no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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Behavioral and Physical Health of LGBTQ+ Youth in Rhode Island: Implications for Clinical Care and Policy

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KEYWORDS: sexual and gender minorities; adolescent; young adult; behavioral health

INTRODUCTION

Adolescents and young adults are shaped by intersecting developmental, social, and structural forces. For lesbian, gay, bisexual, transgender, queer, and other sexual and gender minority (LGBTQ+) youth, these forces often translate into disproportionate exposure to stigma, discrimination, and unmet health needs.[1-4] Nationally and in Rhode Island (RI), LGBTQ+ youth experience higher rates of depression, anxiety, suicidality, substance use, and victimization than their heterosexual and cisgender peers.[2,3,5-8] At the same time, strong evidence demonstrates that affirming families, schools, communities, and health care environments substantially improve outcomes.[4,9-11]

Rhode Island offers a unique context. The state has strong legal protections for LGBTQ+ people, including bans on conversion therapy and protections against discrimination targeting gender identity and sexual orientation. Yet, marked health disparities persist for LGBTQ+ youth. This commentary synthesizes available RI-specific data on the behavioral health of this population, supplemented by national evidence and clinical experience, to describe the size and characteristics of the LGBTQ+ youth population, summarize key health outcomes, identify protective factors, and highlight actionable opportunities for providers, school systems, health systems, and policymakers. A separate commentary in this issue will describe the policy landscape and implications for LGBTQ+ youth in RI.

LGBTQ+ YOUTH IN RHODE ISLAND: SIZE AND TRENDS

Population-based estimates of LGBTQ+ youth in RI primarily come from the Youth Risk Behavior Surveillance System[12,13] (YRBS), the RI Department of Education, and the UCLA Williams Institute[14] [**Table 1**]. YRBS data indicate that of the approximately 45,000 high school students in RI, about 19% (roughly 8,000) identify as LGBTQ+, including about 3.5% (roughly 1,500) who identify as transgender.[5] These estimates are comparable to national figures,[14] with RI reporting slightly lower overall LGBTQ+ prevalence but similar proportions of transgender youth. Over time, the proportion of youth identifying as LGBTQ+ has increased in RI and nationally.[15] For example, RI Department of Education estimates suggest LGBTQ+ identification rose from approximately 10% in 2016 to nearly double that figure in recent years.[16] While increased visibility and social acceptance likely contribute, limitations in earlier data collection—particularly the late inclusion of gender identity questions—make it difficult to determine whether observed increases reflect true population changes or improved measurement.

Importantly, available data likely underestimate transgender and nonbinary youth, as many surveys rely on single-item gender identity questions that exclude youth who are questioning or have nonbinary identities. Additionally, many youth use labels to describe their sexuality and gender beyond those commonly used in survey questions. However, a strength of the RI YRBS is its inclusion of "questioning" youth, both in sexual orientation and gender identity. At the same time, fear of stigma and safety concerns may further suppress disclosure, particularly among youth experiencing marginalization in other domains.[17]

Table 1. Rhode Island LGBTQ+ and transgender youth demographic characteristics by source

Source	Total LGBTQ+ Population: n (%)	Total Transgender Population: n (%)	Methodology/Sample
RI Department of Education (DOE) and Department of Health (DOH)[4]	10%	N/A	Synthesized data from CDC YRBS, RI Kids Count, DOH Surveillance
RI Youth Risk Behavior Surveillance System (YRBS)[1,2]	8021 (19%)	1503 (3.5%)	Data from 2021 and 2023 samples weighted to obtain statewide population estimates
UCLA Williams Institute[3]	6000	400	Combines own estimates with US Census and YRBS data to develop report

MENTAL AND BEHAVIORAL HEALTH OUTCOMES

Mental and behavioral health disparities are among the most striking inequities facing LGBTQ+ youth in RI. State and national data consistently show elevated rates of anxiety, depression, and suicidality compared with heterosexual and cisgender peers.[1-4,6,8,12,15,18-21] In RI, over half of LGBTQ+ youth report symptoms of anxiety or depression. Compared to heterosexual youth, gay/lesbian/bisexual and queer/questioning youth have much higher rates of seriously considering suicide (H: 26%, LGB: 60%, Q/Q: 71%) and attempting suicide (H: 6%, LGB: 17%, Q/Q: 20%) Rates are also substantially higher among transgender and nonbinary youth when compared to cisgender youth. More than one in two transgender youth in the state has seriously considered suicide, and more than one- third concerning proportion report suicide attempts, compared to 14% and 8% of cisgender youth.[6] Similar trends are seen at the national level.[12,13]

These outcomes are strongly shaped by social context. Only about 43% of transgender and nonbinary youth in RI describe their home as affirming,[8] and family rejection is a powerful predictor of poor mental health outcomes and suicidality.[22,23] Conversely, access to gender-affirming care—including mental health services, family-based interventions, and social affirmation—has been associated with improved psychological wellbeing.[24,25] Despite high need, access to mental health care remains limited. More than one-third of RI LGBTQ+ youth who sought mental health services in the past year were unable to obtain them.[8] Common barriers include fear of involuntary hospitalization, cost, lack of affirming providers, and concerns about privacy—particularly when care is delivered virtually. Conversion therapy, defined as efforts to change an adolescent's actual or perceived gender identity, gender expression, or sexual behavior, is known to cause severe psychological distress, depression, substance abuse, and suicidality among LGBTQ youth.[26,27] It is present, but fortunately not common in RI. Seven percent of LGTBQ+ young people in RI report being threatened with conversion therapy and 3% were subjected to conversion therapy, despite the practice being legally banned in the state.[8]

PHYSICAL HEALTH, SUBSTANCE USE, AND SAFETY

LGBTQ+ youth in RI also experience disparities in physical health outcomes that reflect heightened exposure to stress, violence, and discrimination. Bullying and victimization remain pervasive among LGBTQ+ youth, and some disparities vary by sexual orientation and gender identity.[6] For example, in RI, more than one-third of transgender youth report in-person bullying, and over 40% report online harassment.[5] These experiences are associated with absenteeism, substance use, psychological distress, and increased risk of injury.[28] Transgender youth also report struggling with substance use—specifically alcohol, marijuana use, and vaping nicotine—compared to cisgender peers,[29] patterns that mirror national findings among sexual minority compared to heterosexual youth.[30] For example, prevalence of current marijuana use was higher among gay, lesbian, and bisexual students (32.0%) than heterosexual students (20.7%).[30] However, in this same study, no differences were seen in behaviors related to birth control, nutrition, or physical activity between heterosexual versus gay, bisexual, and lesbian youth.[31]

SEXUAL AND REPRODUCTIVE HEALTH EDUCATION

Comprehensive, inclusive sexual and reproductive health (SRH) education is essential for LGBTQ+ youth,[32–34] yet remains inconsistent.[35] Most RI high schools report covering gender identity and sexual orientation, but fewer provide LGBTQ+-inclusive education on HIV, sexually transmitted infections, and pregnancy prevention.[35] Available data are limited by reliance on district self-report and do not assess instructional quality or student outcomes. Gaps in inclusive SRH education leave many LGBTQ+ youth without accurate, relevant information, increasing vulnerability to adverse sexual health outcomes and reinforcing stigma.[34,36] Improved monitoring and evaluation of SRH education—including student-centered assessments—are needed at the district and state level to ensure curricula are comprehensive and inclusive, health teachers are comfortably and confidently implementing the curricula, and the instruction translates into meaningful knowledge and skills for all youth.

ACCESS TO AND EXPERIENCES WITH HEALTH CARE

Direct RI-specific data on health care experiences among LGBTQ+ youth are limited, but existing evidence suggests mixed progress. Barriers to care operate at multiple levels: individual fears of disclosure, interpersonal discrimination, insufficient provider training, limited availability of affirming services, insurance gaps, and broader societal stigma.[37] Experiences of discrimination remain common, as nearly two-thirds of LGBTQ+ youth in RI report mistreatment in school related to sexual orientation or gender identity.[6,12] Discrimination is independently associated with poorer physical and mental health outcomes, even after accounting for socioeconomic factors.[38] Analyses of RI claims data indicate that transgender adolescents receive preventive services at rates comparable to or higher than cisgender peers, though often outside traditional primary care settings.[39] Addressing these barriers requires coordinated, multilevel strategies.

INTERSECTIONAL DISPARITIES

Intersectionality provides a critical framework for understanding how overlapping systems of oppression intensify health inequities.[40] Although RI-specific data are sparse, national evidence indicates that LGBTQ+ youth who are also youth of color, immigrants, or from low-income backgrounds experience compounded disparities.[41-44] Studies show that LGBTQ+ youth of color face higher levels of school hostility, reduced access to mental health services, and greater unmet health needs than White LGBTQ+ peers.[45] These patterns likely extend to RI, underscoring the urgency of collecting and analyzing disaggregated data by race, ethnicity, gender identity, and socioeconomic status to guide equitable interventions. Affirming peer and adult support, including communities formed through online and virtual spaces, may be especially critical for youth with intersecting marginalized identities who often face reduced access to in-person supports and thus rely more heavily on alternative networks to buffer compounded stress.[46]

PROTECTIVE FACTORS AND RESILIENCE

Despite elevated risks, LGBTQ+ youth demonstrate remarkable resilience when supported by affirming environments. Family acceptance is among the strongest protective factors, associated with lower rates of depression, substance use, and suicidality.[47–49] Yet, fewer than one-third of RI LGBTQ+ youth report high levels of family support, with even lower rates among transgender youth.[50] Schools and communities also play a critical role. LGBTQ+-affirming school policies, supportive staff, inclusive curricula, and access to Gender and Sexuality Alliances (GSAs) are associated with improved academic and mental health outcomes.[51] In RI, fewer than half of LGBTQ+ youth describe their schools as affirming, highlighting significant room for improvement.[52]

Community-based organizations and online spaces also provide vital support, fostering belonging and identity affirmation. For example, Youth Pride (https://www.youthpride ri.org/) and local PFLAG chapters (https://pflag.org/find-achapter/), offer direct services such as peer support groups, youth programming, and family counseling. These organizations help foster a sense of belonging and safety for LGBTQ+ youth, which is essential for their mental and emotional development. While online communities can mitigate isolation—particularly for transgender youth[46]—they also can expose youth to harassment,[53] reinforcing the need for digital literacy and safety initiatives.

IMPLICATIONS FOR POLICY AND PRACTICE

Closing health equity gaps for LGBTQ+ youth in Rhode Island requires coordinated action across systems. Recent anti-LGBTQ+ policies at the local, state and national level are not evidence-based and will only worsen health outcomes and equity in this population.[54,55] Priority strategies include: 1) **Expanding access to affirming mental health care**, including insurance coverage, workforce development, and youth-centered telehealth models; 2) **Improving provider education and clinical training** on LGBTQ+ youth health and gender-affirming care; 3) **Strengthening data collection**, including routine, disaggregated sexual orientation and gender identity measures; 4) **Enhancing school-based supports**, such as inclusive SRH education, establishing and providing adequate funding for Gender and Sexuality Alliances (GSAs), and anti-bullying policies; and 5) **Investing in families and communities**, particularly programs that promote acceptance and culturally responsive care.

Rhode Island has a strong foundation of legal protections and community assets. Leveraging these strengths—while addressing persistent gaps—offers a clear opportunity to improve the health and wellbeing of LGBTQ+ youth statewide.

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Disclosures

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Strategies, Policies, and Practices to Support the Health of LGBTQ+ Youth in Rhode Island

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KEYWORDS: sexual and gender minorities; adolescent; young adult; health policy

INTRODUCTION

Adolescence and young adulthood represent a critical developmental period for lesbian, gay, bisexual, transgender, queer, and other sexual and gender minority (LGBTQ+) people.[1] During this stage, young people undergo profound physical, emotional, cognitive, and social development, including identity formation, increasing autonomy, and transitions across educational, health care, and social systems. Optimal health across the lifespan—including for LGBTQ+ populations—cannot be achieved without sustained attention to health and wellbeing before adulthood. This requires that youth have access to developmentally appropriate and affirming health care services, are supported by trusted adults in their families, schools, and communities, and are provided with safe opportunities to learn, grow, and thrive.[2,3] An article in this issue describes the epidemiology and health outcomes of LGBTQ+ youth in Rhode Island (RI).[4] Building on that foundation, the present commentary focuses on the systemic barriers and facilitators shaping health for LGBTQ+ adolescents and young adults (AYA) in the state, with particular attention to gender-affirming care, LGBTQ+-competent health care services, research and access to data on LGBTQ+ AYA health, and K–12 school-level policies and practices relevant to this population.

GENDER-AFFIRMING CARE FOR YOUTH

Gender-affirming care (GAC)—developmentally-appropriate care oriented toward understanding and appreciating people's gender experience ideally delivered by a multi-disciplinary team[5,6]—is an evidence-based practice supported by all major U.S. medical organizations—including the American Academy of Pediatrics, the Endocrine Society, and American Medical Association.[5,7,8] One plastic surgery group signaled concerns about surgery in minors[9]—procedures that are rare[10]—but further examination suggests this effort was led by a very small number of members and does not reflect the consensus of the organization.[11,12] GAC for youth encompasses a broad range of care that may include one or more of the following, depending on the age of the patient: social affirmation, puberty- blocking medications, cross-sex hormone therapy, gender-affirming surgery, and/or legal affirmation.[5,6] A growing body of literature links access to GAC with improved mental health outcomes for transgender youth, including reduced depression and suicidality.[5,7,13]

Despite this evidence and clinical consensus, GAC for youth is facing unprecedented political and legal attack nationally, including efforts to intimidate clinicians and pressure hospitals to curtail or close programs, with ripple effects even in states with stronger protections.[14–16] Across the U.S., an expanding patchwork of restrictive policies has narrowed access to care for minors and increased legal risk for clinicians; these restrictions have affected a substantial proportion of transgender youth and have discouraged providers from offering GAC.[14,15] Supporters of these initiatives have raised concerns about the perceived overuse of gender-affirming surgical procedures and hormonal interventions among transgender and gender diverse minors; however, research indicates these occurrences are rare[10,17] and align with the current standards of care.[6,7]

RI has historically maintained legal protections for LGBTQ+ communities,[18-21] but proposals seeking to restrict or penalize provision of GAC to minors are introduced repeatedly, requiring ongoing policy vigilance.[22] Even in states like RI where youth have access to GAC, the current national climate carries measurable consequences for gender- diverse youth wellbeing. In RI, many gender-diverse youth receiving hormones worry about losing access to medically necessary care.[23] Exposure to anti-transgender rhetoric and legislation is associated with worsened mental health and stress-related outcomes among gender-diverse people, and these harms are not confined to states that pass restrictive laws.[24] Consistent with this broader pattern, a majority of RI LGBTQ+ youth report that the current political climate has had a large negative impact on their wellbeing.[23,25] Protecting access to GAC for youth is not only a legal or ethical issue, it is a population mental health issue. RI's clinical infrastructure and policy posture can mitigate harm, but only if access is stable, enforceable, and paired with a trained workforce and affirming systems.

ACCESS TO LGBTQ+-COMPETENT HEALTH CARE

Culturally competent care for LGBTQ+ youth includes care that is affirming, non-stigmatizing, and attentive to the social and structural conditions that shape health and access.[26] Yet, many clinical environments still lack basic competencies—such as correct names/pronouns, affirming intake processes, and trained staff—leading youth to delay care, disengage, or avoid health systems altogether.[27] This is particularly concerning, given that over 300,000 youth ages 13–17 in the U.S. identify as transgender or gender diverse.[28]

Provider training gaps remain substantial. For example, a large share of physicians report no formal training in sexual minority health, and even in settings where training exists, many clinicians judge it inadequate.[29] More recent national surveys similarly describe low rates of LGBTQ+ youth-focused training among clinicians and staff, alongside persistent fear of discrimination and distrust of health systems among LGBTQ+ patients—barriers that directly undermine timely preventive care and chronic disease management.[30,31] Nearly one-quarter of transgender Rhode Islanders who accessed care reported at least one negative experience related to being transgender, including refusal of care or harassment.[32]

RI has taken steps to expand affirming care environments, such as "Safe Zone" certifications available to provider organizations statewide through Blue Cross and Blue Shield (https://www.bcbsri.com/safezones).[33] However, voluntary signaling programs do not substitute for standardized, accountable clinical expectations, and their governance and training depth may vary.[34] For youth without reliable transportation, stable insurance, or family support, the presence of a limited number of "affirming" sites can still translate into practical inaccessibility. RI should treat LGBTQ+ competence as a baseline quality standard—embedded in clinical operations, workforce development, and reimbursement models—rather than as optional, self-selected training.

TRAINING THE NEXT GENERATION OF LGBTQ+-COMPETENT PROVIDERS

Best-practice recommendations exist for preparing mental health clinicians to provide LGBTQ+-competent care, which can be adapted to other health professions.[35] RI's legal environment and clinical assets create a strong platform for health professions' education, particularly in pediatrics and adolescent medicine, where clinicians must navigate confidentiality, family dynamics, school contexts, and rapidly changing policy landscapes.

Training needs are especially urgent in mental health care, where demand continues to exceed capacity. National data indicate that most LGBTQ+ youth desire mental health care but many cannot access it.[23] In RI, a substantial proportion of LGBTQ+ youth who wanted mental health care did not receive it, citing barriers such as fear of discussing concerns, worries about involuntary hospitalization, and cost.[23] Even when youth locate care, inadequate LGBTQ+-specific training can lead to invalidation or frayed trust, discouraging further help-seeking and worsening untreated distress. These concerns are amplified by the persistence—despite bans and broad professional repudiation—of "conversion therapy" narratives and practices that continue to shape some clinical interactions.[36,37]

We recommend the following four health care worker education and workforce strategies, which are possible even in constrained environments: 1) **Integrate LGBTQ+ health longitudinally**: Embed content across core courses and clinical training rotations so competence is reinforced by repetition and practice; 2) **Use scalable resources**: Supplement local instruction with virtual modules and continuing education from reputable organizations to standardize baseline competencies; 3) **Create accountability**: Require demonstrated skills (not just attendance) in affirming communication, documentation, confidentiality, and referral pathways; and 4) **Protect learners and faculty**: Establish support structures and clear institutional expectations for inclusive clinical learning environments, particularly during periods of political hostility. RI's ability to maintain affirming services depends on a pipeline of clinicians who are trained, supervised, and supported to provide evidence-based care.

RESEARCH AND ACCESS TO LGBTQ+ YOUTH HEALTH DATA

LGBTQ+ health research and data systems have become targets of federal action, with efforts to terminate or redirect grants and to restrict public access to LGBTQ+-relevant datasets.[14,38,39] These actions carry local consequences, including threats to RI's research enterprise and broader life-sciences ecosystem.[40,41] Beyond funding, attempts to restructure how federal grants are announced and awarded raise concerns about politicizing science and weakening peer review.[42] Federal data systems matter for RI because they anchor surveillance, benchmarking, and needs assessments of health outcomes for youth across the state. For example, the Youth Risk Behavior Surveillance System (YRBS) is foundational for adolescent health monitoring nationally and at the state level.[43] Efforts to remove or limit YRBS access undermine public health planning far beyond LGBTQ+ topics, affecting injury prevention, substance use surveillance, and mental health monitoring.[44] In response, independent preservation efforts have emerged, including digital archives designed to maintain access to LGBTQ+-related public information and resources (e.g., https://www.thelgbtqarchive.org/).[44,45] RI stakeholders should continue to treat LGBTQ+ data infrastructure as essential public health programing by protecting data availability, investing in state-level measurement, and preserving questions about sexual orientation and gender identity.

SCHOOL-LEVEL CHALLENGES AND RECOMMENDATIONS

Youth spend nearly as much of their time in school as not, and like any setting, schools can be a place where students' personhood is affirmed or marginalized. While a comprehensive review and summary of school-level barriers and facilitators to LGBTQ+ youth health is beyond the scope of this review, several excellent reviews of this topic have been published recently.[46-49] Whether public, private, or parochial, K–12 schools in RI can take active steps informed by evidence to promote the health and wellbeing of LGBTQ+ youth, some of which are summarized with examples and resources in **Table 1**.

Table 1. Resources for schools and educators to promote LGBTQ+ youth health and wellbeing

Category	Description	Links to Resources
Youth of Color	Attend to intersectional marginalization of students, such as Black LGBTQ+ students, through initiatives like policies on responding to racist and anti-LGBTQ+ behavior from peers or school staff	• GLSEN
Professional Development	Provide teachers and staff with meaningful professional development related to working with LGBTQ+ youth	• GLSEN • HRC Foundation's Welcoming Schools • Advocates for Youth • National Education Association (NEA)
Gender-Sexuality Alliances	Provide and support optional opportunities for LGBTQ+ students to gather and build community, such as Gender and Sexuality Alliances (GSAs)	• Youth Pride Inc • GSA Network • GLSEN
Inclusive Curricula & Spaces	Provide inclusive curricula, such as a) teaching about the history of LGBTQ people in the US, b) comprehensive sexual health education that is engaging and relevant to all students (not just heterosexual or cisgender students) and c) access to physical education and athletic activities consistent with their gender identity.	• RIDE guidelines on supporting gender diverse students • Queer History of the United States for Young people • Amaze.org • Planned Parenthood Curriculum • Advocates for Youth 3Rs Curriculum • Our Whole Lives (OWL)

POLICY PROTECTIONS IN RI AND WHY THEY MATTER

RI's policy environment is comparatively protective, including anti-discrimination statutes, youth protections (including a ban on conversion therapy for minors), and policies supporting gender identity recognition.[50] State-level protections are increasingly important as federal actions and interstate legal conflicts expand. A major recent example is RI's Health Care Provider Shield Act (S2262/H7577), enacted in June 2024, which aims to protect clinicians and patients involved in lawful gender-affirming and reproductive health care from out-of-state legal actions and related coercive processes.[21] This type of legal protection is designed to stabilize access, reduce provider fear, and preserve confidentiality in a fragmented national environment.

Policy protections are not merely symbolic. Evidence suggests that state conversion therapy bans are associated with reductions in adolescent suicidality, with larger effects among LGBTQ+ youth.[51] In other words, legal protections can translate into measurable population mental health benefits. RI should continue to pair legal protections with implementation by enforcing laws and regulations on insurers, health systems and providers, schools, and professional boards align practice with protections, and that youth can actually access health care allowed by law.

CONCLUSION

For RI's LGBTQ+ youth—especially transgender and nonbinary youth—health outcomes are strongly shaped by whether providers and systems deliver evidence-based care in affirming environments, supported by stable policy protections and robust data infrastructure. GAC improves mental health for many youth and is supported by major medical organizations, yet national attacks threaten access and amplify distress even in protective states.[13,24,51] RI providers and policy makers can respond with a coherent strategy: protect access to care through insurance regulation and provider protection, standardize LGBTQ+ clinical competence as a quality expectation, expand workforce training (especially in mental health), and defend the data systems needed to monitor and improve outcomes. Where protections are strong, our leaders can implement them; where gaps persist, we can close them with policy and practice aligned to evidence.

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Disclosures

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Strengthening Health and Aging Services for LGBTQ+ Older Adults in Rhode Island

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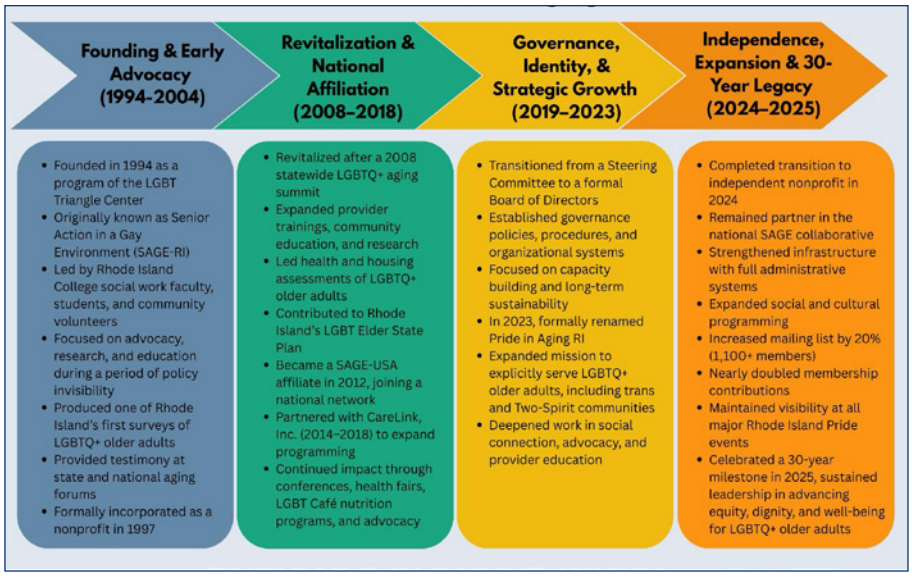
INTRODUCTION

Lesbian, gay, bisexual, transgender, and queer (LGBTQ+) older adults represent one of the fastest-growing aging communities in the United States, with an estimated three million adults aged 65 and older identifying as LGBTQ+, a number expected to double by 2060.[1] Despite this growth, LGBTQ+ older adults experience distinct health and aging inequities shaped by lifelong exposure to stigma, discrimination, and systemic exclusion, differentiating them both from younger LGBTQ+ adults and heterosexual, cisgender peers.[1-3] These experiences are associated with higher rates of chronic illness, mental health concerns, social isolation, and avoidance of healthcare and senior services, with invisibility often functioning as an adaptive response to non-affirming environments.[4-6]

In Rhode Island, community-level data indicate that LGBTQ+ older adults face limited access to identity-affirming aging and healthcare services, with few senior centers or providers offering targeted or inclusive programming, contributing to unmet needs and increased risk of hospitalization and premature institutionalization.[7-9] Community-based research and practice initiatives led by Pride in Aging Rhode Island (PIARI) have documented these gaps while generating community-informed expertise that can be translated into practical guidance for healthcare and aging service professionals.[10] This underscores the critical role of nonprofit organizations in reducing isolation, building provider capacity, and advancing culturally responsive, person-centered care for LGBTQ+ older adults within Rhode Island's healthcare systems. Given these persistent disparities and gaps in identity-affirming services, there is a need to examine strategies for improving health, social support, and services for LGBTQ+ older adults in Rhode Island.

Since 1994, PIARI (formerly SAGE-RI) has worked to ensure that LGBTQ+ older adults in Rhode Island are seen, supported, and empowered. Through social programming, community partnerships, and statewide education efforts, the organization works to ensure that LGBTQ+ older adults have access to affirming services, supportive environments, and opportunities to participate fully in decisions that affect their lives. PIARI has served as a leading voice for LGBTQ+ older adults. Rooted in research and community engagement, the organization has collaborated with agencies such as the Rhode Island Foundation, the Office of Healthy Aging, Carelink, and numerous academic, nonprofit, and healthcare partners to provide social programs that reduce isolation, deliver high-quality, cultural competence training to healthcare and aging professionals, and ensure LGBTQ+ older adults can access safe, affirming services. Over the past 30 years, PIARI has grown from a small volunteer effort into a statewide leader supporting LGBTQ+ older adults. Today, PIARI continues this legacy through intergenerational programs, community cafés, educational initiatives, and advocacy that promotes equitable access to culturally responsive care. Drawing on 30 years of LGBTQ+ older adult advocacy in Rhode Island [**Figure 1**] —and emerging LGBTQ+ older adult health research—this commentary weaves together PIARI Board's collective wisdom to highlight actionable, community-informed strategies for strengthening aging services, supports, and systems to advance health, well-being, and inclusion statewide.

Figure 1. 30 Years of LGBTQ+ Aging Advocacy in Rhode Island: A Timeline of Pride in Aging RI



PATHWAYS TO STRENGTHEN LGBTQ+ OLDER ADULT HEALTH IN RHODE ISLAND

Advancing Visibility Through LGBTQ+-Affirming Aging Environments

Many older adults served through PIARI lack children or family members to advocate for them, and may be less positioned to self-advocate within healthcare, housing, and long-term care systems that continue to presume heterosexuality and cisgender identity. As LGBTQ+ older adults age, social networks often contract due to illness, loss, or mobility limitations, making intentional community connection increasingly vital.[11,12] PIARI's work reinforces that effective support must be *relational* rather than solely programmatic, rooted in trust, visibility, and belonging for LGBTQ+ older adults. In Rhode Island, the limited number of LGBTQ+-affirming programs and services makes this relational approach essential to prevent social isolation and ensure LGBTQ+ older adults feel recognized and supported statewide. There is a critical need for LGBTQ+-affirming senior centers, adult day programs, assisted living settings, and dementia-capable services across the state. Implementation of LGBTQ+-affirming environments within such services can help close existing service gaps, and even create a model for other states seeking to improve LGBTQ+ aging equity.[13]

Addressing Ageism and Advocacy Fatigue Through Intergenerational Solidarity

There is a pervasiveness of ageism both in broader society and within LGBTQ+ communities themselves, resulting in a widening generational divide, as the lived experiences of older LGBTQ+ adults (shaped by eras of criminalization, concealment, and survival) often differ sharply from those of younger LGBTQ+ people.[14-16] This disconnect can lead to diminished interest and investment in LGBTQ+ older adult issues, leaving LGBTQ+ older adults feeling marginalized even within spaces meant to serve them.[17] Persistent ageism, combined with limited capacity, energy, and people power, can make sustained advocacy feel like a losing battle. Strengthening intergenerational connections in Rhode Island's LGBTQ+ community is critical to build resiliency among LGBTQ+ older adults while energizing younger advocates, creating sustainable local networks that support both social inclusion and advocacy. Intergenerational engagement strategies that honor LGBTQ+ older adult leadership, preserve community memory, and renew shared responsibility for LGBTQ+ aging equity is a critical priority for LGBTQ+ older adult health care.[18] Rhode Island's smaller population and concentrated services mean that such community cohesion can directly influence older adults' access to affirming care and social support.

Building Intersectional and Cross-Sector Approaches to LGBTQ+ Aging Equity

There is no single LGBTQ+ aging experience; rather, later life is shaped by intersecting identities related to race, ethnicity, gender identity, disability, immigration history, socioeconomic status, and HIV status, alongside cumulative exposure to stigma across the life course.[19-21] PIARI has witnessed how policy and systems-level gains—such as explicit protections for same-sex partners in long-term care, inclusion of sexual orientation and gender identity data in assessments and state planning, and mandated cultural competency training—have meaningfully increased visibility and safety, even as these gains remain inconsistent and politically vulnerable.

Moreover, recent federal political actions in the United States have directly targeted members PIARI serves, including transgender, gender non-conforming, and immigrant LGBTQ+ older adults—severely impacting their sense of safety, access to care, and overall health.[22-24] Cross-sector collaborative efforts are urgently needed during this time to help ensure that LGBTQ+ older adults feel safe in Rhode Island. There remains a critical need for wider networking and stronger partnerships among aging services, healthcare systems, housing providers, behavioral health organizations, assisted-living and nursing home facilities, and LGBTQ+ community organizations to ensure affirming and sustainable support for LGBTQ+ older adults throughout the state, particularly those who are the most targeted by violent federal policies.

CONCLUSION

Three strategies have been identified as key pathways to strengthen the LGBTQ+ aging community: increasing visibility through LGBTQ+-affirming environments, fostering intergenerational solidarity and advocacy, and building cross-sector approaches to LGBTQ+ equity. The Rhode Island medical community is uniquely positioned to champion these strategies through both individual and collaborative action. Deepening visibility and awareness of LGBTQ+ older adults, cultivating an ethos of welcome and belonging in care, and advancing affirming healthcare environments are vital to supporting LGBTQ+ older adults.[25,26] More robust state-level data on LGBTQ+ older adults in Rhode Island is also critically needed to inform coordinated service response and respond to the needs of the community—especially amid heightened political and social challenges.

Since its founding in 1994, PIARI has evolved to meet the changing needs, strengths, and resilience of LGBTQ+ older adults. Rhode Island's close-knit communities provide a strong foundation for building intergenerational opportunities and networks that celebrate and honor the experiences of LGBTQ+ older adults while energizing the next

generation. Fostering intergenerational engagement in programming also offers a promising strategy to combat ageism, as multigenerational knowledge-sharing and chosen families remain central to LGBTQ+ aging, especially among transgender, Black, Indigenous, and other BIPOC same-gender-loving communities.[27,28]

In the nation's smallest state, Rhode Island's medical community—working alongside PIARI—is strategically positioned to lead LGBTQ+ older adult health equity by leveraging its more centralized, coordinated health systems to address disparities across both rural and urban communities. This proximity also makes it more feasible to build and sustain cross-sector partnerships across aging services, healthcare, housing, and policy systems, supporting relationship-based action. At the policy level, advancing LGBTQ+ aging equity in Rhode Island requires aligning statewide strategies, particularly with organizations such as the Rhode Island Office of Healthy Aging, Rhode Island Department of Health, Executive Office of Health and Human Services, and Behavioral Healthcare, Developmental Disabilities & Hospitals to support inclusive, coordinated, and sustainable approaches. By continuing to build visibility, foster intergenerational connections, and strengthen cross-sector collaborations, Rhode Island can create a sustainable, inclusive aging ecosystem that meets the evolving needs of LGBTQ+ Rhode Islanders, and serve as a model for other states, now and into the future.

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In 2025, Attacks on LGBTQ+ People's Civil Rights and Access to Healthcare Reshaped the US and Medical Professions

ANGELA KEMP, MSW; RYAN FONTAINE, BS

Reports by The Trevor Project and Movement Advancement Project (MAP) show a mass migration underway in the United States by LGBTQ+ youth, their families, and LGBTQ+ adults.[1,2] It's no wonder when you consider that year-over-year increases through the last decade culminated in the American Civil Liberties Union tracking over 600 bills introduced in United States (US) state legislatures in 2025 that would discriminate against LGBTQ+ people.[3] MAP's equality map showed 27 states, and three US territories are no longer safe for LGBTQ+ people.[4]

Rhode Island is not immune from this legislative onslaught. Proposals from curriculum censorship to bathroom and healthcare bans have all been heard in the committee rooms at 82 Smith Street. The difference is that these proposals are defeated year after year, while those that do advance have positioned Rhode Island among the 15 states offering the most civil rights protections for LGBTQ+ people in the US.[4] Similarly, local communities continue to reject efforts to make our schools unsafe for LGBTQ+ students.[5] Anecdotally, medical professionals and supportive agencies can tell you that, because of Rhode Island's civil rights' protections, many LGBTQ+ people and their families fleeing their home states are coming to Rhode Island.

What happens when these attacks are no longer escapable by crossing state borders? We are finding out in real time as the project to restrict the civil rights of LGBTQ+ people reached new heights in 2025. Passage of the 2025 National Defense Authorization Bill containing restrictions on healthcare for the transgender dependents of military service members in December 2024 set the stage for the year to come.[6] A wave of anti-LGBTQ+ stand-alone bills, and countless riders washed up in the 119th session of the US Congress. Only a new round of sports restrictions for transgender people in military academies in the 2026 National Defense Authorization Act prevailed, but the 119th session is ongoing.[7]

More immediate and devastating actions flowed from the executive branch. Nearly as quickly as he took the oath of office, Donald Trump began issuing executive orders to end-run the legislative process, override state laws, and enforce discriminatory policies across the country. Resulting agency actions have removed LGBTQ+ health data; erased LGBTQ+ people from federal programs; twisted civil rights law to discriminate against LGBTQ+ people; restricted the ability to obtain accurate identity documents; and defunded programs and institutions based on their acknowledgment LGBTQ+ people even exist.[8,9] Immediate legal challenges have successfully impeded many of these discriminatory actions.[9] However, the Supreme Court of the United States (SCOTUS) reached down in two pending lower court cases, allowing the bans on transgender people in the military and accurate passports for transgender people to take effect.[9] Additionally, 2025 SCOTUS merits' decisions allowed state bans on best-practice medical care for transgender young people and religious intolerance for LGBTQ+ inclusive curricula in K-12 schools.[10] More cases impacting LGBTQ+ rights will be decided by SCOTUS in 2026.

Federal actions targeting LGBTQ+ people for unequal treatment were so numerous in 2025 that entire databases were established to monitor these actions. It is impossible to concisely summarize these events in a single article. This onslaught has put transgender people and the entire practice of medicine in dire straits. In May 2025, HHS published "Treatment for Pediatric Gender Dysphoria." The conclusions of this attempt to rewrite the standards of care were foregone—reject medical consensus and consistent evidence for gender-affirming care and push psychotherapy as a de-facto attempt to stop young people from being transgender. Breaking all scientific norms, the authors and peer reviewers of the HHS report were not made public until almost seven months after its release. Not a single expert in healthcare for transgender young people was among them.[11]

Also in 2025, federal agencies subpoenaed 20 hospitals seeking to obtain the detailed medical records of transgender adolescents and their medical professionals; threatened states that provide health insurance coverage for necessary healthcare to transgender people under age 18 or 19; used multiple levers of power to threaten healthcare professionals providing necessary healthcare to transgender young people; and platformed the worst anti-LGBTQ bigotry that pales in comparison during the first Trump administration.[8]

The worst was yet to come by year's end. During the summer, it became public knowledge that the Centers for Medicare and Medicaid (CMS) was preparing two proposed rules restricting access to essential medical care for transgender young people. On December 19th, the published full text revealed the intent to prevent federal Medicaid dollars from being used to cover medical transition for anyone under 18,

or under 19 for Children's Health Insurance Program recipients, and to stop hospitals from providing medical transition care to anyone under 18, regardless of payor source, by threatening their participation in Medicare and Medicaid. A declaration from the US Secretary of Health and Human Services accompanied these rules, effectively attempting to bypass the federal rulemaking procedures to immediately begin excluding healthcare professionals and systems that provide transgender healthcare to young people from federal health programs. All these actions are based on circular references to the HHS Report, England's discredited NIH Cass Review, and limitations on care enacted by a scant few European countries, in direct contradiction to the best medical evidence.[8]

To be clear, at the time of this writing, essential medical care for transgender people of any age is still legal federally and in many states. Countless lawsuits are challenging the discriminatory actions by the federal government, including nearly 50 brought by the Rhode Island Attorney General.[12] These cases, by and large, have been successful in putting these discriminatory actions on hold while litigation proceeds.[9] That has not been enough to stop the harm as agencies and healthcare systems dependent on federal funding are pressured into pre-compliance, even in Rhode Island and other protective states. Whether those withdrawals of care are permissible under the laws of supportive states will soon be tested in state courts.[13]

The implications for medical professions extend well beyond the direct care to LGBTQ+ people, with the potential to entirely reshape medical practice. As seen with the national reports cited above, the effects on LGBTQ+ people will be felt more strongly along class lines. Those who can leave discriminatory states, the country, or access care through private clinics not under threat will have a buffer not available to many others. LGBTQ+ people are shown to experience economic hardship due to persistent discrimination and, as a result, rely on supportive government services at higher rates than straight, cisgender people.[14] That is an impossible position when the government's policies seek to exclude LGBTQ+ people, while authorizing and attempting to regulate private individuals and institutions to do the same.

Now is the time to engage with our state and local leaders to demand Rhode Island remain a place where everyone is treated with equal dignity under the law. The medical community has proved a powerful force in the Ocean State, like with the swift passage of the 2024 Health Care Provider Shield Act.[15] Connect with your professional associations and the many local organizations and volunteer groups supporting this work, including LGBTQIA+ Action Rhode Island, The Womxn Project, GLBTQ Legal Advocates and Defenders, Planned Parenthood Votes RI, ACLU RI, and others to ensure Rhode Island's state motto of Hope continues to apply to everyone.

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