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An Exploratory Study Examining Needs, Access, and Competent Social Services for the Transgender Community in Phoenix, Arizona

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Phoenix is the sixth largest city in the United States, with a vibrant yet underserved lesbian, gay, bisexual, transgender, and queer (LGBTQ) population. Despite an extensive community presence, social service delivery bias persists among members of the LGBTQ community, but more often among transgender individuals. Existing research has examined social services from the perspective of either the client or the practitioner. This exploratory study specifically examines social services in the Phoenix metropolitan area for the transgender community. Data collected from interviews with participants and providers contributed to an assessment of the current level of social services for the transgender community, with a specific emphasis on identifying service gaps and recommendations for culturally competent and comprehensive services.

Keywords: Arizona, discrimination, LGBTQ, social services, transgender

INTRODUCTION

In recent years there has been heightened attention related to understanding the intersection of how sexual orientation, gender identity, gender expression, and gender nonconformity influence the delivery of social services (Knochel, Quam, & Croghan, 2010; Stotzer, Silverschanz, & Wilson, 2011). Homophobic and/or transphobic social service environments often discourage lesbian, gay, bisexual, transgender, and queer (LGBTQ) individuals from seeking, utilizing, and maintaining access to such services. Specifically, social service environments can be overtly or subtly homophobic and/or transphobic through discriminatory, uncomfortable, unaccepting, and/or uninformed interactions with staff, other participants, and offered amenities (Stotzer et al., 2011). Limited research has been conducted to assess service barriers within rural and urban settings such as the Phoenix, Arizona, metropolitan area, particularly to meet the diverse needs of the adult transgender community.
For the transgender community, identifying within the broader LGB community is often a necessity, because community organizations and services rarely offer any distinction when providing services for sexual minority populations. Services and programs for the LGB community are often provided within the same office spaces and settings as those for the transgender community, and it may be relevant to acknowledge that the broader LGBT community is not homogenous, as well as it is important to validate each unique and individualized experience of marginalization and stigma. Examples of social services typically provided to members of the transgender community include services aimed at reducing or eliminating homelessness, financial education, case management, health, mental health, sexual health, financial education/counselling, and other supportive services (Kenagy, 2005).

While the transgender community faces many of the same challenges of the broader LGBQ community (e.g., stigma, oppression, and hostility), the issues unique to their health and mental health related to sex, gender, gender identity, and sexual minority status are specific only to those within the widely diverse transgender community. The purpose of this study was to examine the delivery of existing social services, needs, and gaps identified by transgender individuals—along with the perspective of social service agencies that serve this minority community within one urban city. An additional purpose of this study was to identify some of the unique social service experiences of the transgender community and how such interactions determine whether they maintain or discontinue care.

While this research focuses on the specific geographic region of Phoenix and more broadly, Maricopa County, Arizona, the relevance of the data provided likely holds implications for other urban and rural regions as well. Maricopa County is a region with both urban cities (populations near to or exceeding 500,000) and rural towns (populations with less than 500); thus the experiences of the participants may reflect such unique settings. Ongoing research with regard to service user experiences—as well as service provider experiences—is vital because of a dearth of best practices related to meeting the needs of many minority populations, such as the transgender community, as well as to deepen an understanding for how such individuals seek, utilize, and maintain care.

BACKGROUND

Affirming Models of Care

The distinct histories, stories, experiences, and needs of LGBTQ populations call for competent, sensitive, and well-trained providers that understand the unique needs of each subset of the broader group. Recognizing that the LGBTQ community has a distinct culture (Irving, 1994 as cited in Bardella, 2001), uniquely lived experiences are best understood through validation and affirming each person’s reality (Cross & Epting, 2005). Crisp and McCave’s (2007) affirming model of practice provides an example of extending an equal level of care and empathy with regard to the client’s sexual orientation and/or gender expression (Button, 2001). Affirming practice models focus on empowerment and client strengths, as well as cultural sensitivity and validation of each client’s life experience (Crisp & McCave, 2007). A long history exists of challenges and cultural barriers faced by members of the transgender community when seeking and receiving social services. Similarly, social service providers often struggle in offering competent care related to those services sought by the transgender community. The literature examining social service provision for members of the wider LGBTQ community has typically come from the perspective of the client separate from the provider (Eady, Dobinson, & Ross, 2011; Jessup & Dibble, 2012). Yet many LGBTQ-specific service providers have extensive histories and knowledge of this diverse community’s unique needs—with a keen ability to identify gaps in services and affirming
approaches. However, it may be helpful to first understand differences in language and meaning associated with the terms sexual orientation, gender identity, and gender expression, and then to examine demographics regarding the transgender community including specific needs and concerns related to health, mental health, homelessness, poverty, and domestic violence services.

**Language and Meaning**

The language, meaning, and use associated with the terms sexual orientation, gender identity, and gender expression are by no means identical and often become intermixed and entwined when discussed within research and literature. However, sexual orientation is defined as a characteristic describing emotional and/or physical attraction for intimate, affectionate, and sexual needs—and can include people of the same gender or opposite gender (HRC, 2013b; Morrow & Messinger, 2006). Specifically “heterosexual,” “bisexual,” and “homosexual” are all sexual orientations. Gender identity is the “deeply felt psychological identification as male or female, which may or may not correspond to the person’s body or designated sex at birth (i.e., the sex listed on a birth certificate)” (HRC, 2013b, para. 2). Gender expression is broadly defined as “the manifestation of characteristics in one’s personality, appearance, and behavior that are culturally defined as masculine or feminine” (Committee on Lesbian, Gay, Bisexual, and Transgender Health, 2011, p. 26). When gender identity and gender expression do not align, gender dysphoria can result. Specifically, gender dysphoria describes “a sense of inappropriateness in one’s gender role, and a strong and persistent identification with and desire to live in the role of the other sex” (Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities Board on the Health of Select Populations Institute of Medicine, 2011, p. 26). Gender identity bias refers to the ongoing practice, and acceptance, of perceived stereotypes, myths, and misconceptions resulting in clouded professional judgment (Stotzer et al., 2011). In addressing gender identity bias, awareness about gender variance is essential as is the need to think less rigidly and more fluidly about these matters (Monro, 2005). Gender variance refers to the degree to which one identifies with the socially constructed idea of being male or female (Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues, 2011).

The terms transsexual and transgender often imply similar meaning (Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities Board on the Health of Select Populations Institute of Medicine, 2011); however, the term transgender is “increasingly used to encompass gender-variant identities and expressions” (Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities Board on the Health of Select Populations Institute of Medicine, 2011, p. 26). Individual and geographic preferences, barriers, and concerns are encountered when using the term transsexual or transsexual (Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities Board on the Health of Select Populations Institute of Medicine, 2011); therefore the term “transgender community” will be used throughout this study. The transgender community refers to a broad range of gender variant people but does not necessarily include information about their sexual orientation or their views on gender reassignment surgery.

**Demographics**

One study estimates that roughly 3.4% of Americans publicly identify as lesbian, gay, or bisexual, with 0.3% identifying as transgender (Gates, 2011; Gates & Newport, 2012); representing an estimated 10,723,630 individuals nationwide (United States Census, 2012). However, the exact prevalence of the transgender community varies. Nationwide estimates range from “1 in 11,900 to 1 in 45,000 for male-to-female individuals (MtF) and 1 in 30,400 to 1 in 200,000 for female-to-male (FtM)” (World Professional Association for Transgender Health, 2011, p. 169). Additionally
the LGBTQ community comprises of a mix of racial and ethnic groups (Balsam, Molina, Beadnell, Simoni, & Walters, 2011). Estimated racial/ethnic group percentages from the Gates and Newport (2012) study include African Americans (4.6%), Asians (4.3%), Hispanics (4.0%), and non-Hispanic whites (3.2%).

Health and Gender Reassignment Surgery

Members of the transgender community face many health-related challenges along with barriers to care. Some health-related concerns may be related to sexually transmitted infections including HIV/AIDS, suicide attempts, violence, victimization, and trauma (Kenagy, 2005), challenges related to hormone therapy treatments (Lawrence, 2007), as well as those health matters typically associated with their birth gender, race/ethnicity, or other such cofactors. Developing competency related to the health care needs of the transgender community is not a requirement for physicians, nor is it a medical school specialty (American Medical Association, 2013). Health care accessibility and medical resources remain a persisting struggle for many members of the transgender community. (Khan, 2011). Although the existence of competent medical practitioners is important, health care still eludes many who are seeking gender reassignment surgery or those in the midst of transitioning. A common misconception about the transgender community is that all transgender individuals will seek gender reassignment surgery, while many individuals have their own reasons for opting not to have surgery. Such reasons may revolve around personal choice, finances, availability of insurance coverage and eligibility, and the dearth of qualified physicians (Brownstein, 2009; Motmans, Meier, Ponnet, & T’Sjoen, 2012).

The World Professional Association for Transgender Health (WPATH, 2011) has established standards of care for the health of transsexual, transgender, and gender nonconforming people. Such standards of care include suggested practitioner guidelines such as (1) appropriate assessment of gender dysphoria, (2) provision of competent therapeutic care regarding gender identity/expression and affirming interventions, (3) assessment, diagnosis, and treatment options for coexisting health concerns, (4) if applicable, assess eligibility, prepare, and refer for hormone therapy, and (5) if applicable, assess eligibility, prepare, and refer for surgery (World Professional Association for Transgender Health, 2011). Additionally, to qualify for reassignment surgery, up to three recommendations from qualified mental health providers are suggested to ensure appropriate and professional care (World Professional Association for Transgender Health, 2011). Although organizations and standards of care assist in establishing universal health care protocols, the individual needs and concerns of each individual must remain balanced with such protocols (Clark, Landers, Linde, & Sperber, 2001). Ultimately, although the process of transitioning genders is quite complicated and multifaceted, it is vital for social service, health, and mental health providers to be comprehensively trained in competent standards of care to best meet their transgender client’s needs.

Mental Health

Overall members of the LGBTQ community struggle with emotional well-being more so than their heterosexual counterparts because of stigma, discrimination, poor insurance coverage, and lack of competent care, among other reasons (Krehely, 2009). Twenty percent of LGB adults experience psychological distress versus 9% of non-LGB individuals; 22% LGB adults are likely to need medication for emotional health issues versus 10% for non-LGB individuals; and 50% of transgender adults have suicide ideation versus 5% of the general population (Krehely, 2009). Lawrence (2007) underscores strong parallels between the transgender and the lesbian, gay, and bisexual communities in terms of mental health challenges, which are often linked to an intolerant society (Heck, Flentje, & Cochran, 2012). Transgender individuals may experience mental health
challenges that may be compounded by social isolation, economic marginalization, incarceration, substance use and addiction, suicide ideation and attempt, and histories of abuse and trauma, among other concerns (Herbst et al., 2008).

Challenges with mental health and mental illness are some of the leading reasons individuals become homeless (National Coalition for the Homeless, 2011). One estimate suggests that 20–40% of homeless youth identify as LGBTQ (Center for American Progress, 2010), while homeless transgender adult statistics are even more troubling: “one in five transgender persons have unstable housing and are at risk or in need of shelter services” (Minter & Daley, 2003 as cited in Spicer, Schwartz, & Barber, 2010). Homelessness and poverty are directly related while also creating persistent issues for many LGBTQ individuals and couples. The notion that LGBTQ individuals are affluent is inaccurate since up to 25% of the lesbian, gay, and bisexual community is poor (Albelda, Lee, Badgett et al., 2009), defined as an income of $11,702 for a single adult between the ages of 18 and 65 (United States Census, 2011). Specifically, Albelda et al. (2009) note 24% of lesbians and bisexual women are poor, compared with only 19% of heterosexual women (p. ii); 15% of gay and bisexual men are poor, a rate nearly equal to those of heterosexual men at 13% (p. ii); and 2.2% of male same-sex couples and 1.3% of female same-sex couples receive cash assistance, compared to 0.9% of different-sex married couples (p. iii). What is most troubling is that the transgender community is four times as likely to live in poverty and twice as likely to be unemployed (Sears & Badgett, 2012). Many LGB individuals—and especially transgender individuals—are more susceptible to poverty because of a lack of supportive employment opportunities.

Domestic violence and mutual partner violence further compound challenges for the LGBTQ community living in poverty (Albelda et al., 2009; Hetling & Zhang, 2010). Domestic violence is typically defined as physical, psychological, emotional, sexual, or financial abuse where a power differential is a motivating factor (Baird, Gregory, & Johnson, 2011; Flury, Nyberg, & Riecher-Rossler, 2010). Lesbians and gay men struggle with the same rate of domestic violence as opposite sex couples (Blosnich & Bossarte 2009; Burke & Follingstad 1999; Murray & Mobley 2009 as cited in Capaldi & Langhinrichsen-Rohling, 2012). Incidents of domestic violence for couples including at least one individual in the transgender community are reportedly as high as 50% (National Resource Center on Domestic Violence, 2007). Research has highlighted various risk factors for domestic violence including age, education level of both partners, number of children, alcohol and drug use, community norms, violence in either partner’s family of origin, and childhood experiences of violence (Abramsky et al., 2011; Kiss et al., 2012). Despite these findings, it is believed incidents in the LGBTQ community may be underreported because of several factors that include “heterosexual” definitions, meaning, and understanding of domestic violence (i.e., men abusing women), fear of discrimination (Turell, Herrmann, Hollander, & Galletly, 2012), a lack of appropriate law enforcement training, and community awareness.

**CHALLENGES WITHIN THE STATE OF ARIZONA**

This study examines specific concerns and needs of the transgender community and service providers within Phoenix, Arizona. Therefore, it may be useful to review five distinct and concrete examples of persistent social, medical, and legal challenges for members of the broader LGBTQ community in the state including (1) a lack of employment protections, (2) challenges with marriage equality, (3) complications with parenting rights, (4) a scarcity of health insurance and competent providers, and (5) a lack of necessary resources.

**Employment Protections**

Arizona has few LGBTQ employee workplace protections by offering no legal protection from discrimination (Arizona State Legislature, 2007b). Specifically, sexual orientation and gender

Marriage/Relationships

Current statistics reveal Arizona has approximately 21,000 same-sex couples (Harrington, 2011), with the largest population in the Phoenix-Mesa area (Urban Institute, 2004). Despite a strong presence in Arizona, those in the LGBTQ community struggle to establish recognized and enforceable rights. In fact, until 2001, same-sex relations were considered illegal in the state (Walzer, 2004). However, along with the current movement for marriage equality across the United States, the U.S. District Court ruled against Arizona’s constitutional amendment banning marriage equality in October 2014 (HRC, 2014). This is significant to note because historically same-sex relationships were not legally recognized nor were marriages from other states (Arizona State Legislature, 2007a). Additionally, new antidiscrimination legislation has been passed in the city of Phoenix to protect LGBTQ individuals in housing, public accommodations, and employment (Blair, 2013).

Parenting

The 2010 United States Census cites “between 23 and 27% of same-sex households are raising families” (Donaldson James, 2011, para. 3). In recent years, medical technology has advanced rapidly allowing couples who cannot conceive children to use assisted reproductive therapy (Palmer, 2011). Associated expenses of surrogacy, from finding a surrogate to the birth of the child, can cost $150,000 (James, Chilvers, Havemann, & Phelps, 2010)—an expense that cannot be deducted from taxes (Holcomb & Byrn, 2010). Many same-sex couples choose adoption because the cost rarely exceeds $40,000, a majority of which is tax deductible (Dorocak, 2007). For transgender individuals who have had gender reassignment, after the gender change is successful, legal recognition of both their relationship and/or their parenting rights remains complicated (Biblarz & Savci, 2010), because legality of the relationship is unclear (LGBTQ Nation, 2013). For lesbian, gay, and transgender individuals, coparenting or second-parent adoptions may also be an option (Starnes, 2012). Second-parent adoption is a part of the adoption contract providing an exception for a spouse or stepparent (Beekman, 2010), which recently became recognized in Arizona (Movement Advancement Project, 2013). Coparenting is often used in the context of divorced parents; however, it can be a legal route for same-sex couples to secure parenting rights (Starnes, 2012).

Health Care

Those who identify in the transgender community regularly struggle with health insurance coverage (Khan, 2011) at many levels. In 2015 the Arizona Health Care Cost Containment System, the state-run Medicaid program, offered no coverage for hormone therapy or supportive medical services for the transgender population (Arizona Health Care Cost Containment System, 2015; U.S. Department of Health and Human Services, 2012). This discrepancy forces many needing hormone therapy, medications specific to transitioning genders, and other supportive medical services to initiate a grievance and appeal process. Although transgender individuals may have some degree of access to medical professionals, it does not imply such services or care providers are competent to best meet their needs. If employers opt for inclusive health insurance plans, expenses for transgender employees are minimal. Although the language of health insurance companies is complicated, covering
health care for transgender employees is cost effective (HRC, 2013a). The assumption that health care for the transgender community is a financial burden to employers is not supported (HRC, 2013a).

VA Health Care Provision

Phoenix is home to a large Veterans Administration (VA) health care setting, serving 5.75 million veterans (Arizona Department of Veterans Services, 2009) that will pay for medical and necessary care provided to “enrolled or otherwise eligible intersex and transgender veterans, including hormonal therapy, mental health care, preoperative evaluation, and medically necessary postoperative and long-term care following sex reassignment surgery. Sex reassignment surgery cannot be performed or funded by VHA or VA (Department of Veterans Affairs, 2011, p. 2).” The VA provides more support than many local governments. In Maricopa County 10 physicians are competent in treating individuals within the transgender community, with offices located in Phoenix and Mesa (This is HOW, 2012).

Additional Resources

One variable to consider regarding access to medical care is transportation because Maricopa County encompasses 9,224 square miles (United States Census, 2000). Access and mobility from an outlying town into central Phoenix can be a challenge if relying on public transportation. For example, if an individual lived in central Mesa, at Luke Air Force Base, or in northern Scottsdale, it could take more than two hours to get into central Phoenix for an appointment during business hours (Valley Metro, 2013). If an individual is disabled or lives outside of public transportation boundaries, additional significant challenges arise. Similar challenges remain with regard to homelessness and poverty as up to 25,000 individuals and families experience homelessness every night in Arizona (Arizona Department of Economic Security, 2011). Ultimately, it remains clear that the vast and unique transgender community at large and within the state of Arizona faces multiple challenges even before attempting to access necessary social, health, mental health, and medical services. This study examines the delivery of existing social services, needs and gaps identified by transgender individuals, along with the perceptions of social service agencies that serve the transgender community in Phoenix.

METHODS

Procedure

This study employed a grounded theory approach (Charmaz, 2014) allowing participants and service providers the opportunity to share their own stories and experiences and to explore concrete ideas regarding potential improvements. Two separate open-ended surveys were utilized for transgender “participants” (Appendix A) and service “providers” (Appendix B) seeking their assessment of the current quality of services as well as seeking suggestions for a more comprehensive service network. Social service providers were asked to give feedback about their services in relation to the LGBTQ community, as a whole, because transgender specific social services are rare. All participants and service providers were given pseudonyms to protect their identity, and each interview lasted approximately 30 minutes. Study protocols were approved by the Institutional Review Board of the primary author’s institution.
Sample and Recruitment

Participant criteria for the study included (1) being age 18 or older, (2) self-identification as transgender or with experience serving the transgender population, and (3) consent to participate. A poster was displayed at a transgender community safe house in addition to using word-of-mouth through snowball recruitment. Prospective participants e-mailed or telephoned the researcher to set a time and place to be interviewed. Interviews were scheduled at the participants’ convenience and at a location of their choosing (e.g., coffee shop, library) between June 6, 2012, and July 30, 2012. Before the interview, participants were asked for their permission to digitally audio record the interview, and interviewees were informed they could skip questions or end the interview at any time.

Analysis

Audio interviews were transcribed verbatim within seven days of interview, transcribed promptly, and audio files deleted. NVivo 9 was used to assist in categorizing themes. For the purpose of this study, a theme was defined as a topic covered by either all participants or all providers. Emergent themes were cross-checked for triangulation with colleagues. Data for all questions were analyzed for themes using line-by-line coding and constant comparison methods until authors were confident saturation of the data had been achieved (Charmaz, 2014).

RESULTS

Five transgender identified participants who accessed services in the past or present in Maricopa County were interviewed, ranging in age from 20s to 40s. Three were female-to-male and two were male-to-female; four identified as non-Hispanic White, and one was of Hispanic origin. Seven social service providers with experience in the social services sector, currently or over the past 5 years, were also interviewed. Five social service respondents were male and two were female. Four of the seven identified as heterosexual, two identified as gay, and one as lesbian. Five had experience with shelter and/or case management services within domestic violence, homeless services, or at general social service agencies providing services for the general public. Two social service providers had experience with LGBTQ-specific social services.

PARTICIPANT PERCEPTIONS

Four overlapping themes were found among study participants: (1) lack of resources and availability of resources, (2) discrimination, (3) lack of empathy from service providers, and (4) the need for support from the community.

Availability of Resources

All participants identified a lack of community resources that were both accessible and appropriate. They reported that many services in Maricopa County are located in the central Phoenix corridor. For example, one participant commented on the spread-out nature of Phoenix and noted that the lesbian and gay community has an identified neighborhood in north central Phoenix. As Avery explained, “The transgender community doesn’t co-locate, we are spread out.” All participants have experience living outside central Phoenix and mentioned how outlying areas offer limited public transportation or none at all on weekends. Additionally, they reported that medical
practitioners for the transgender community are sparse, and those that do exist often limit their hours for hormone treatments. Rory reported that his “doctor offers hormone treatments only on one Friday per month making it difficult to get the needed weekly treatments.”

Additionally, there is a lack of services for the transgender community who are homeless. If an individual in the transgender community does not appear to match the gender on their identification materials, homeless shelters are unsure how to proceed because they are usually segregated by sex. Harper stated, “I didn’t seek services. I wouldn’t have told you I was homeless as a young person. Very few people have positive experiences.”

Discrimination

Participants reported struggles with staff refusing to use proper pronouns and unprofessional office conduct. All participants shared how the use of proper pronouns demonstrates to clients that staff is sensitive and how proper pronoun usage can help validate the experiences of those who are transgender. There were discussions about service providers having individuals admitted to psychiatric hospitals when clients were not suicidal, forced to be sent for gender verification to secure shelter, and loud public conversations in waiting rooms making clients feel ashamed.

Each participant emphasized how important it is for providers to recognize that not all individuals who identify within the transgender community also identify within the broader lesbian, gay, bisexual, questioning, and/or queer community. For those who do, they may choose not to disclose to staff “because that leads to another layer of discrimination” as Rowan stated. Additionally, participants wish providers would recognize an individual’s significant other as this serves to validate the relationship. Quinn highlighted the issue by sharing, “Dating relationships would be fine if they are on board. . . . If they are pro-gay and lesbian, they will typically be okay treating my partner. But they will treat it as gay/lesbian regardless.” Avery touched on how a lack of cultural sensitivity can impact services: “I didn’t want to go back to him. I mean there are some areas you can take a stand and make a point and there are some areas where your personal health care is not where you want to take the fight.”

Avery also said about this provider, “he was obviously extremely uncomfortable for him to the point I felt it was compromising the quality of care I was getting.” When needing services, Quinn, a participant, shared:

The big thing about living in trans is fear. So we aren’t just going to experiment with that sort of thing. Who is going to be tolerant? We will go with that before we go there. We make these inquiries in advance instead of taking a risk.

Lack of Knowledge/Empathy

Participants want providers to understand issues associated with transitioning genders, including legal complications, medical processes, social stigma, and related issues of securing employment, housing, and education. Discussions were held around providers minimizing the experience of transitioning and not being empathetic toward the associated costs, which are often prohibitive. Another troublesome gap was a lack of culturally competent providers from medical to psychiatric to governmental assistance staff (case workers for nutritional assistance or Medicaid). Additionally, services are lacking for the transgender community who are homeless. One essential way to promote cultural competence, is how “we [transgender individuals] would like to have a gender-neutral bathroom” as Rowan shared. There was discussion among most participants about attention needing to be paid to the transgender community working in prostitution in order to survive, particularly those who have lost their employment. Quinn stated, “There are a lot of people who do that, who try to survive.”
If professionals would work toward increasing their cultural competency and awareness, situations such as those described by Avery might be avoided: “Each doctor has their own style of medicine, and that can be a bit odd. Some of the transgender community will go to two separate doctors to get their mix and match and get your own. It’s awkward.”

Supports

All participants reported a strong transgender community support network in Phoenix. Harper reported: “Phoenix is among the best cities in the country for community services for [the] transgender community that we create[d] for ourselves. We have support groups we create ourselves.” There is a “take care of your own” approach, as Quinn said, in the circle of the transgender community and “everyone watches out for each other.” Harper echoed what all the participants felt and described Phoenix in positive terms:

This is a surprisingly tolerant city. It’s not necessarily accepting but it is tolerant. There is a distinction. Tolerance is you leave people alone to do their thing if you disagree with it. Acceptance is if you are really cool with what they are doing. And you openly accept them for what they are.

Priorities

Participants were asked to identify three priorities for social service providers. All participants cited a desire for social service providers to (1) be more aware of pronoun usage as this would improve sensitivity above all, (2) make services more available and more competent (e.g., improved hours, decreased fees, accessible office locations, and gender-neutral bathrooms), and (3) affirm their experiences as an individual in the transgender community so the agency can be a welcoming environment that realizes their significant others are vital supports. Participants recognized how difficult change is for agencies but also acknowledged how powerful it is for recipients to see positive change in service delivery.

PROVIDER PERCEPTIONS

All providers reported five major themes: (1) lack of data, (2) lack of training and education, (3) barriers with funding sources, (4) need for current and updated policies, and (5) an overall lack of collaboration.

Lack of Data

Providers are unclear about how to utilize best practices because of little data about their clients who identify as LGBTQ. Providers indicated that agencies do little in the way of data collection on their intake forms or at intake appointments to collect data about the LGBTQ community. If information on intake, assessment, and other agency forms were expanded to include LGBTQ demographics, a more thorough understanding of the population could be gathered. Addressing data collection, Emery explained:

I think that no doubt there is less attention because we are not collecting or identifying the information. In today’s intakes there is almost always a question about military status. When I started there was not … but now, after a lot of education, they ask if you’ve served in the military. Now that we are identifying that, people are getting more and better services. Theoretically, that would cross over to the LGBTQ community. When you identify the community, you get better services to support people.
Lack of Training/Education

All providers indicated a desire for training and educational opportunities to better understand the LGBTQ community. Providers said that they did not understand the process to change genders nor did they feel the trainings offered are sufficient to help them provide competent services. As a result of budget constraints fewer staff with university degrees are being hired. Without training, participants acknowledged an impact on “quality of services” and a need for “sensitivity meetings.” Education and training also helps staff recognize their relationships as valuable and important in their clients’ lives. However, when discussing romantic relationships in clients’ lives, staff often “frown upon this type of relationship and believe that such [a] relationship just compounds the problems both individuals are facing” as Blake shared. To make training more accessible, one idea suggested by Kennedy was to “have a coalition or a rep from agencies to come together to exchange ideas.”

Funding

Providers discussed the need for additional funding, but explained that religious organizations or governmental organizations often are the primary funding sources. Some examples shared included “local churches and the Department of Economic Security” as Jamie shared. Religious organizations place restrictions on how they can deliver services and want services to reflect their values. Blake explained how this could manifest:

I tried working with the [religious organization] to make it a more inclusive or welcoming space and right before I left that position I was able to advocate for a trans individual to come into the shelter. However, she was only there for a couple of weeks before other people on campus, mainly staff and administrators, were uncomfortable with her presence.

Additionally, Terry touched on the fact more services exist for youth and young adults but “there is a lack of services available for the age group 25–55.” Kennedy shared, “because of [the] shortage of funding, there is competition” with other service providers and that “individuals that work for agencies can be territorial.” Emery explained how “even with the economic downturn, programs in this area are very center [agency] focused” which, as a result, focuses more on meeting the needs of the agency, rather than those of the populations being served.

Policies

All providers discussed antidiscrimination statements, mission statements, and organizational policies. Many view these policies as outdated. Agency policies do not address inclusive language or afford protections for sexual minorities or gender variant clients. Providers understand protections include being free from harassment and assault and the ability to feel safe. Yet policies “need to be clearly written” explained Jamie. Tristan stated, “the wording that we use, it needs to be more sensitive.” Jamie stated, “Agencies do have the power to develop/change their policies.” Despite a lack of specific LGBTQ policies, “Some agencies participate in LGBTQ activities, such as Pride and the Rainbows Festival, which is beneficial” as Terry shared. Although there is a demonstrated “trend of being more inclusive,” as Jaime shared, continuing to do so means “providing training to staff and administration of how to intervene. Policy creation that is specific to these situations. It is the individual organization’s role to make sure everyone is safe in the program.” This does not always happen, as Blake explains, “Trans individuals who need services get denied because they have disclosed they are trans. They are often asked to leave.” Emery, a provider, shared how “There are just way too many barriers that exist currently overcoming stereotypes, fears. This is what we need to focus on to improve the standard of care.”
Lack of Collaboration

Providers shared insights about a lack of leadership and an unwillingness to collaborate with other agencies. Providers shared their desire to collaborate as they feel most agencies tend to “specialize” in a population or issue such as domestic violence, financial support, homelessness, nutrition assistance, etc. Tristan shared how collaboration needs to focus “more education of the different programs and the resources they [other agencies] have available.” The benefit of collaborating is not translating into programs as Payton shares: “I think it is almost nonexistent … programs are very individualistic, very isolated, very just wanting to focus on themselves and maintain their sense of identity. So I think collaboration is almost like a bad word.” Tristan shared how agencies need to “find common ground and focus on what you do best and then collaborate with other agencies.”

Stress was placed on learning on to collaborate and giving each other the space to do what they do best; as Blake shared, “We need more education of the different programs and the resources they have available.”

Priorities

Providers were asked to identify three priorities to be able to improve social service delivery for the transgender community. All providers cited a need for (1) improved education/training opportunities and support from their employers, (2) an increased opportunity for networking events to improve agency collaborations, and (3) inclusive policies to meet the needs of the LGBTQ community and especially to help transgender individuals feel welcomed, safe, and protected.

DISCUSSION

This study found a significant amount of agreement between participants and providers with regard to identifying challenges in the social services delivery system for members of the transgender community of Phoenix, Arizona. Providers were particularly vocal in identifying specific actions that service providers and agencies could take to support the LGBTQ community, and especially the transgender community, even with limited budgets. Providers in this sample were able to recognize when their services do not meet the needs of the broader LGBTQ community, often felt unprepared to do so, and wished to improve their understanding of community organizations to refer clients appropriately. This supports the findings of existing literature underscoring challenges faced by the transgender community related to oppression and an increase in risk factors, psychological stressors, and barriers to care, ultimately reducing the likelihood of effectively and safely meeting their needs (Benjamin, 2012). Quite often, grant deliverables or outcome-driven reporting tends to focus on accountability to the funder, not to the client. A shift in accountability reporting from that of the funder to meeting the needs of the client would likely impact overall program effectiveness (Benjamin, 2012). Thus, service providers should recognize the need to shift the focus solely on meeting agency outcomes to ensuring their transgender clients’ needs are being met.

Overall, participants reported a general dissatisfaction with service delivery. This remains a pervasive challenge, even when service utilization rates are high—as social service delivery remains a dissatisfactory experience for the LGBTQ community—partly due to perceived levels of discrimination (Rutherford, McIntyre, Daley, & Ross, 2012). Although participants reported poor service delivery experiences, providers similarly and consistently identified a need for more training and education. Services for the transgender community appear to be largely unavailable and/or misunderstood, but a strength of many service providers was the interest in finding services and solutions to benefit their clients, even when they were not equipped to do so.
This study also highlights discrepancies between client and staff perceptions of experiences within the social service sector and especially within homeless shelters. In such settings, clients may encounter overt and covert discrimination, stigma, and microaggressions. Providers acknowledged the transgender community needs additional supports and assistance in navigating the shelter system where they may often feel rejected by staff, which may be due to a lack of sensitivity training and education (Stotzer et al., 2011).

A number of limitations can be identified in this study. Participants were self-referred and thus may not represent the views of the larger transgender community or network of service providers throughout Arizona or the United States. Phoenix is a large metropolitan area with few, but growing, protections for sexual minorities. Significant differences remain with regard to understanding the needs of the transgender community in rural and urban settings. The small, nonrandom study conducted in Phoenix limits the findings, because it is likely that transgender individuals living in smaller cities or suburban or rural areas may have different experiences. Diverse experiences among members of the transgender community may occur in communities where more formal antidiscrimination laws and policies exist. The small sample size and the limited range of participant ages may also have influenced findings and an expansive perspective of this diverse population. It is unclear if transgender individuals with disabilities, those living in rural areas, or those over the age of 50 would have had different perceptions of needed services.

Participants did, however, report issues (e.g., lack of resources, discrimination) similar to those suggested by other studies of the transgender community, while providers offered observations (e.g., need for training) similar to those found in the literature (Rutherford et al., 2012; Stotzer et al., 2011). Although limitations exist, the consistency of themes found among participants and providers suggests that this study may be reflective of other study samples.

**CONCLUSIONS**

A significant need remains for cultural sensitivity when working with the transgender community. Such sensitivity may include validating a transgender client’s life experience, along with ensuring appropriate service provider training to improve the overall quality of care. Many trainings and materials are available online at minimal cost, and recommended trainings might include options such as “Ending Invisibility: Better Care for LGBTQ Populations” and “Understanding the T in LGBTQ: A Role for Clinicians” (Fenway Institute, 2012), “Community Engagement with LGBTQ Issues” (Keshet, 2012), and “Gender Spectrum Professional Conference” (Gender Spectrum, 2013). Another method for additional training opportunities would be to partner with networking groups to offer a reduced cost membership for agency staff. Some networking groups in the Phoenix area include Young Nonprofit Professionals Network, The Phoenix Suns Charities, and local nonprofit state coalitions. Additionally, if agencies could extend collaboration efforts and open interagency trainings to other organizations, it may be mutually beneficial. One option would be to offer online trainings, such as those provided through the National Association of Social Workers (2013).

Additionally, budget constraints may influence the ability to provide trainings or implement best practices for transgender clients. Some key issues to address without the need for additional funding are the provision of inclusive and affirming language related to sexual orientation, gender identity and gender expression via antidiscrimination policies and statements, mission statements, intake forms, psychosocial evaluations, and gender-neutral bathrooms. The need for utilization of inclusive language involves staff as well. Case managers, health care practitioners, and social workers build competency through learning how to use preferred names and gender pronouns, while consistently addressing clients as they wish to be addressed.
Future research might benefit from a more expansive study specifically examining the perceptions of various levels of agency staff including administrators, program staff, janitorial staff, etc. Interviewing additional providers that may not solely serve the LGBTQ community as well as staff members may be insightful and illustrate other barriers to providing services and improving care for transgender clients. Future research should target a broad array of providers to get a more diverse perception of both needs and services. The findings of this study outline the strengths and acknowledge areas for growth within the Phoenix social service sector. Although the transgender community participants identified gaps in cultural competency, the social service providers seem to be aware of these issues and wish to address these gaps. Advocacy efforts by both professional social service staff and community groups is an essential first step in recognizing the depth of the problem and engaging in a dialogue with members of the transgender community to best improve services.

REFERENCES


Gates, G. J. (2011). *How many people are lesbian, gay, bisexual and transgender?* Retrieved from https://escholarship.org/uc/item/09he684x2


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**APPENDIX A: PARTICIPANT SCRIPT**

**Assessing social service needs among the transgender population**

**Statement of Purpose**

My name is ____________ and I am a social work student at Arizona State University. I am interested in learning more about how transgender individuals view social services in Phoenix. I will be asking you to share your experiences and opinions regarding social services in general and especially those for the transgender community. Your input may help shape how services could be strengthened and resources expanded to better serve the community. Some examples of a social service agency we might discuss include those that provide vocational rehabilitation, food stamps, homeless shelters, domestic violence shelters, drug and alcohol treatment centers, and AHCCCS.

This interview will last approximately thirty minutes.

**Guidelines for Discussion**

All opinions and experiences are important. The following guidelines can encourage the participation of everyone.

Confidentiality is important. Please do not share the discussion here tonight with anyone else. The report that will be written to summarize the information and ideas that come out of the discussion will not include any identifying information about participants.

You do not have to answer every question.

You may end the interview at any time.

Do you have any questions before we begin?

**Questions**

1. Would you please share with me about how you got to Phoenix?

   **Probes:**
   - How long have you been here? (months or years)
   - Factors associated with local climate to LGBT?
   - How safe, supportive, and welcoming is Phoenix?
2. How open are you about your sexual orientation/gender identity?
   Probes:
   • Where are you out? (family, friends, work, health/service providers, school, neighbors)
3. How many social service agencies have you had experience with?
   Probes:
   • Which ones and how did you find out about them?
   • If you needed a referral, was this an easy process?
4. How adequate are social service for the transgender community?
   Probes:
   • What is lacking? Examples: flexible hours, fees that are affordable, centrally located facilities, sensitive/competent staff, coordination with other agencies, etc.
   • How can already existing services be improved?
   • What services/agencies are working well in meeting the needs of the transgender community?
5. What needs, if any, still need to be met?
   Probes:
   • Health, emotional/mental, academic, employment, legal, social needs
6. Have you, or anyone you know that is transgender, been homeless or close to homeless? And what is your impression of housing services for the transgender community?
   Probes:
   • Biggest barriers
7. What are your impressions of existing Phoenix social service agencies?
   Probes:
   • Available resources, programs
   • Are the intake and other forms within the agency culturally appropriate?
   • If you have a significant other, how do they treat this relationship?
   • If multiple agencies are involved, how well do they work together?
   • How would you rate the ease of securing services at these agencies?
   If needed: prompt from list of resources.
8. What are the most important challenges facing the Phoenix transgender community?
   Probes:
   • Biggest barriers
   • How do you feel agencies should respond to other clients treating the transgender community?
9. If you could determine priorities for social services in Phoenix for the transgender community, what would be your top three?

Closing
I’d like to go back and review what I’ve heard, to make sure I captured your ideas and experiences. (Summarize key themes around each topic.) Are there any points that I have missed? Is there anything not yet mentioned that you think should be added? (Pause and wait for other input) Thank you for your time and for sharing your experiences. It is very much appreciated!

APPENDIX B: SERVICE PROVIDER SCRIPT

Assessing social service needs among the transgender population

Statement of Purpose
My name is __________ and I am a social work student at Arizona State University. I am interested in learning more about how social service providers view services for transgender
individuals in Phoenix. I will be asking you to share your experiences and opinions regarding social services for the LGBTQ community. I am especially interested in services for the transgender community. Your input may help shape how services could be strengthened and resources expanded to better serve the community. This interview will last approximately a half hour. You can end the interview at any time and skip any questions.

Questions

1. Participant Introduction
   Probes:
   • First name
   • Agency and position
   • Years at job and/or in the field of social services
   • Education level

2. In your work with the LGBTQ community/clients, how many other social service agencies have you interacted with?
   Probes:
   • Which ones?
   • How did you find out about them?

3. How well do these agencies work together to serve the LGBTQ community?
   Probes:
   • If release of information is needed, answer presuming a release is completed
   • Do you think agencies could work with each other better? If so, how?
   • Is there a planning or coordinating committee?

4. How adequate are social services for the transgender adult community?
   Probes:
   • What is lacking? Examples: flexible hours, fees that are affordable, centrally located facilities, sensitive/competent staff, coordination with other agencies
   • What services could be enhanced?
   • What services are working well?

5. What do you think the transgender community would identify as unmet needs?
   Probes:
   • Examples: health, emotional/mental, academic, employment, legal, social needs

6. Have you had direct experience with homeless transgender individuals?
   Probes:
   • Biggest barriers

7. What do you think of the existing services for transgender adults?
   Probes:
   • Available resources, programs
   • How does your agency respond to romantic relationships for those in the transgender community?
   • How do agencies coordinate their services?
   • How would you rate the ease of securing services at your agency?
   • Are the intake and other forms within the agency culturally appropriate?
     Example: Is relationship status limited to single/married/divorced/widowed
     Example: Is gender limited to male/female

8. What are the most important challenges facing the Phoenix transgender community?
   Probes:
   • Biggest barriers

9. If you could determine the priority for social services in Phoenix for the transgender community, what would be your top three priorities?
Closing
I’d like to go back and review what I’ve heard, to make sure I captured your ideas and experiences. (Summarize key themes around each topic.) Are there any points that I have missed? Is there anything not yet mentioned that you think should be added? (Pause and wait for input) Thank you for your time and for sharing your experiences. It is very much appreciated!