Testimony of Diana Christian
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Hearing before the New York City Council Committee on Mental Health, Developmental Disability, Alcoholism, Substance Abuse and Disability Services
RE: Int. 1225- Requiring the DOHMH to develop a plan for serving the mental health needs of LGBTQ individuals.
Res. 0130 – Designates as professional misconduct, engaging in sexual orientation change efforts by mental health care professionals upon patients under 18 years of age.
Res. 0613 – Declaring the practice of "curative therapy," also known as "reparative" or "conversion" therapy, or any attempt to change, alter, or "correct" a person's sexual orientation, to be unethical.
New York City Council Chambers
Tuesday, January 10, 2017

Thank you Chairperson Cohen and members of the Committee for the opportunity to speak this afternoon, and particular thanks to Council members Torres and Drumm for introducing this important legislation. My name is Diana Christian and I am the Chief Policy Advisor at Community Healthcare Network. CHN is a network of 11 Federally Qualified Health Centers, plus two mobile medical vans and a school-based health center. We provide affordable primary care, dental, behavioral health and social services for 85,000 New Yorkers annually in four boroughs.

On behalf of CHN, we fully support the New York City Council in passing the bills before you, and would like to testify specifically on Int. 1225- requiring the DOHMH to develop a plan for serving the mental health needs of LGBTQ individuals. We are encouraged by the strides that the city is making to properly address the unique needs of LGBTQ New Yorkers, and urge the Council to recognize how critical it is for the city to work in partnership with existing community organizations when developing physical or mental health plans. We very much support the provision of the bill requiring the DOHMH to develop the plan in consultation with not-for-profit organizations with expertise, and in particular, federally qualified health centers. At CHN, we provide both one-on-one behavioral health services, as well as group counseling. The group settings for LGBTQ communities are tremendous, and we have found them to result in an increase in medical visits, return rates, and proactivity in healthcare.

There are a few issues I would like to address here, the first being the backbone of a plan like this – there are simply not enough behavioral health providers in New York City that serve low-income individuals – LGBTQ or otherwise. Organizations like ours struggle tremendously to identify and hire mental health professionals – and for most community providers, wait lists are often weeks or months before there is an opening for an appointment. There is no shortage of desire for services, but neither the city nor the state is creating incentives or support for mental health professionals to go into serving these populations. Also, current city plans, such as ThriveNYC, work outside the existing framework of community providers.

As a provider of comprehensive health care services in underserved communities for over three decades, CHN has extensive experience serving the LGBTQ community. In order for us and others to provide better care, there needs to be increased support, with both money and resources, towards training for all providers and healthcare staff in LGBTQ specific competencies. Few providers have even baseline familiarity with issues specific to the LGBTQ population, much less expertise. Nearly one-third (30.7%) of respondents in a recent NYS LGBTQ Health & Human Services needs assessment reported not enough LGBT-trained health professionals as a barrier to health care. Receiving medical care in a setting which is not culturally sensitive to LGBTQ individuals can cause additional trauma and result in avoidance of care. Cultural competency with LGBTQ individuals should exist at all levels – from the front desk staff to providers.

Additionally, there is a long history of LGBTQ communities being pathologized by the medical community. Mental health concerns endorsed by a patient should not be automatically assumed to be related their gender identity- as is often assumed with untrained providers. We must also examine how social determinants impact mental health needs. For example, people that have experienced violence against them – at home or socially, been kicked out of their homes or

school system, or other instances, have mental health needs that do not solely rest on their gender identity. In the same HHS needs assessment, nearly one in five (17.7%) LGBT respondents had been homeless at some point in their lives. We have found this to be particularly true for our transgender patients in the Bronx. It is far too common for them to have been rejected by loved ones and been victims of abuse and discrimination from family, friends and others in the community.

Circumstances often have additional layers of complexity for LGBTQ youth. The Centers for Disease Control and Prevention (CDC) recently reported, in the most comprehensive study to date, which does not yet include the option to identify as transgender or non-binary, that 8% of the high-school population identifies as lesbian, gay, or bisexual (LGB). In New York City, that equals 80,000 individuals. It also found staggering statistics on the substantially higher levels of harassment and physical and sexual abuse that LGB youth face compared to those who identify as straight, such as, 42.8% of LGB youth have considered suicide in the last year, compared to 14.8% of straight individuals, and 29.4% of which attempted suicide, compared to 6.4% of straight youth. They also face much higher levels of bullying, skipping school out of fear of safety, being forced to have unwanted sexual intercourse, and sexual violence. According to a NYS transgender discrimination survey, 75% of transgender and gender non-conforming (TGNC) students in grades K-12 reported high rates of harassment, 35% reported physical assault, 12% reported sexual violence, and 14% reported that harassment was so severe it led to their leaving school.

For the transgender community, seeking mental health services is often not a choice; rather, they are mandatory to attaining transition surgery. Medicaid requires two letters – one from a psychiatrist and one from a therapist. This is mandated therapy with providers that may not be trained to be sensitive in LGBT services – thus forcing patients into a system which can ultimately lead to further trauma and negative health outcomes. Transgender patients at CHN are often afraid to see a mental health therapist due to past negative situations – including being asked their "real" name, or personal questions about genitalia. Unfortunately, it is not uncommon for providers to be curious about the individual's gender dysphoria more than their mental status.

Finally, these services are still too expensive for many New Yorkers. Despite progress, many LGBTQ individuals are still fired from their job or lack spousal or parental support. This results in a community of people that are unemployed or underemployed and cannot afford services. At CHN we have a sliding fee scale for individuals with no health insurance, which allows individuals to pay $40 or $50 out-of-pocket to see one of our providers. This is still a tremendous amount for many individuals, especially youth if they are not supported by their parents.

On the two remaining bills, other states have shown leadership in these areas, and as New York prides itself on our progressiveness, it is time for us to take the steps to eliminate all forms of unwanted provider intervention in gender identity. Rather, we must solely support exploration of gender identity and be affirming of an individual's right to exist without stigma or bias. Further, conversion therapy or curative therapy has been rejected by the American Psychological Association (APA) and has been demonstrated to be harmful to patients. It is medically proven that children are born with their gender identity. It is how they feel, and how they express. They know what gender they are, regardless of what they are born with. Forcing them into oppressing

their gender identity overwhelmingly results in negative health outcomes, including depression, anxiety, suicide, and others. Sexual orientation is not different.

In closing, I strongly encourage the New York City Council to pass these three bills before you.

Additional: CHN Patient Examples

Patient 1: Patient is a 42 year old HIV positive transgender woman. Patient was recruited through an outreach event in May of 2015. Patient is an event organizer and social event planner at different clubs throughout Queens. Patient showed interest in transferring care to Community Healthcare Network based on her needs and the comprehensive services we offer to the LGBT community.

Patient has a long history of trauma inflicted by her older brothers. Patient was raised by her mother who had an alcohol problem. Her father died when patient was very young. Patient continues to mourn the death of her father. Patient suffers from trauma inflicted by her brothers for being transgendered.

After Program Manager completed a psychosocial assessment, patient was referred for behavioral services due to her traumas; patient is ambivalent to trust others. Patient was diagnosed with PTSD (Post Traumatic Stress Disorder). Her employment requires her to be around individuals that may be drinking alcohol. She reported often feeling nervous around individuals who are drinking often placing her job in jeopardy because she had to leave the establishment to compose herself. Both service provider and patient felt that therapy would be beneficial.

For the past year patient attends weekly therapy sessions and is compliant with all appointments. Patient continues to be virally suppressed. Patient has also engaged in support groups offered at the clinic. Patient recently obtained legal status, she was very happy with the news. Patient has shown improvement in mood and motivation for life. During reassessment, patient talked about her desire to work to improve his emotional health.

Patient 2: Patient is a 30 year old, newly diagnosed HIV Positive. Patient was referred by AVP (Anti-Violence Project) where patient is receiving legal assistance against ex-partner for domestic abuse to Community Healthcare Network. Patient is interested in primary care, hormone treatment, mental health and support group. Patient has history of suicidal ideation, attempted once prior to coming to the program. Patient also has experienced traumatic events, molestation.

Patient began receiving care at Community Healthcare Network, became virally suppressed, engaged in support groups, and attends weekly therapy visits. She is currently on medication to help with depression. She is actively working to obtain legal status, recently granted permission to work, and received her name change. Patient is currently in a relationship, she states she feels more confident expressing her needs due to her therapy session and support from friends that attend the group. Overall patient is doing better.