SURVEYING
THE ROAD TO EQUITY

2019 ANNUAL STATE OF LGBTQ COMMUNITIES REPORT

#Out4MentalHealth

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TABLE OF CONTENTS

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Background & Introduction

#Out4MentalHealth is a California statewide LGBTQ mental health initiative of the California LGBTQ Health and Human Services Network and Cal Voices[1], funded by the MHSOAC using Mental Health Services Act (MHSA) dollars. #Out4MentalHealth creates and advocates for an LGBTQ mental health equity policy agenda through the inclusion of LGBTQ Californians' voices, novel research, public outreach and communications, and the provision of free community and provider training.

Each year, #Out4MentalHealth produces an Annual State of LGBTQ Communities Report to provide insight into project findings and highlight issues that are relevant to the health and well-being of LGBTQ Californians. We hope community advocates use the information in this Report to support their local efforts, providers learn how to improve their practice for effective and inclusive services to LGBTQ clients, and legislators hear the voices of their LGBTQ constituents calling for continued changes in public policy and priorities throughout this document.

In 2018, #Out4MentalHealth reached out to LGBTQ communities across California through a series of Town Halls, Round Tables, Key Informant and County Interviews, as well as community events like Pride, conferences, advocacy events, and policy meetings. #Out4MentalHealth utilized what we learned from members of LGBTQ communities in 2018 to help inform our 2019 online LGBTQ Community Survey. We also held virtual Town

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[1] Formerly, NorCal Mental Health America.

Halls to learn more about the intersection of LGBTQ communities and sex work, as well as the needs of LGBTQ refugees and asylum seekers. As in 2018, Project Staff again participated in community events, conferences, advocacy events, and policy. All of these activities inform the following Report.

The LGBTQ Acronym

The acronym LGBTQ (Lesbian, Gay, Bisexual, Transgender, Queer/Questioning) is used in this Report because it is recognizable, it is consistent with the language used in recent California policy (some of which funds this work), and it provides for brevity in this Report. Although some professional and governmental entities (e.g., National Institute of Health) are using the term "sexual and gender minorities" (SGM), this is not a term that is necessarily familiar to or in usage by the communities the term represents. Our usage of LGBTQ in this Report, however,

> comes with the caveat that the LGBTQ acronym does *not* represent all individuals or populations whose sexual orientation, gender identity or gender expression is seen as outside society's expected norms. The myriad of self-described identities, attractions and expression by individuals from all races, ethnicities, cultures, genders, ages, and background cannot begin to be covered by a simple acronym developed predominantly in a white, Western, comparatively affluent context (Mikalson, et al., 2012, p. 19-20).

There are many individuals, cultures, and communities who identify as sexual orientation and/or gender identities which fall outside the LGBTQ acronym; they too face health disparities, lack of targeted research, and do, anecdotally, struggle with barriers to health access in California. The acronym does not take into account #Out4MentalHealth's constant recognition that no person is ever just their sexual orientation or gender identity, as they are also a person living at the intersections of racial, ethnic, class, national, religious, ability, and additional identities. Although the LGBTQ acronym is used in this Report, #Out4MentalHealth writes with the entirety of our diverse communities in mind and a commitment to raising up the voices of those least heard.

Looking Back:

The 2018 Annual State of LGBTQ Communities Report is designed with another report in mind: Mikalson, Pardo, and Green's 2012 *First, Do No Harm: Reducing Disparities for Lesbian, Gay, Bisexual, Transgender, Queer and Questioning Populations in California*, of the California Reducing Disparities Project, Phase 1. *First, Do No Harm* provided groundbreaking research, an important update on LGBTQ mental health in California, and acted as the reference for both the #Out4MentalHealth Project and the California Reducing Disparities Project, Phase 2. Today, *First, Do No Harm* remains an important resource to reflect on histories and current realities of LGBTQ mental health in California and to learn about LGBTQ-community-based interventions for mental health. To read the *First, Do No Harm* Report, visit **www.out4mentalhealth.org.**

The #Out4MentalHealth Logo

The #Out4MentalHealth Project Team and the #Out4MentalHealth Workgroup worked together to create a logo for the project which would convey the many perspectives of our diverse LGBTQ communities. For 2017 Pride Month, the Philadelphia Office of LGBT Affairs' *More Color, More Pride* campaign created a new official pride flag with the addition of black and brown stripes to symbolize the inclusion of people of color (Paynter, 2017).

#Out4MentalHealth has included in our logo both the rainbow and the black and brown stripes to reflect #Out4MentalHealth's foundation and commitment to viewing LGBTQ mental health through an *intersectionality* lens (Crenshaw, 1989)—that is, with a recognition of how racism, classism, heterosexism, cissexism, sexism, and other systems interact with each other to create individual experience and population health disparities. #Out4MentalHealth therefore works from the belief that the liberation of LGBTQ people from heterosexist and cissexist systems must involve fighting racism, classism, sexism, and all other intersecting systems of oppression, as all of these systems are intertwined together.

The State of LGBTQ Communities in California

Surveying the Road to Equity: The Annual State of LGBTQ Communities, 2019 builds on and adds to the #Out4MentalHealth report *Mapping the Road to Equity: The Annual State of LGBTQ Communities, 2018.* Both reports provide critical insight into the experiences of

LGBTQ Californians. The 2019 report focuses on the data from #Out4MentalHeath's LGBTQ

Community Survey & Bisexual Needs Assessment, as well as the findings from virtual Town

Halls. Topics included in this Report are explored specifically because LGBTQ Californians

have spoken about these issues on a consistent basis at most or all #Out4MentalHealth

events.

COMMUNITY SURVEY
FINDINGS

Over 2,800 LGBTQ California residents responded to the Community Survey.

36%

Over one-third of all respondents reported a gender identity (binary or nonbinary) that **did not match their sex assigned at birth.**

Community Survey Findings

In 2018, #Out4MentalHealth hosted eight Town Hall and Round Table discussions to explore the needs of LGBTQ communities across California. The qualitative findings from those events can be found in *Mapping the Road to Equity: The Annual State of LGBTQ Communities, 2018* available at: www.out4mentalhealth.org. In order to expand and deepen what was learned at these in-person discussions, #Out4MentalHealth launched a quantitative, online LGBTQ Community Survey (CS). The CS also included sets of questions directly targeted to people of color, bisexual and other non-monosexual individuals, and binary and nonbinary transgender individuals. The CS was open to all Californians identifying somewhere along the LGBTQ spectrum, and was available in both English and Spanish. Multiple distribution methods were used to encourage diverse and widespread participation, including but not limited to social media and other electronic outreach strategies. #Out4MentalHealth also partnered with multiple LGBTQ-serving organizations across California to help increase distribution. Over 2,800 LGBTQ California residents (N = 2,875) responded to the CS, exceeding original expectations.

The online format of the CS, and its distribution, was chosen for multiple reasons, including the ability to reach youth, individuals in rural areas, and those who may not be strongly connected to LGBTQ communities. One major limitation of this method is that it may fail to reach those who do not have access to a computer, tablet, smart phone, or the Internet. In addition, an online format may have a cultural bias privileging white, Western,

comparatively affluent methods of collecting data. To help counteract these limitations,

survey completion events were held at Translatin@ Coalition and Gender Justice LA. While

this did allow some of the most vulnerable individuals to respond to the CS, the findings in

this report most likely do not reflect all the needs and disparities of the most at-risk

individuals. For a more detailed discussion of the survey development and structure,

please see the Methods section in Appendix A.

General Demographics

Sexual Orientation

CS participants were first asked to describe their sexual orientation in their own

words. Participants were then asked to choose the term which *best* described their sexual

orientation. Respondents were provided with seven terms to choose from. Figure 1 shows

respondents by sexual orientation.

Monosexual and non-monosexual orientations. Individuals who are attracted to

one gender are considered to have a *monosexual* sexual orientation. Monosexual

orientations include lesbian, gay, [2] and heterosexual/straight. Individuals who are attracted

to two or more genders are considered to have a *non-monosexual* sexual orientation. Non-

monosexual orientations include bisexual and pansexual. Some individuals who identify as

queer or questioning may have a monosexual or non-monosexual sexual orientation,

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[2] In this report, gay refers to male-identified people who are solely or predominantly attracted to other male-identified people, and not as a broader term that could refer to anyone of any attraction who does not identify as heterosexual/straight.

depending on their attractions. In addition, people who identify as lesbian, gay, or

heterosexual/straight may actually have a non-monosexual orientation, but are using a

monosexual identity label for various reasons, including (but not limited to) being seen by

others as lesbian, gay, or straight based on the gender of their partner/spouse. (For more

discussion on non-monosexual individuals, please see the Bisexual section of this report.)

Based solely on the sexual orientation terms participants chose, almost half the CS sample

(46%) indicated monosexual identities and 40% indicated non-monosexual identities.

Figure 1. Respondents by Sexual Orientation

Lesbian	Gay	Bisexual	Pansexual	Queer	Questioning	Straight
14%	21%	24%	16%	18%	2%	6%
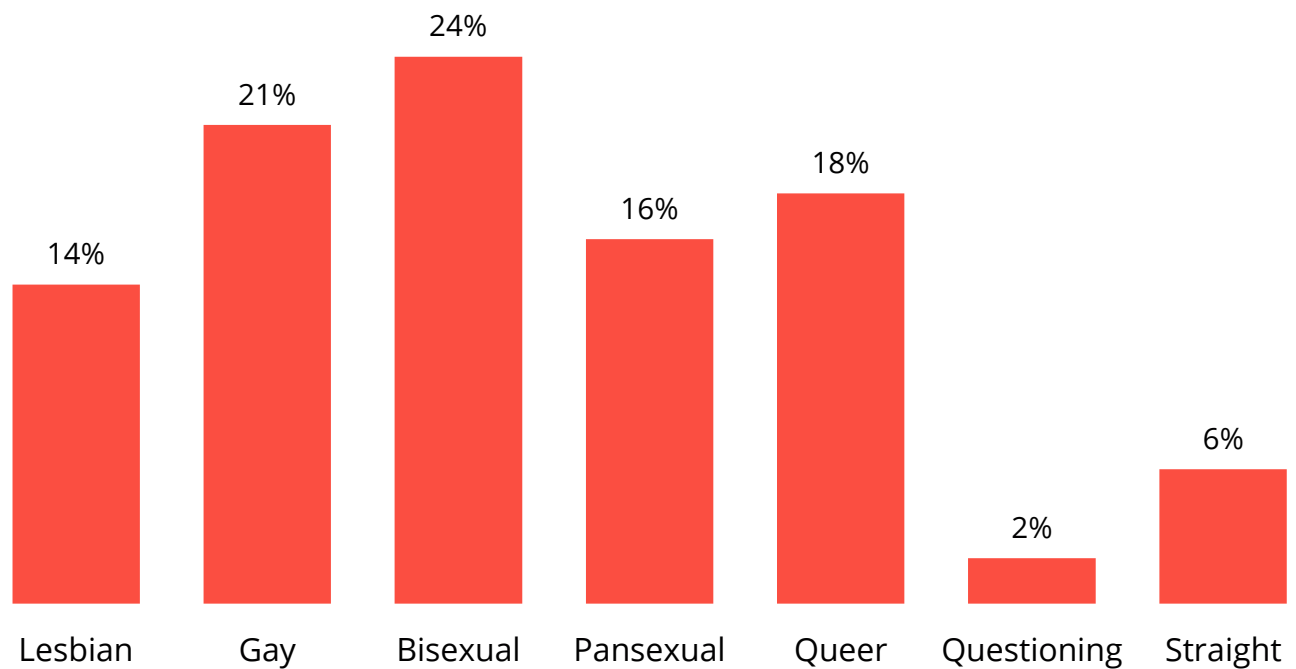
Can heterosexual/straight people be LGBTQ? Sexual orientation and gender identity are two very different aspects of a person's identity. Therefore, people who are transgender, genderqueer, two spirit, or another gender identity that is represented by the "T" in LGBTQ, may identify their sexual orientation as heterosexual/straight. CS participants who indicated they are heterosexual/straight also indicated a gender identity that is part of LGBTQ communities.

What about asexual? In general, *asexual* refers to someone "who does not experience sexual attraction [and] …is an intrinsic part of who [they] are" (The Asexual Visibility and Education Network, 2020a, para. 1). Asexuality is, therefore, different from choosing to abstain from sexual activity. The CS asked participants: "Do you identify or describe yourself as asexual, demisexual, graysexual, or a similar term?"[3] Approximately 16% of respondents answered "yes" to this question.

Research on asexuality is still fairly new. Currently, there is a debate whether or not asexual is a unique sexual orientation or something else. Brotto and Yule (2017) concluded "asexuality… likely meets conditions for a sexual orientation, and that researchers should further explore evidence for such a categorization" (Abstract). Asexual is an umbrella term and there is diversity of asexual experience within this population. For example, asexual individuals may experience romantic attraction and desire romantic relationships, while others may not feel attraction of any type. Romantic orientations, just like sexual

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[3] For definitions of these and other terms, as well as a deeper discussion about asexuality, please go to https://www.asexuality.org

orientations, often identify the gender of attraction. Terms used in this manner include, but

are certainly not limited to: *heteroromantic, homoromantic, biromantic,* and *panromantic*

(The Asexual Visibility and Education Network, 2020b).

Asexual participants in the CS were given the opportunity to also identify a label that

best fit how they identify their sexual orientation (see Table 1). It is important to note that,

although Asexual respondents were given the same sexual orientation questions as all CS

respondents, their choices do not necessarily reflect sexual attraction, but could instead

refer to romantic attraction.

Table 1. Sexual Orientation of Asexual Respondents	
Queer	31%
Pansexual	22%
Bisexual	18%
Gay	11%
Lesbian	8%
Questioning	6%
Straight	4%
Asexual	1%

Gender Identity

The CS used an empirically supported method for asking about gender identity (The

GenIUSS Group, 2014; National LGBT Health Education Center, 2016). It is important to

note that this method is recommended for adults, and not adolescents, at least when

surveying a general population. The CS only surveyed those who identify within LGBTQ

communities, and therefore LGBTQ adolescents who responded to the CS may have been

able to navigate the gender identity questions more accurately than the general adolescent

population.

　　　　CS participants were asked to first describe their gender identity in their own words.

Respondents were then given a two-step question which asked their: sex assigned at birth

(SAAB) and current gender identity. Over two-thirds of respondents (69%) indicated they

were assigned female at birth (AFAB), while 31% indicated they were assigned male at birth

(AMAB). Figure 2 shows the distribution of respondents by current gender identity.

Figure 2. Respondents by Gender Identity
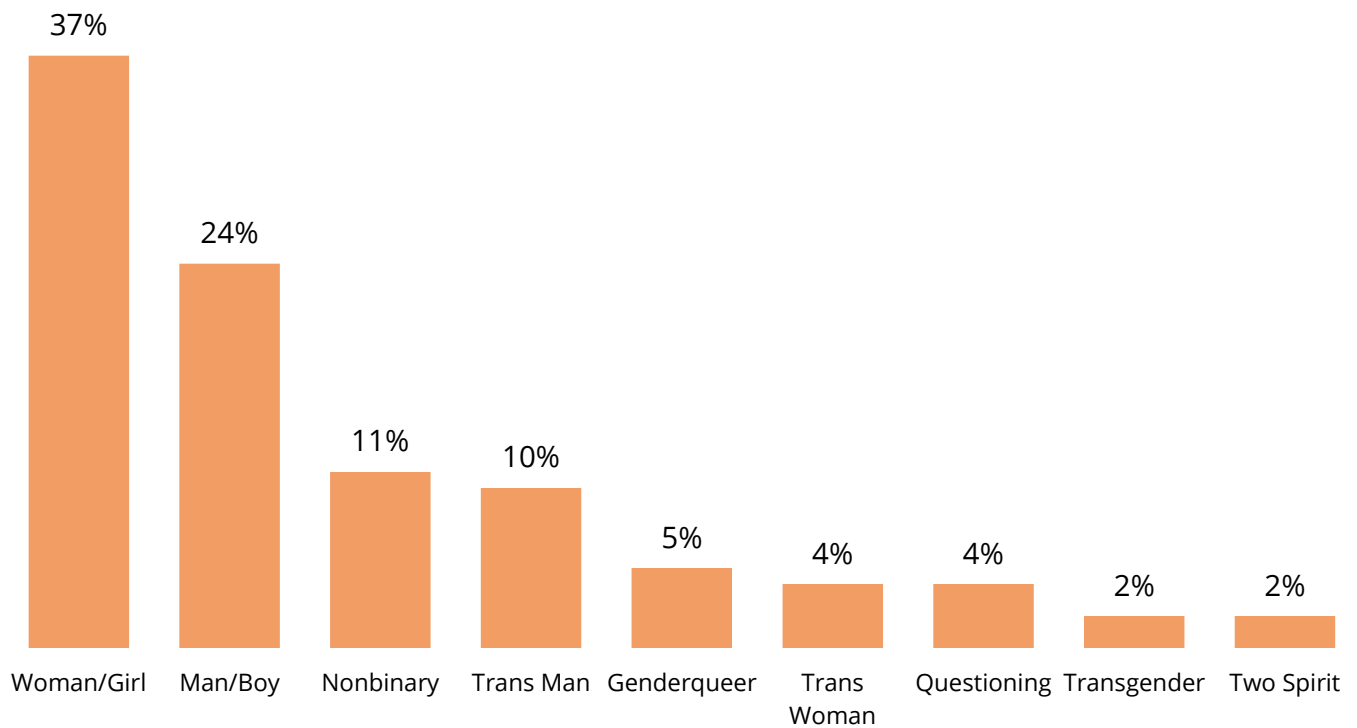
A majority of respondents (75%) identified their gender along the gender binary—

woman/girl/trans woman[4] or man/boy/trans man, [5] while 16% of respondents identified as

Genderqueer (5%) or Nonbinary (11%). Genderqueer and Nonbinary (GQNB) individuals

are those who do *not* identify along the gender binary. In other words, they do not identify

as a woman/girl/trans woman or man/boy/trans man, but rather in some other way not

captured by binary terms. There is little academic literature regarding GQNB people, and

more research is needed. Findings from the CS suggest that GQNB individuals may

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[4] Trans woman: AMAB, now identifying as a woman or trans woman
[5] Trans man: AFAB, now identifying as a man or trans man

experience mental health disparities at similar rates to binary Transgender people, and

may also have their own unique minority stressors.

In this report, gender identity was recoded into three subgroups: LGBQ Cisgender,[6]

Transgender, and GQNB. (For more information on gender identity coding, please see the

Methods section located in Appendix A.). LGBQ Cisgender refers to respondents who

identified as LGBQ and whose gender identity matches their SAAB. Transgender

respondents are those who identified as a binary gender other than their SAAB. GQNB are

those individuals who identified as Genderqueer or Nonbinary. Figure 3[7] shows the

distribution of respondents based on these subgroups. Finally, almost half of all

respondents (44%) reported a gender identity (binary or nonbinary) that did not match

their SAAB. In this report, these respondents are referred to as the Trans Spectrum

subgroup.

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[6] Cisgender: a person whose gender identity matches their SAAB. For this report, the subgroup
LGBQ Cisgender are respondents who fall under the Lesbian, Gay, Bisexual, Queer, etc, umbrella for
sexual orientation and whose gender identity matches their SAAB.
[7] This figure does not include those who identified as Two Spirit or Questioning. For a more detailed
explanation, please see Appendix B: Methodology.

Figure 3. Gender Identity by #Out4MentalHealth
Subgroups

Genderqueer/
Nonbinary

Transgender/
Trans Man/
Trans Woman

17%

19%

64%

LGBQ
Cisgender
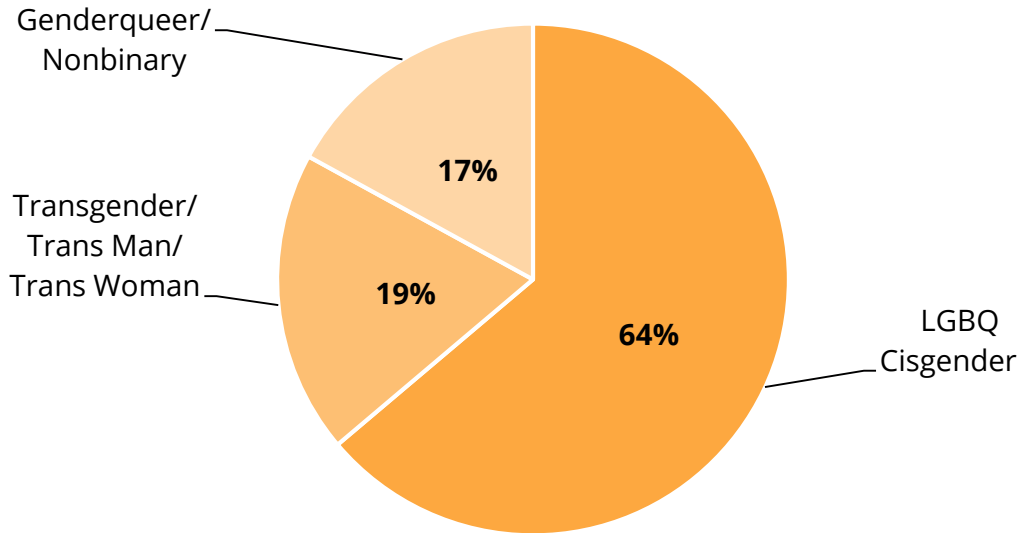
Intersex

Intersex is an umbrella term for over 100 conditions where individuals are born with genitalia, reproductive organs, and/or a chromosome pattern that does not align with typical binary definitions of male or female. It is estimated that 1 in 2000 babies are born with an intersex condition. In California, babies who are born with visible intersex traits (usually genitalia that do not conform to socially and/or medically accepted norms) are still assigned male or female on their birth certificate, rather than intersex. While the SAAB designation can be legally changed in the future, there continues to be no intersex designation for those individuals on their birth certificate (interAct Advocates for Intersex Youth, 2019).

At present, the prevailing medical practice for intersex babies and children who have medically visible intersex traits is to perform one or more surgeries in order to match their body to the sex-assignment recommended by the doctor. These surgeries can create negative outcomes, such as scarring, incontinence, sterility, poor sexual functioning, mental health issues such as Post-Traumatic Stress Disorder (PTSD), and gender mis-assignment. These surgeries are usually performed before a child can talk or express their gender identity. In addition, parents have reported feeling pressured by medical professionals to consent to these surgeries, and intersex advocates report that parents are not given adequate information or support in order to give truly informed consent (interACT Advocates for Intersex Youth, 2019).

In the CS, 63 participants (2.5% of the sample) answered "yes" to the question "Do you consider yourself to be intersex?" When referencing LGBTQ populations, intersex individuals are generally included as part of transgender communities, although not all intersex people identify as transgender.[8] Regardless of identity or diagnosis, both transgender and intersex communities "grapple with a loss of decision-making authority over their own bodies."

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[8] Transgender individuals have a gender identity that differs with their SAAB, but their biology typically conforms with the sex they are assigned. While intersex people have atypical anatomy, they may still identify with their SAAB, or they may have a different gender identity and also identify as transgender, or they may identify as intersex and not transgender (interAct Advocates for Intersex Youth, 2016)
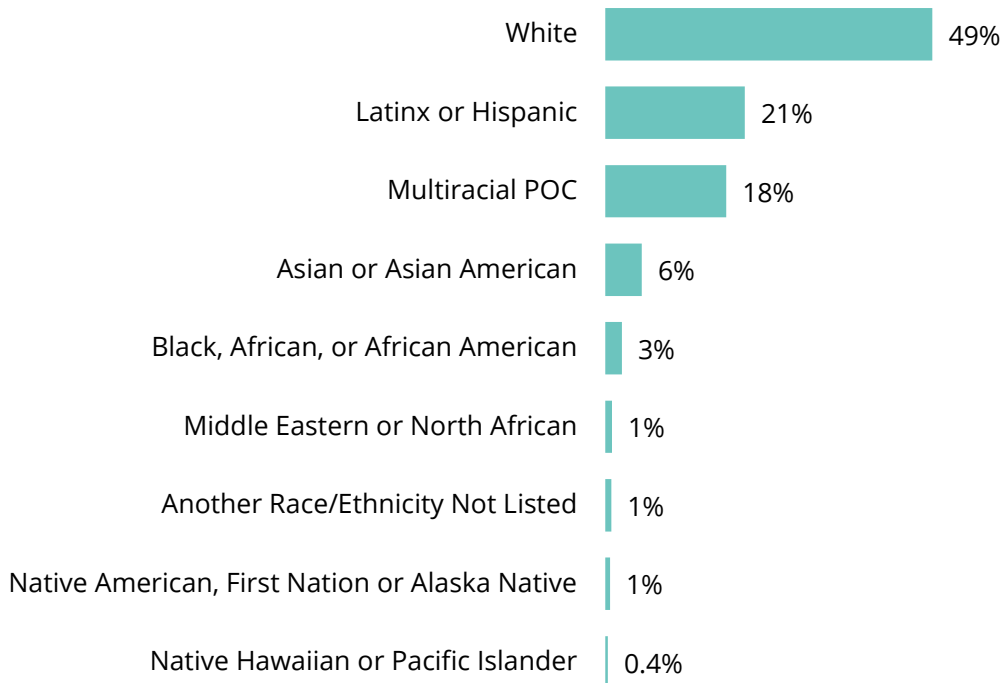
interAct works across the nation and beyond to protect children born with intersex traits and ensure that human rights abuses experienced by the **Intersex community** are put to an end. interAct advocates on behalf of Intersex youth in the courts, and in the development of local and national policy. They also collaborate on research to address pressing issues identified by the Intersex community.

For more information visit **interactadvocates.org**

Race and Ethnicity

CS respondents were given the opportunity to check one or more identities that are associated with a person's race or ethnicity. Participants who checked only one identity label are represented in Figure 4 under a specific racial or ethnic identity. Those who picked two or more identity labels are represented as Multiracial POC (people of color). Finally, those who wrote in another identity not already listed are labeled as such. Unlike the United States Census and other data gathering bodies, #Out4MentalHealth included Latinx or Hispanic as an identity label within the race and ethnicity question, rather than considering it a separate category. With these parameters, Figure 4 shows the distribution of CS respondents by race/ethnicity.

Figure 4. Respondents by Race/Ethnicity

Race/Ethnicity	Percent
White	49%
Latinx or Hispanic	21%
Multiracial POC	18%
Asian or Asian American	6%
Black, African, or African American	3%
Middle Eastern or North African	1%
Another Race/Ethnicity Not Listed	1%
Native American, First Nation or Alaska Native	1%
Native Hawaiian or Pacific Islander	0.4%

Throughout this report, race and ethnicity are analyzed in different ways in order to best represent the findings. More information on how race and ethnicity data were used can be found in the Methods section located in Appendix A and in the "Racism and Heterocissexism" section. For much of this report, race and ethnicity are represented by the following subgroups: Monoracial White, Monoracial POC and Multiracial POC. For this report, the term *monoracial* refers to those who identified with only one racial/ethnic identity in the CS. Therefore, Monoracial White respondents only checked white as their race/ethnicity and Monoracial POC only one race/ethnicity option other than white. Multiracial POC respondents are those who selected more than one race/ethnicity. Figure 5 shows the percent of respondents within each of these subgroups.

Figure 5. Respondents by #Out4MentalHealth
Race/Ethnicity Subgroups

Multiracial POC

19%

Monoracial
White

50%

31%
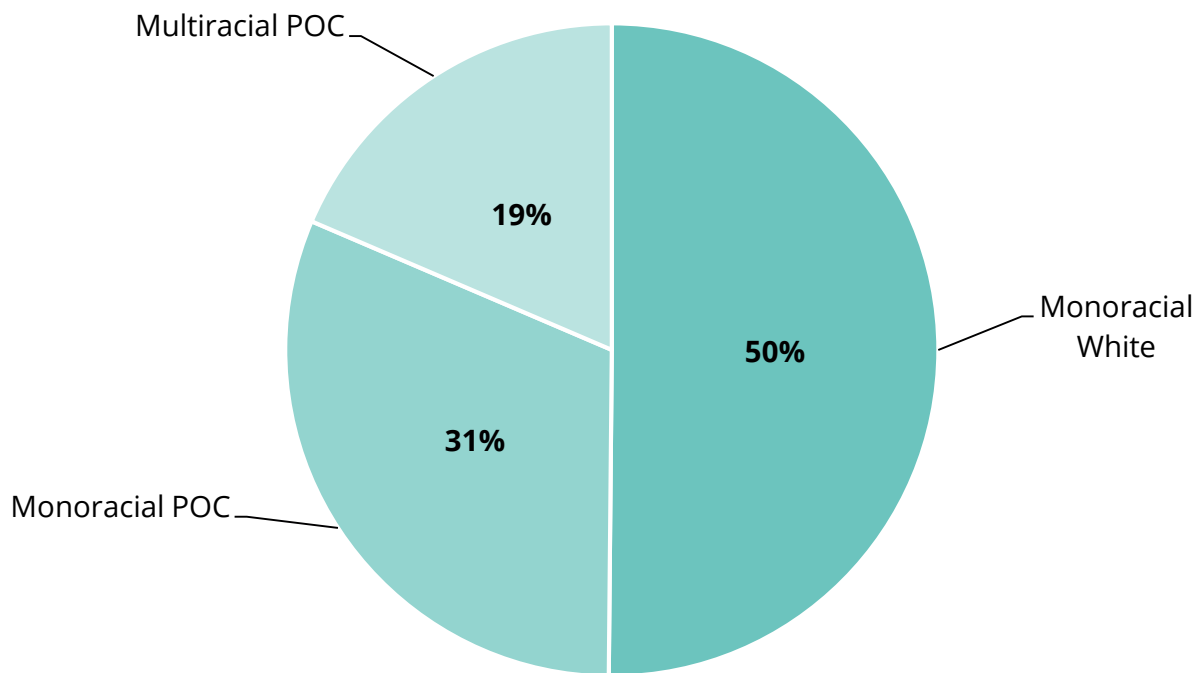
Monoracial POC

In areas where analysis showed little or no difference between Monoracial POC and

Multiracial POC, the findings may be represented with the subgroups POC (combing

Monoracial and Multiracial) and Monoracial White. For example, POC respondents

comprised 50% of the entire sample.

Age

The #Out4MentalHealth project is funded with Mental Health Services Act (MHSA)

dollars. MHSA groups Californians into the following age groupings: Child (0-15), Transition

Age Youth (TAY, 16-24), Adult (25-59), and Older Adult (60+). Table 2 shows the distribution

of CS respondents by MHSA age groups.

Table 2. Respondents by MHSA Age Groups	
Child 0-15	17%
TAY (16-24)	33%
Adult (25-59)	40%
Older Adult (60+)	10%

MHSA age groupings can be problematic, particularly when attempting to adequately represent the needs of LGBTQ individuals across the age spectrum. For example, a 16-year-old LGBTQ youth is most likely still living at home, and therefore may have less agency regarding their ability to express their sexual orientation or gender identity, or to seek mental health services than someone who is 24 years old—yet they are all placed in the same age category of "TAY." Similarly, 25-year-old individuals are facing very different challenges than 59-year-old individuals, yet they are both categorized as "Adult." #Out4MentalHealth analyzed CS data by both the MHSA age categories and by six more distinct alternative categories. The results strongly suggested that the six distinct categories provided a more accurate and nuanced representation of the findings. Therefore, for age spectrum analysis of the CS and this report, respondents are categorized into the following age groups:

- Youth (12-17)

- Transition Age Youth (TAY, 18-24)

- Emerging Adult (25-34)

- Adult (35-54)

- Transition Age Older Adult (55-64)

- Older Adult (65+)

Figure 6 presents the breakdown of respondents by the #Out4MentalHealth age categories. Almost half of respondents (49%) were between the ages of 12-24, with 69% under the age of 35. This has ramifications for interpretation and generalizability of the data, as they are heavily informed by Youth, TAY, and Emerging Adult responses.

Figure 6. Respondents by #Out4MentalHealth Age Groups
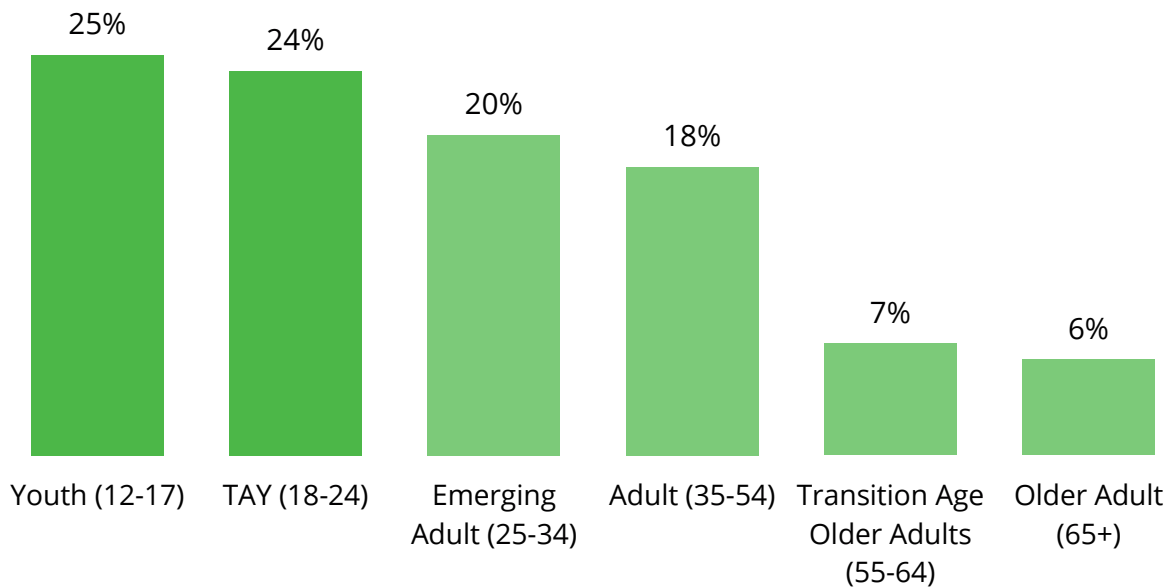
Rural vs. Urban

In order to develop the Rural and Urban subgroups for data analysis, CS participants were asked to provide their zip codes. The zip codes were then compared to the Rural-Urban Commuting Area (RUCA) codes from the 2010 US Census to determine their designation as either rural or urban. Figure 7 presents the distribution of respondents based on their rural or urban location. The graph indicates that outreach to rural LGBTQ individuals was successful. Only 2% of California's population live in rural areas, yet 6% of CS respondents are designated as rural Californians by their zip code of residence.

Figure 7. Urban and Rural Representation

Rural: Community Survey 6%, California 2%
Urban: Community Survey 94%, California 98%

Community Survey   California
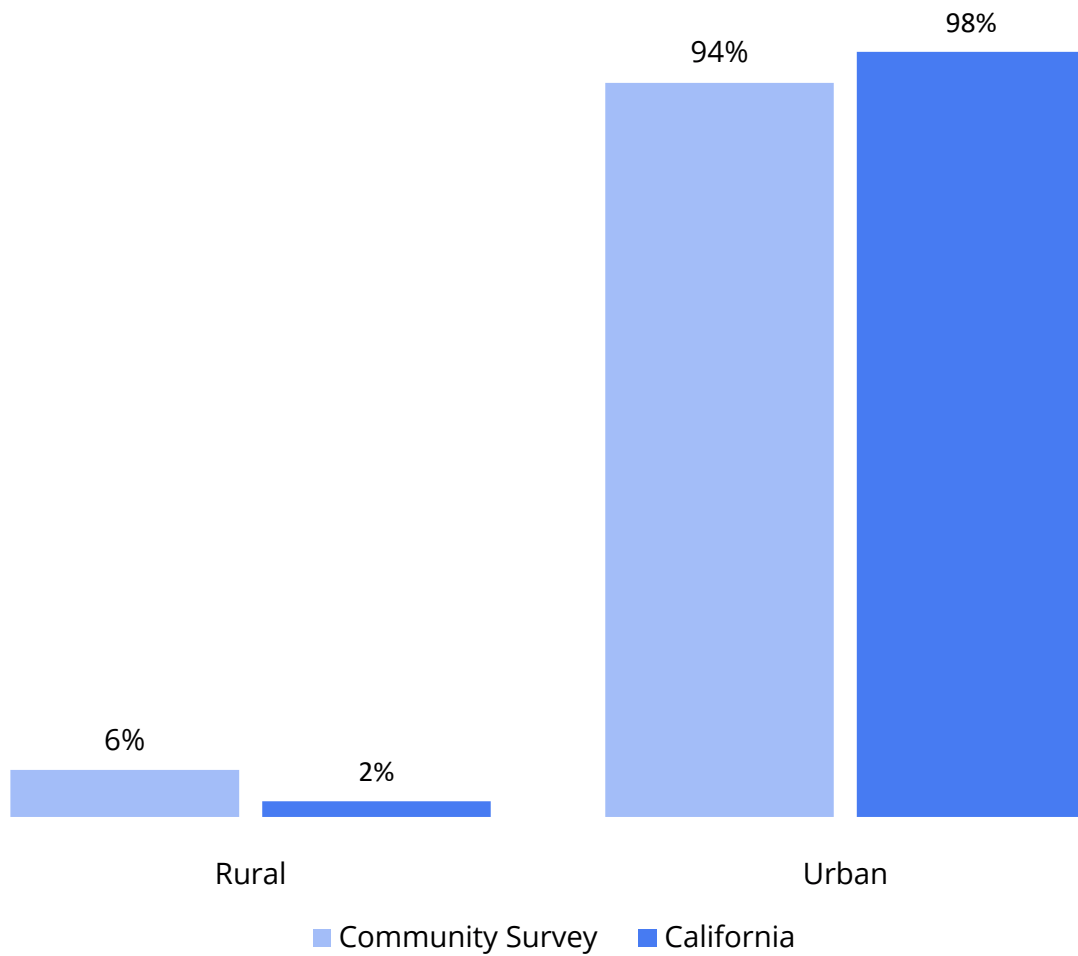
QTPOC

EXPERIENCES OF **INTERSECTIONAL** OPPRESSION

Results from the Community Survey show that regardless of race or ethnicity, queer and trans people of color (QTPOC) respondents reported experiencing **racism within LGBTQ communities and heterocissexism within their respective communities of color.**

Queer and Trans People of Color:

Experiences of Intersectional Oppression

Queer and Trans People of Color (QTPOC)[9] face negative impacts on their well-being and mental health due to the simultaneous systemic oppressions they experience, such as racism, heterosexism, and cissexism (Balsam et al., 2011; Meyer, 2010). They face marginalization, rejection, and various forms of discrimination within LGBTQ communities because of their ethnic or racial social group memberships (Balsam et al., 2011; Morales, 1989; Parra & Hastings, 2018) as well as within their cultural, ethnic or racial communities because of their non-heterosexual and/or non-cisgender status (Balsam et al., 2011; Diaz et al., 2001; Diaz et al., 2006; Parra & Hastings, 2018; Ryan et al., 2009). This intertwining of systems of oppression is referred to as *intersectionality* (Crenshaw, 1989). These multiple systems combine to increase the level of discrimination and disadvantage for marginalized groups. They act simultaneously and do not exist independently of one another.

Research consistently shows that QTPOC are at high risk for negative mental health outcomes (Kertzner et al., 2009; Santos & Van Daalen, 2016; Sarno et al., 2015; Shramko et al., 2018), due to their experiences of heterosexism and racism (Szymanski & Meyer, 2008; Shramko et al., 2018; Thoma & Huebner, 2013; Velez et al., 2015). Yet, there is limited information on how LGBTQ POC's experiences of racist, heterosexist, and cissexist

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[9] QTPOC is generally used by LGBTQ communities of color, rather than LGBTQ POC, and is considered both an inclusive and uniting term (Schalk, S., 2018).

discrimination co-occur, which leads to a lack of understanding about how these

intertwining experiences affect the well-being of LGBTQ POC. The #Out4MentalHealth

Community Survey (CS) assessed the degree to which QTPOC respondents experienced

racism and heterocissexism[10] within their LGBTQ communities and ethnic or racial

communities, respectively.

QTPOC respondents were asked questions assessing racism and heterocissexism

within LGBTQ and ethnic or racial communities. These questions were drawn from the

Culture and LGB Identity Scale developed by Sarno and colleagues (2015). To be more

inclusive, the scale was adapted to expand the LGB acronym to LGBTQ. Questions were

also added to assess heterocissexist discrimination within ethnic or racial communities. By

including items that captured experiences of racism and heterocissexism, the CS hopefully

produced a more comprehensive understanding of the lived experiences of QTPOC living in

California. Both the racism and heterosexism scales were scored as instructed in Sarno et

al., (2015).

QTPOC experiences of racist discrimination in LGBTQ communities
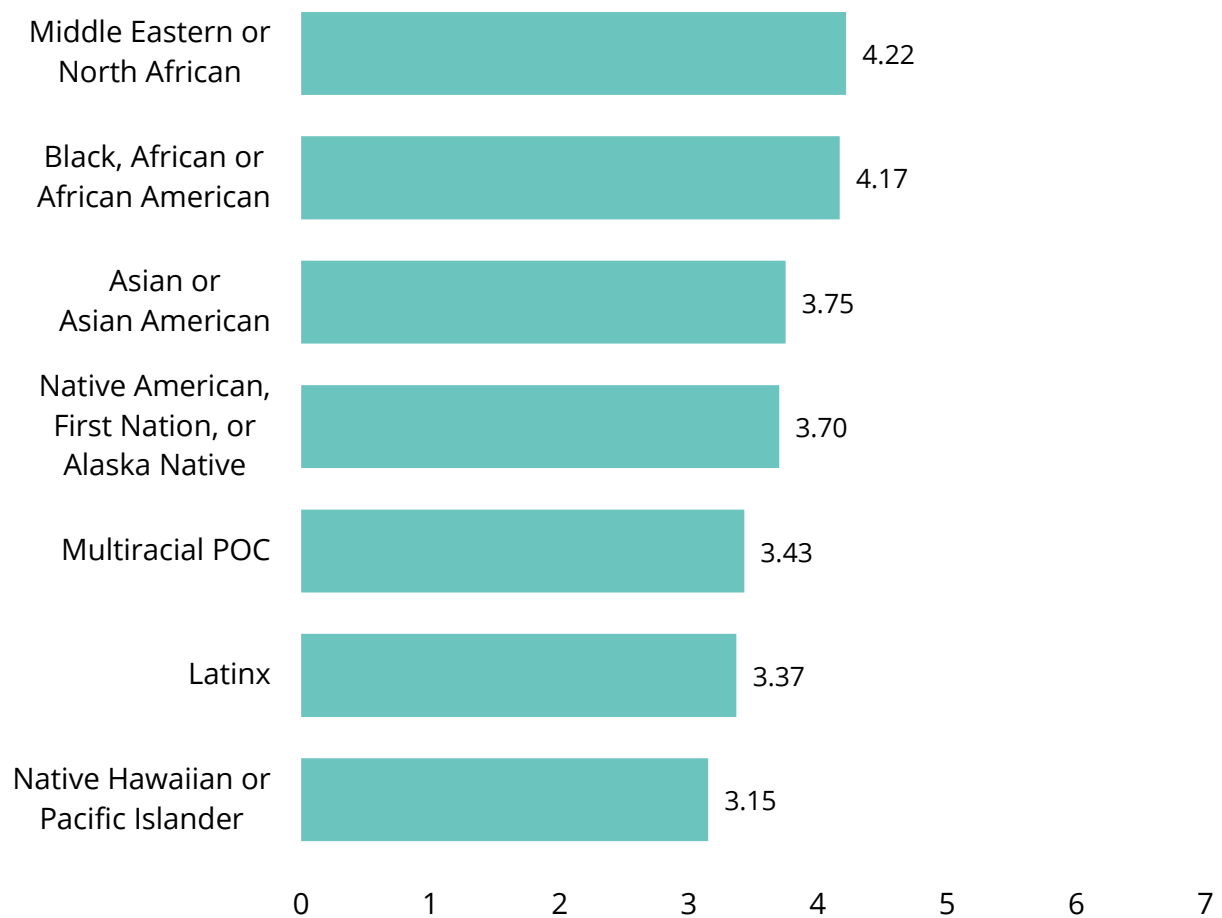
Results from the CS show that regardless of race or ethnicity, QTPOC respondents

reported experiencing racism within LGBTQ communities. Some race/ethnicity subgroups,

however reported higher rates of experiencing racism within LGBTQ communities (see

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[10] The term heterocissexism is used in this report to exemplify the intersectionality of sexism, heterosexism, and cissexism.

Figure 8). Experiences of racism within LGBTQ communities was assessed on a scale from

1= Strongly disagree to *7 = Strongly agree.* Higher average scores represent higher rates of

experienced racism within LGBTQ communities. The figure shows that Middle Eastern and

North African (MENA) and Black, African, and African American (Black) respondents

reported the highest rates of racist discriminatory experiences within LGBTQ communities.

Figure 8. Reported Racist Discrimination in LGBTQ Communities

Category	Score
Middle Eastern or North African	4.22
Black, African or African American	4.17
Asian or Asian American	3.75
Native American, First Nation, or Alaska Native	3.70
Multiracial POC	3.43
Latinx	3.37
Native Hawaiian or Pacific Islander	3.15

QTPOC experiences of heterocissexist discrimination within communities of color

Heterocissexist discrimination was assessed on a scale from *1= Strongly disagree* to *7 = Strongly agree.* Higher average scores represent higher rates of experienced heterocissexism within communities of color. All QTPOC respondents reported having experiences of heterocissexism within their respective communities of color, albeit at different rates based on their ethnic or racial group memberships (see Figure 9).

Figure 9. QTPOC Experiences of Heterocissexism in Communities of Color

Group	Score
Middle Eastern or North African	5.39
Black, African, or African American	5.22
Asian or Asian American	5.15
Native American, First Nation, or Alaska Native	4.83
Multiracial POC	4.82
Latinx	4.25
Native Hawaiian or Pacific Islander	3.60
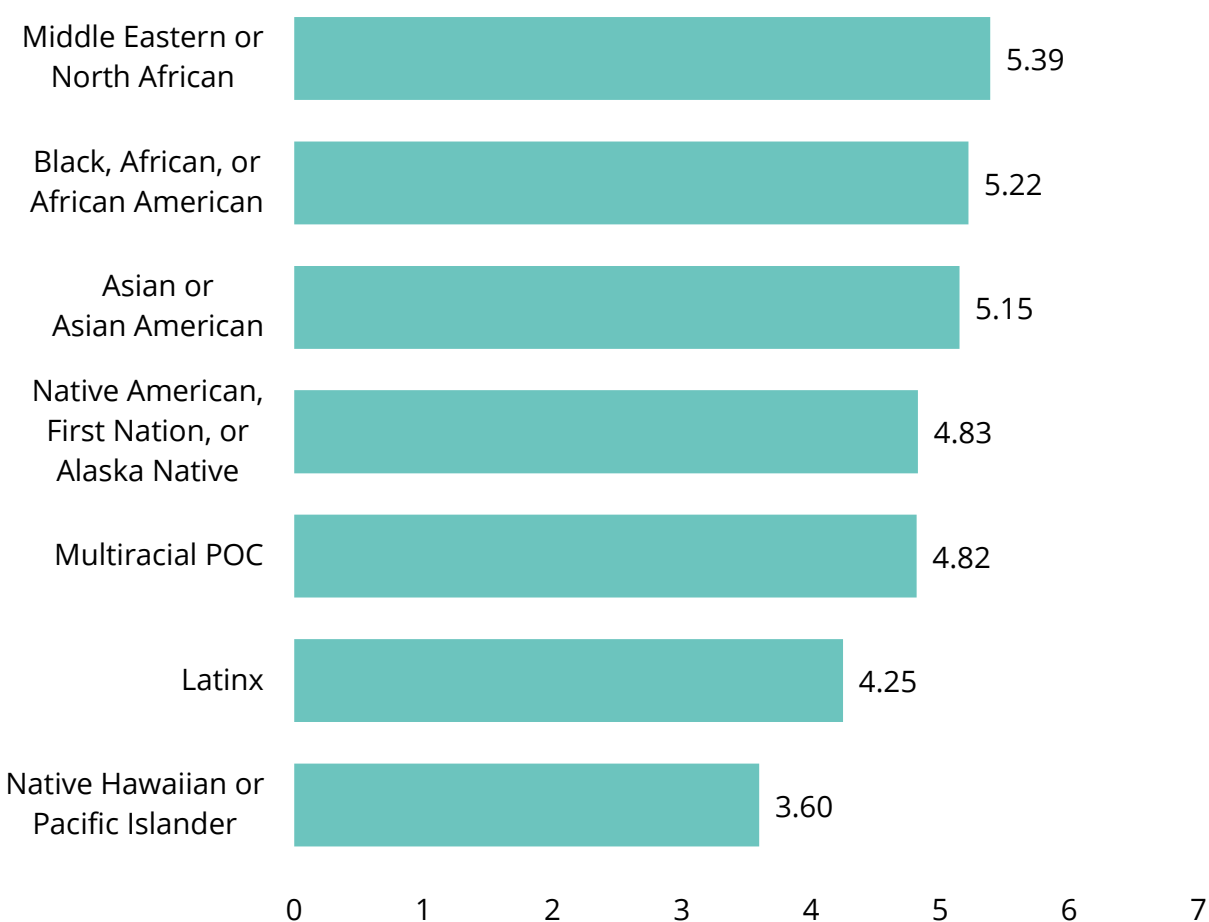
The figure shows that MENA, Black, and Asian/Asian American (AA) respondents reported the most incidents of heterocissexist experiences within their respective communities of color. Multiracial POC, Latinx and Native Hawaiian/Pacific Islander (NH/PI) respondents, on average, reported more heterocissexist discrimination than the Native American/Alaska Native (NA/AN) subgroup who in turn reported less heterocissexist discrimination in their native communities than all other ethnic or racial groups.

Conclusion

By using an intersectional lens to assess how multiple systems of oppression intertwine to further marginalize people with more than one marginalized social identity, findings from the CS are able to show that interpersonal relationships in LGBTQ communities are cross-cultural, cross-ethnic, cross-racial, and dynamic. The findings reveal that QTPOC are oppressed by both of the oppressed communities they identify with. Particularly, MENA and Black respondents experienced racism in the LGBTQ community at higher rates than other QTPOC respondents, suggesting anti-blackness and Islamophobia, specifically, are prevalent ideologies in LGBTQ communities.

MENA and Black respondents also reported experiencing heterocissexist discrimination within their respective ethnic or racial communities at higher rates than all other QTPOC subgroups. The findings suggest that each ethnic or racial community might differ in their attitudes and beliefs about sexual orientation and gender identity. Although explaining the specific cultural beliefs and ideologies for each ethnic or racial community is

beyond the scope of this report, *understanding* such belief systems may help advocates, community leaders and mental health professionals to provide services and advocacy for QTPOC. Therefore, they should seek to understand the cultural beliefs and ideologies surrounding sexual orientation and gender identity for the communities they serve.

Considering how these experiences of discrimination affect the ability of QTPOC to adapt is also important. QTPOC report finding themselves living between divided social worlds because they do not always feel accepted by LGBTQ communities because of their ethnic or racial background nor do they feel accepted by communities of color because of their LGBTQ status (Santos & Van Daalen, 2016; Sarno et al., 2015). Experiences of racist and heterosexist discrimination may impact how QTPOC integrate their multiple marginalized social identities (Meyer, 2010; Moradi et al., 2010; Shramko et al., 2018), but less is known about the specific ways in which cissexism contributes to challenges to identity integration for transgender and nonbinary POC. Recent research suggests that, experiences of discrimination are associated with elevated depressive symptoms in QTPOC (Santos & Van Daalen, 2016; Sarno et al., 2015; Shramko et al., 2018). These associations are likely to extend to transgender and nonbinary POC, but further research is needed to support those suggestions. Nonetheless, intervention efforts to support QTPOC in coping with discrimination from LGBTQ communities and the ethnic and racial communities that they identify with may combat and protect against poor mental health outcomes.

Recommendations

- LGBTQ communities and LGBTQ-serving organizations must prioritize efforts to combat racism and educate members of LGBTQ communities to become culturally affirming, inclusive, and supportive of ethnically and racially diverse LGBTQ people.

- LGBTQ community advocates and providers should hire staff and provide leadership opportunities for people from impacted communities, and seek education and trainings for all staff and volunteers to understand the cultural beliefs and ideologies surrounding sexual orientation and gender identity for the communities they serve.

- LGBTQ community advocates and providers should address mental health disparities by developing and funding targeted interventions for QTPOC that focus on experiences of discrimination from LGBTQ communities and the ethnic and racial communities with which they identify.
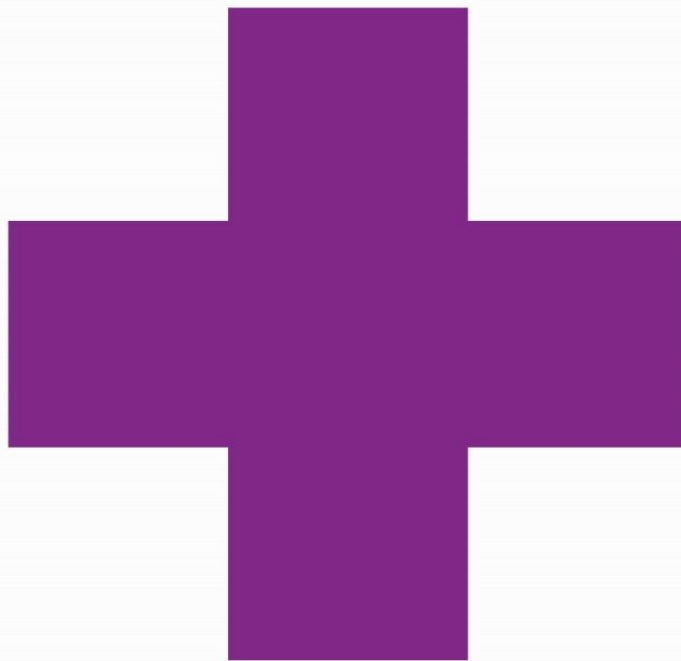
ASSESSING THE NEEDS OF

BI

INDIVIDUALS

More than half of the sample experienced each of the sexual orientation instability stereotypes in which others dismissed their bisexuality as invalid. **Family members, LGBTQ communities, school environment, and friends were the most common sources of these anti-bisexual experiences.**

Assessing the Needs of Bi+ Individuals

According to research by the Williams Institute (Gates, 2011), bisexual people

constitute the majority of LGBTQ people. They also have distinct and considerable

vulnerabilities compared to heterosexual individuals and lesbians and gay men (Feinstein &

Dyar, 2017). Prior research has demonstrated that bisexual people are at considerably

higher risk for mood and anxiety disorders, substance use, and suicide behaviors (Blosnich

et al., 2016; Bostwick et al., 2010; McCabe et al., 2009; Ross et al., 2018). These mental

health disparities can be explained in part by bi-specific stressors that uniquely impact

bisexual individuals, such as sexual orientation-based discrimination, bisexual invisibility

and erasure, and lack of bisexual support (Ross et al., 2018). Bisexual invisibility or erasure

is a particularly pervasive problem, in which the existence or legitimacy of bisexuality is

questioned or blatantly denied (Ulrich, 2011). For example, bisexual individuals' sexual

orientation and lived experiences are often dismissed as being illegitimate and unstable,

with bisexual people stereotyped as being confused, hypersexual, and are just in denial

about being gay or lesbian (Bostwick & Hequembourg, 2014; Brewster & Moradi, 2010;

Flanders et al., 2016). Indeed, a recent national survey of US adults demonstrates that

these stereotypes and negative attitudes toward bisexual people are pervasive in both

heterosexual, and gay and lesbian communities (Dodge et al., 2016).

Due to these specific experiences based on sexual orientation identity, and

consistent with recommendations for research on sexual orientation, findings were

disaggregated from the #Out4MentalHealth Community Survey (CS) to identify patterns

that held for non-monosexual people compared to monosexual people. Included in these findings are data collected from people who met a definition of non-monosexual in terms of attraction to more than one gender, regardless of identity label.

This section uses the terms *Bisexual, Bisexual subgroup,* or *Bisexual subsample* to capture the diverse identities and lived experiences of this broad group as they relate to individuals who are non-monosexual. Bisexual participants were also asked about their interactions with other bisexual people and community, anti-bisexual experiences, and internalized stigma. This section highlights some of the experiences and findings of the participants in the Bisexual Needs Assessment of the CS.
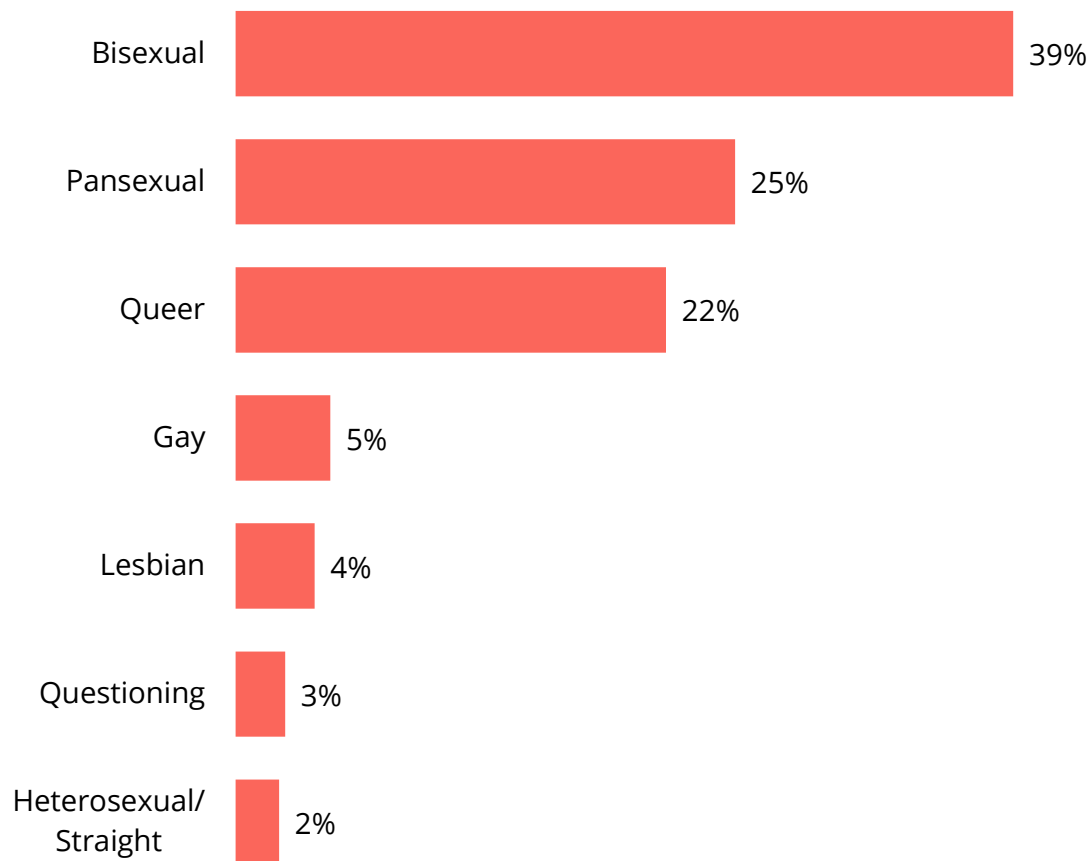
General Demographics

Sexual orientation. Sexual orientation identity, sexual behavior, and romantic/sexual attraction are not always synonymous. Indeed, estimates of those who report any lifetime same-sex sexual behavior and any same-sex sexual attraction are substantially higher than estimates of those who identify as LGB (Gates, 2011). Approximately 42% (n = 1321) of all CS participants met the definition for the Bisexual subgroup and completed the additional questions for this subgroup. Figure 10 summarizes sexual orientation identity among this subset of participants. Although the majority of the subsample identified as Bisexual, Pansexual, or Queer, approximately 14% of the Bisexual subsample respondents chose a sexual orientation label not typically associated with attraction to more than one gender. This highlights the importance of assessing bisexual

mental health disparities by also using attraction measures and not only by self-identified

sexual orientation labels.

Figure 10. Sexual Orientation Identity Among the Bisexual Subgroup

Category	Percentage
Bisexual	39%
Pansexual	25%
Queer	22%
Gay	5%
Lesbian	4%
Questioning	3%
Heterosexual/Straight	2%

Gender identity. Figure 11 summarizes the percentage of individuals in this

subsample who currently identify as LGBQ Cisgender, a different gender than their sex

assigned at birth (Trans Spectrum), or Questioning their gender identity. About half of the

subsample stated they are Cisgender, and of those individuals, the majority identified as

cisgender women (78%). This is consistent with prior population-based research

demonstrating that cisgender women are substantially more likely than cisgender men to

identify as bisexual (Williams Institute, 2011). Several studies have also suggested that

attraction to more than one gender is common among transgender and gender nonbinary

individuals (Katz-Wise et al., 2016; Kuper et al., 2012; Meier et al., 2013). This was true in the

current study, where a large proportion of individuals attracted to more than one gender

also identified themselves as having a gender different from their sex assigned at birth.

Figure 11. Cisgender, Transgender, & Questioning
Gender Identities Among the Bisexual Subgroup

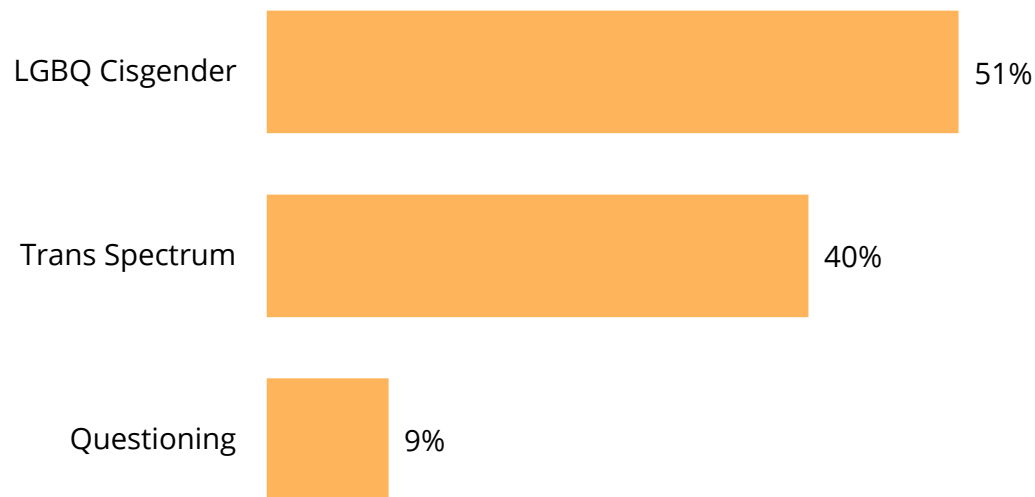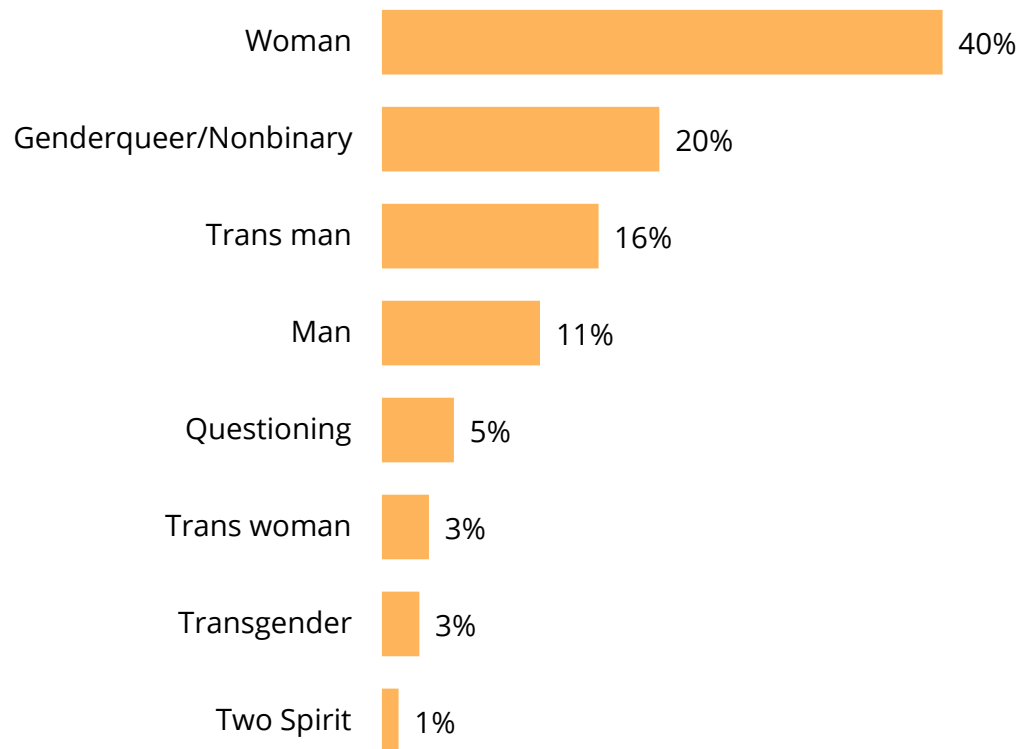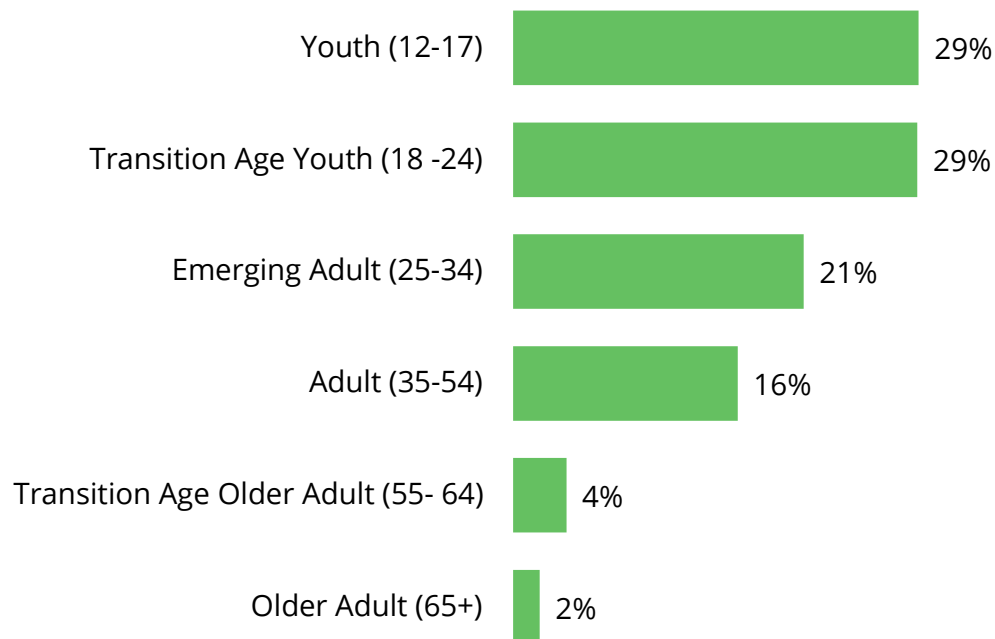| Category	Percentage
LGBQ Cisgender	51%
Trans Spectrum	40%
Questioning	9%

Figure 12 describes gender identity among the subsample in a bit more detail. When

participants were asked to pick a label that best describes their current gender, almost half

of the sample identified as a Woman and just under a quarter identified as Genderqueer or

Nonbinary.

Figure 12. Gender Identity Among the Bisexual Subgroup

Gender Identity	Percentage
Woman	40%
Genderqueer/Nonbinary	20%
Trans man	16%
Man	11%
Questioning	5%
Trans woman	3%
Transgender	3%
Two Spirit	1%

Age. The age of these participants ranged from 12 to 85, with an average age that was slightly lower than the overall CS sample (26 vs. 31 years old, respectively). Figure 13 summarizes age across brackets including Youth (ages 12-17), Transition Age Youth (ages 18-24), Emerging Adults (ages 25-34), Adults (ages 35-54), Transition Age Older Adults (ages 55-64), and Older Adults (ages 65+). Age among the Bisexual subsample was consistent with age trends across the entire CS sample, with Youth and Transition Age Youth (TAY) comprising more than half of the subsample and over 75% of the subsample falling below age 35.

Figure 13. Age Among the Bisexual Subgroup

Youth (12-17)	29%
Transition Age Youth (18 -24)	29%
Emerging Adult (25-34)	21%
Adult (35-54)	16%
Transition Age Older Adult (55- 64)	4%
Older Adult (65+)	2%

Race and ethnicity. With respect to race and ethnicity, participants identified as primarily Monoracial White, Multiracial People of Color (POC), or Latinx/Hispanic, as shown in Figure 14. Examining race and ethnicity by monoracial and multiracial categories, Figure 15 shows that a little more than half of participants fell into the Monoracial White category, with approximately 27% identified as Monoracial POC and approximately a 20% as Multiracial POC. Additionally, approximately 93% of the Bisexual subsample indicated that they were born in the United States.
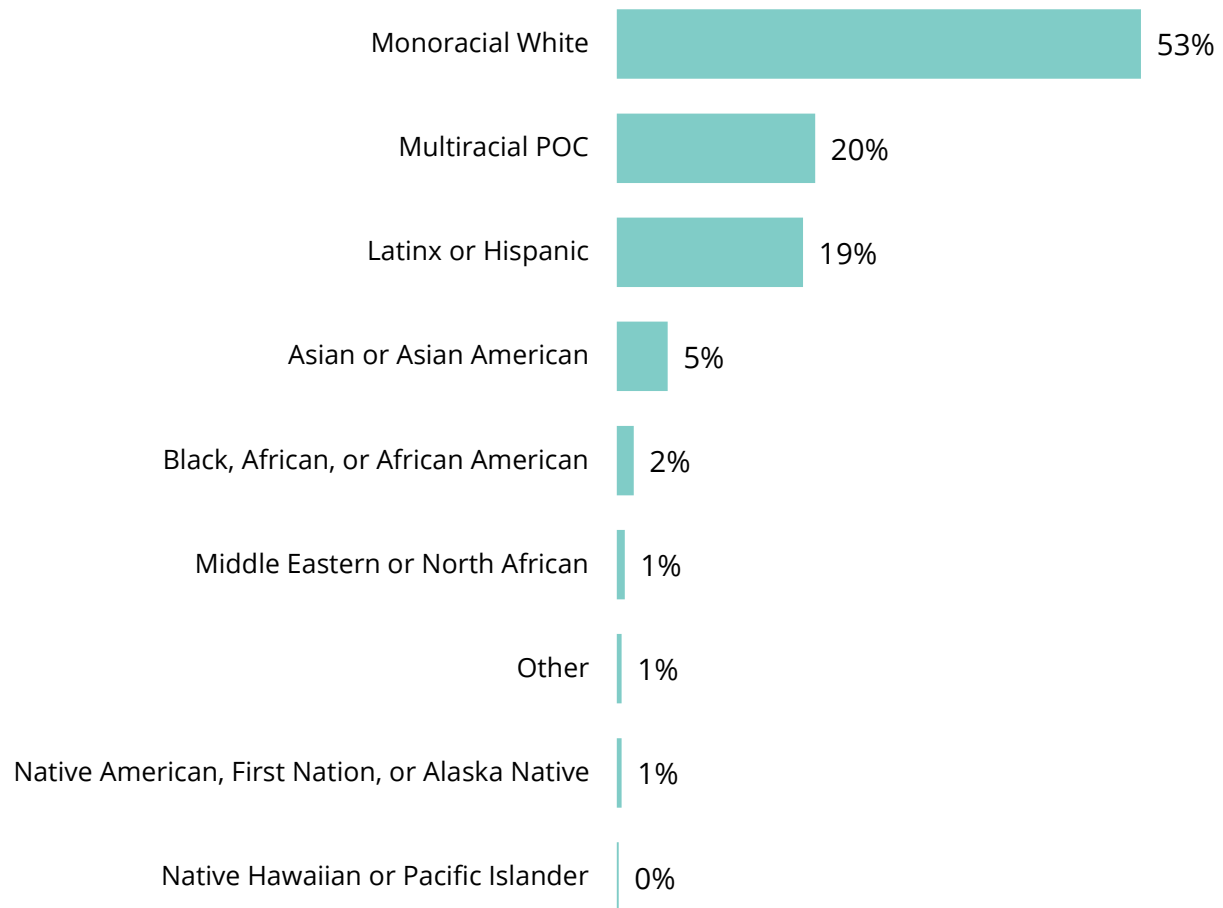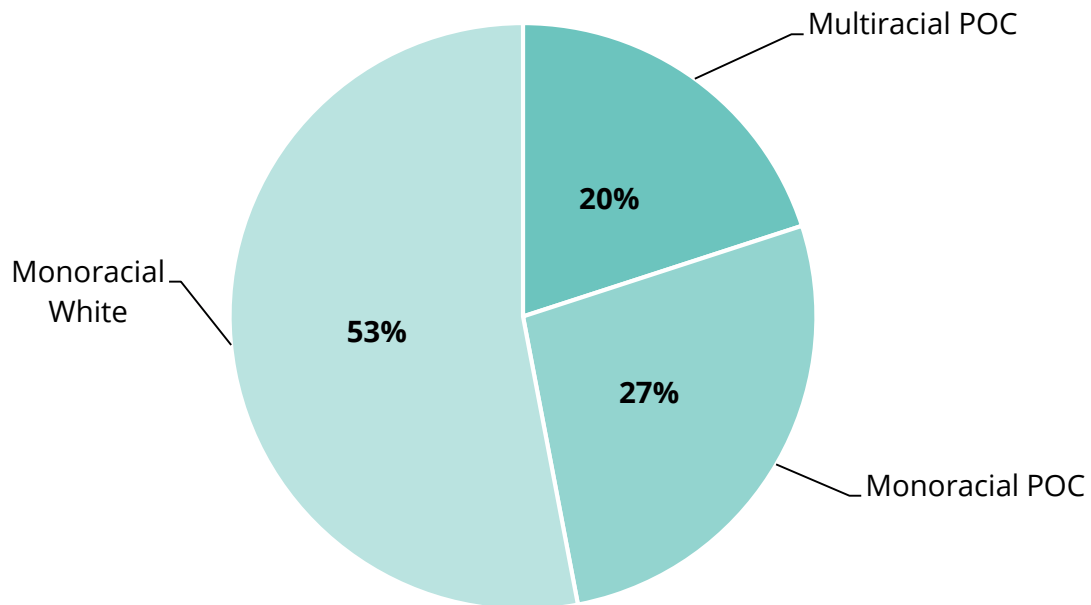
Figure 14. Race/Ethnicity Among the Bisexual Subgroup

Race/Ethnicity	Percentage
Monoracial White	53%
Multiracial POC	20%
Latinx or Hispanic	19%
Asian or Asian American	5%
Black, African, or African American	2%
Middle Eastern or North African	1%
Other	1%
Native American, First Nation, or Alaska Native	1%
Native Hawaiian or Pacific Islander	0%

Figure 15. Race/Ethnicity Among the Bisexual Subgroup

Interactions with Other Bisexual People

Research has indicated that social support from bisexual-identified individuals and

connection to bisexual-specific communities may serve as protective factors for mental

health (Lambe et al., 2017; Ross et al., 2010). To explore this, participants were asked how

they interact with other bisexual people. A "check all that apply" format was used for this

question, allowing participants to indicate whether they interacted with other bisexual

people in a multitude of different settings. The majority of the Bisexual subsample

interacted with bisexual people to some extent, with less than 10% stating that they did not

know or interact with other bisexual people. Indeed, more than 75% of the sample

indicated that they have friends/acquaintances who are bisexual, and more than half

indicated that they interact with other bisexual people on social media. On the other hand, local LGBTQ spaces were not reported as a primary source for meeting other bisexual people.

Table 3 summarizes bisexual interactions among individuals who indicated they were LGBQ Cisgender, Trans Spectrum, or Questioning their gender identity. Compared to LGBQ Cisgender respondents, Trans Spectrum respondents were significantly more likely to have friends/acquaintances who are bisexual; interact with other bisexual people on social media; interact with other bisexual people in local LGBTQ spaces, such as a center, bar, club, or café; and less likely to report that they do not know other bisexual people. Thus, it seems that Trans Spectrum participants may be slightly more connected to other bisexual people across a variety of contexts.

Table 3. How do Bisexual People Interact with Other Bisexuals			
	Trans Spectrum	**Questioning**	**LGBQ Cisgender**
Don't interact with other bi people	2%	2%	4%
Don't know other bi people	4%	7%	8%
On dating apps	23%	15%	20%
I go to local LGBTQ spaces	34%	20%	23%
On social media	73%	64%	59%
I have bi friends/acquaintances	89%	86%	83%

Among the Bisexual subsample respondents who identified as LGBQ Cisgender,

Table 4 summarizes bisexual interactions among non-monosexual cisgender men and

women. Compared to cisgender women, cisgender men were significantly less likely to

have friends/acquaintances who are bisexual or interact with other bisexual people on

social media. Cisgender men were also 2 times more likely to meet other bisexual people

via dating apps, 2 times more likely to report that they do not know other bisexual people,

and 3 times more likely to report that they do not interact with other bisexual people.

Importantly, cisgender men and women were equally likely to meet other bisexual people

in LGBTQ spaces. Overall, these findings suggest that non-monosexual cisgender men, with

the exception of dating apps, are much less connected to other bisexual people across

social contexts.

Table 4. How do cisgender bisexual people interact with other bisexual people?		
	Cisgender women	**Cisgender men**
Don't interact with other bi people	3%	10%
Don't know other bi people	7%	13%
I go to local LGBTQ spaces	20%	25%
On dating apps	14%	37%
On social media	62%	45%
I have bi friends/acquaintances	86%	69%

The high prevalence of individuals who identified as Genderqueer or Nonbinary (GQNB) within the Bisexual subsample (n = 264), provided a unique opportunity to examine bisexual interactions among this under-researched subpopulation. The majority of GQNB individuals (91%) reported having friends/acquaintances who are bisexual and 27% interact with other bisexual people via dating apps. Compared to all other gender identities, GQNB individuals were more likely to interact with other bisexual people on social media (78%) and in LGBTQ spaces (41%) and least likely to report that they do not know other bisexual people (3%). Further, almost all GQNB people (98%) reported interacting with other bisexual people.

Anti-Bisexual Experiences

In addition to heterosexism, bisexual people experience a unique form of systemic oppression called "monosexism" (Nagle, 1995). Monosexism describes a social structure that values and rewards monosexual people at the expense of those who are attracted to more than one gender (Goldberg, 2016), and includes the belief that monosexuality is superior to non-monosexuality. At the individual level, monosexism can be expressed through particular, personalized negative attitudes and behaviors aimed directly against bisexual people, also referred to as "biphobia" (Ochs, 1996) or "binegativity" (Eliason, 2001). Research shows that these anti-bisexual attitudes and experiences have historically fallen into one of three categories (Brewster & Moradi, 2010):

1. Sexual orientation instability stereotypes (e.g. believing bisexual people are confused, experimenting, or in denial about their true sexual orientation);

2. Sexual irresponsibility stereotypes (e.g. believing bisexual people are promiscuous, likely to cheat, and obsessed with sex); and

3. Interpersonal hostility (e.g. intolerance toward bisexual people that results in negative treatment).

To capture these experiences, participants completed a brief version of the Anti-Bisexual Experiences Scale (Dyar et al., 2019). For each of the eight items, participants indicated the degree to which they experienced the event on a scale from "never" to "almost all the time." Figure 16 summarizes the percentage of individuals who reported

experiencing each event occasionally, frequently, or almost all the time. Markedly, more

than half of the sample experienced each of the sexual orientation instability stereotypes in

which others dismissed their bisexuality as invalid by:

- acting as if their bisexuality was only a sexual curiosity,

- not taking their bisexuality seriously, and

- addressing their bisexuality as if they were confused about their sexual orientation.

Though a smaller percentage of individuals experienced sexual irresponsibility

stereotypes and interpersonal hostility, still at least a quarter of the sample reported

experiencing these as well. These findings highlight the high extent to which bisexual

people receive negative messages that a part of their identity is instable and irresponsible.

They are subsequently treated negatively by those around them due to biphobia,

binegativity, and monosexism.

Figure 16. Anti-Bisexual Experiences

People have acted as if my bisexuality is only a sexual curiosity, not a stable sexual orientation — 67%

People have not taken my sexual orientation seriously because I am bisexual — 55%

People have addressed my bisexuality as if it means that I am simply confused about my sexual orientation — 53%

Others have acted uncomfortable around me because of my bisexuality — 38%

People have assumed that I will cheat in a relationship because I am bisexual — 37%

Others have treated me negatively because I am bisexual — 30%

People have treated me as if I am obsessed with sex because I am bisexual — 27%

I have been alienated because I am bisexual — 26%

Bisexual people may experience anti-bisexual prejudice and discrimination across heterosexual and gay and lesbian communities (Roberts et al., 2015). Therefore, participants were asked to indicate which context(s) their anti-bisexual experience applied. Table 2 summarizes anti-bisexual experiences across each context. The percentages in the table are of those who both experienced the event and were out to others in the respective

context. For example, the findings for "family members" represent the percentage of those who both experienced the event and were out as bisexual to their family.

In general, family members, LGBTQ communities, school environment, and friends (respectively) were the most common sources of anti-bisexual experiences, though at least 25% of participants had encountered anti-bisexual experiences in a faith community, with a partner, at work, and in health/mental health service provider contexts. In contrast to this general picture is the high percentage of partners (61%) who assume that a bisexual person will cheat in a relationship. Also notable are the relatively elevated feelings of alienation and discomfort of others in school, faith, and work environments. Together, these findings suggest that anti-bisexual experiences may be context-dependent, with the greatest need for intervention in family, LGBTQ communities, school, and friend environments.
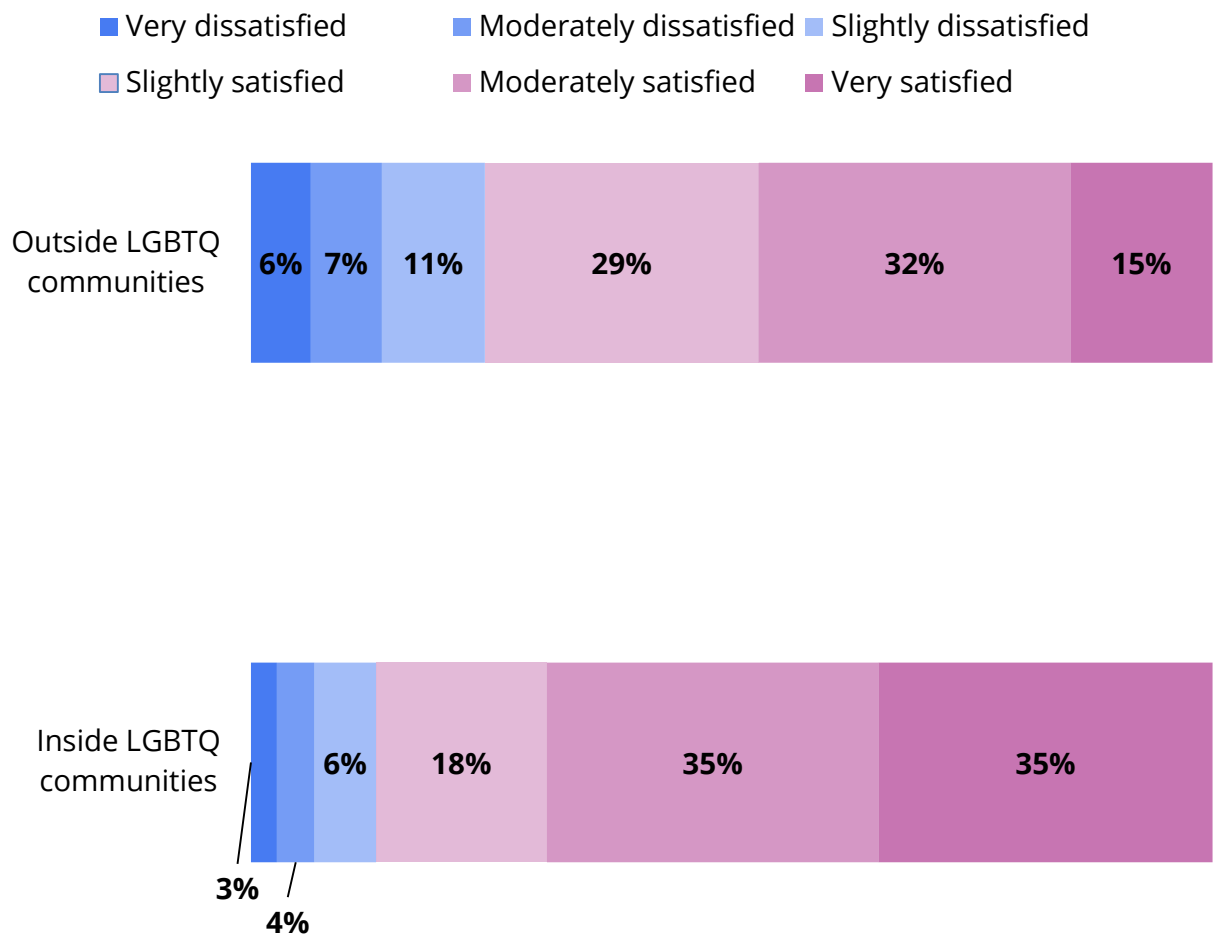
Table 5: Anti-Bisexual Experiences Across Contexts

	Family	LGBTQ People	School	Friends	Faith community	My partner(s)	Work-place	Health/ mental health providers
Because I Am Bisexual...								
People have not taken my sexual orientation seriously	72%	62%	56%	58%	40%	31%	29%	24%
Others have acted uncomfortable around me	50%	32%	73%	63%	40%	24%	40%	17%
People have assumed that I will cheat in a relationship	40%	57%	54%	53%	26%	61%	19%	11%
Others have treated me negatively	62%	57%	66%	49%	42%	31%	41%	27%
People have treated me as if I am obsessed with sex	42%	51%	50%	65%	31%	42%	27%	23%
I have been alienated	56%	61%	73%	51%	53%	25%	42%	23%
People have acted as if my bisexuality...								
Is only a sexual curiosity, not a stable orientation	79%	62%	56%	56%	40%	31%	31%	24%
Means that I am simply confused about my sexual orientation	74%	55%	51%	52%	34%	29%	28%	24%

Social Support

Participants were asked a series of questions to gauge social support within and outside of LGBTQ communities over the last three months. Importantly, 22% of participants indicated they had not reached out for support from either inside or outside LGBTQ communities. Of those who did seek support, participants reached out to someone within LGBTQ communities about as often as someone outside of LGBTQ communities. More specifically, 78% sought support at least once from someone inside LGBTQ communities and someone outside of LGBTQ communities. However, participants were more likely to seek support from someone inside versus outside of LGBTQ communities "many times" (33% vs. 21%, respectively).

Figure 17 summarizes satisfaction with the social support received in these communities. There were differences in satisfaction with the support received. For example, 88% of the Bisexual subsample reported feeling at least slightly satisfied with the support they received from people inside LGBTQ communities vs. 76% from outside of LGBTQ communities. Further, when asked about general support by LGBTQ communities, only 6% of participants indicated not feeling supported whereas 54% felt somewhat supported, and 40% felt strongly supported. Thus, the majority of participants reported feeling generally supported by LGBTQ communities and experienced greater satisfaction with the support they received from within LGBTQ communities as compared to the support received from those outside of LGBTQ communities.

Figure 17. Satisfaction with Social Support

■ Very dissatisfied   ■ Moderately dissatisfied ■ Slightly dissatisfied
■ Slightly satisfied   ■ Moderately satisfied   ■ Very satisfied

Outside LGBTQ communities: 6% | 7% | 11% | 29% | 32% | 15%

Inside LGBTQ communities: 3% | 4% | 6% | 18% | 35% | 35%

Bisexual interactions and social support. In addition to the social support variables

described above, Bisexual respondents were also asked how supported they felt by LGBTQ

communities more generally. Those who did not interact with other bisexual people in

LGBTQ spaces felt significantly less supported by LGBTQ communities compared to those

who did interact with other bisexual people. Further, those who did not interact with other

bisexual people in LGBTQ spaces also reported feeling significantly less satisfied with the

support received from people in LGBTQ communities compared to those who did interact

with other bisexual people in LGBTQ spaces. Together, these results suggest that having

access to other bisexual people in LGBTQ spaces may be an important factor influencing

how supported bisexual people feel by LGBTQ communities.

Anti-bisexual experiences and social support. Anti-bisexual experiences that

reinforce the erasure of bisexuality may lead bisexual individuals to feel marginalized and

without a sense of community. Therefore, the relationship between anti-bisexual

experiences in LGBTQ communities and how supported bisexual individuals felt by LGBTQ

communities was examined. For 7 out of 8 of the experiences included, experiencing anti-

bisexual prejudice in LGBTQ communities was significantly associated with a decrease in

how supported bisexual individuals felt by LGBTQ communities.

Internalized Binegativity

As bisexual individuals are exposed to prejudice and discrimination linked to their

sexual orientation, they may internalize stigmatizing messages directed toward them by

others. For bisexual people, internalized binegativity refers to the personal acceptance of

society's negative attitudes or feelings about bisexuality that are directed inward toward

one's own bisexual identity (Ochs, 1996). Although all non-heterosexual orientations may

be impacted by internalized homophobia as a result of living in a world that privileges

heterosexuality, internalized binegativity is distinct in that it incorporates bisexual-specific

stereotypes, such as the illegitimacy or instability of bisexuality, and the supposed inability

of bisexual individuals to be faithful sexual partners (Brewster & Moradi, 2010; Mohr &

Rochlen, 1999).

To examine internalized binegativity, participants completed a subset of questions

from the Internalized Binegativity Subscale of the Bisexual Identity Inventory (Paul et al.,

2014). Participants were asked to indicate their level of agreement (using a scale from

"strongly disagree" to "strongly agree") with each of the following five statements:

- My life would be better if I were not bisexual.

- I wish I could control my feelings and aim them at either men or women, not
  more than one gender.

- Being bisexual prevents me from having meaningful intimate relationships.

- I would be better off if I would identify as gay or straight, rather than bisexual.

- It's unfair that I am attracted to more than one gender.

Encouragingly, internalized binegativity was fairly low among the Bisexual

subsample of respondents in the CS. Specifically, more than half of the participants

disagreed to some extent with all five statements. Findings from this section suggest that

having greater social support appears to protect bisexual individuals from internalized

binegativity. People with significantly lower internalized binegativity tended to have

bisexual acquaintances/friends and interacted with other bisexual individuals in LGBTQ

spaces and on social media. In addition, as support from LGBTQ communities increased,

internalized binegativity significantly decreased. Furthermore, greater acceptance by any

one of the following was significantly associated with lower internalized binegativity: one's

partner, children, family of origin, extended family, current faith community, friends, co-

workers, current teachers/professors, other students at school, primary care doctor,

mental health services provider, or non-clinical office staff.

Despite low internalized binegativity in the overall Bisexual subsample, a closer look

at differences in internalized binegativity by sexual orientation identity labels and

race/ethnicity suggests that internalized binegativity was not equal across groups.

Pansexual and Queer participants had particularly low internalized binegativity compared

to those who identified as, Lesbian, Gay, Bisexual, or Questioning. This finding indicates

possible resilience of Pansexual and Queer-identified individuals despite exposure to

biphobia and monosexism. It also suggests that those who experience attraction to more

than one gender, but use a monosexual identity label, may experience more internal

struggles with their bisexuality.

Internalized binegativity was also significantly higher among Monoracial POC

respondents compared to Monoracial White individuals. Although internalized binegativity

was higher among Multiracial POC respondents relative to Monoracial White individuals,

the difference was not statistically significant. Thus, Monoracial POC who experience

attraction to more than one gender may also be relatively more susceptible to internal

struggles with their bisexuality.

Internalized binegativity, anti-bisexual experiences, and suicide. The Minority Stress Model posits that when bisexual individuals experience anti-bisexual prejudice and discrimination and subsequently internalize negative messages about their own bisexuality, their mental health may suffer (Meyer, 2003; Meyer & Frost, 2013). Research has consistently shown that bisexual people represent one of the highest-risk populations for poor mental health outcomes, relative to both heterosexual and lesbian and gay people (Bostwick et al., 2010; Cochran & Mays, 2009; Feinstein & Dyar, 2017), and the risk for suicide among bisexual people is especially high (Blosnich et al., 2016). In the CS, Bisexual and Pansexual participants reported the highest rates of ever having considered suicide, having considered suicide in the past year, making a suicide plan in the past year, and attempting suicide in the past year.

The relationship between anti-bisexual experiences, internalized binegativity, and suicide was examined to attempt to understand which factors contribute to elevated risk for suicide. More frequent anti-bisexual experiences were significantly associated with an increase in having ever considered suicide, making a suicide plan in the past year, and the number of suicide attempts in the past year. Similarly, higher internalized binegativity was significantly associated with an increase in considering suicide, making a suicide plan, and the number of suicide attempts in the past year. It is evident from these findings that, for the Bisexual subsample in the CS, both anti-bisexual experiences and internalized binegativity collectively contribute to high rates of considering, planning and attempting suicide.

Conclusions and Recommendations

Results from the bisexual subsample of the CS provide a snapshot of the unique experiences of bisexual people in California. The findings highlight the need for bisexual-specific funding and services to build bisexual-inclusive communities, eliminate misconceptions about bisexuality, and reduce alarming rates of suicide behaviors among bisexual individuals.

Building bisexual-inclusive communities. Social support appears to be vital to protecting the mental health of bisexual people. Low internalized binegativity in the CS sample was linked to interacting with other bisexual people, feeling supported within LGBTQ communities, and feeling accepted in close relationships (e.g. partners, children, family, and friends) and social environments (e.g. faith community, co-workers, teachers, people at school, primary care doctor, mental health providers, and non-clinical office staff).

Bisexual people comprise a multitude of various intersecting identities that often renders them invisible in both heterosexual and LGBTQ communities (Galupo et al., 2017). For example, erasure may occur when two people in a same-sex relationship are perceived as lesbian or gay, or two people in a different-sex relationship are perceived as heterosexual, without considering that one or both may identify as bisexual. Thus, building bisexual-inclusive communities requires increasing bisexual visibility and directly

combatting bisexual erasure. One potential resource to combat bisexual erasure and

promote bisexual visibility is the #StillBisexual Campaign (Gonzalez et al., 2017).

#StillBisexual is a web-based education and advocacy organization for those attracted to more than one gender that utilizes social media and education programs to debunk myths about bisexuality and raise awareness of unique aspects of bisexual identity. Through the use of personal narratives that reinforce the existence and stable nature of bisexuality, the campaign intends to build and reinforce a sense of community among bisexual individuals.

For more information: **stillbisexual.com**

Eliminating misconceptions about bisexuality through education. Contributing

to bisexual erasure, the majority of participants experienced anti-bisexual prejudice and

discrimination events in which their bisexual identity was disregarded or dismissed by

others. Unfortunately, family members, LGBTQ communities, school environment, and

friends were the most common sources of these anti-bisexual experiences. There is a dire

need to develop resources and tools that can be used to educate the public on bisexuality.

Dyar et al. (2015) propose a set of guidelines for intervention efforts to reduce

binegativity that include multicultural education on the:

- High prevalence of bisexuality;

- Legitimacy of bisexuality as a stable sexual orientation;

- Concept of sexual orientation as being on a continuum rather than a binary choice; and

- Information demonstrating that bisexual individuals are equally likely to engage in committed monogamous relationships as heterosexual or gay and lesbian people.

Reducing high rates of suicide behaviors. Out of the entire CS sample, Bisexual and Pansexual participants reported some of the highest rates of having ever considered suicide, considering suicide in the past year, making a suicide plan in the past year, and attempting suicide in the past year. Findings from this survey suggest that these high rates of suicide behaviors were associated with greater rates of anti-bisexual experiences and internalized binegativity. Therefore, funding must be directed toward developing resources and services that directly target anti-bisexual experiences and internalized binegativity.

Online interventions may be especially useful for targeting groups at risk for higher internalized binegativity, particularly for individuals who experience attraction to more than one gender, but do not identify as bisexual, pansexual, or queer. *Releasing Internalized Stigma for Empowerment*, an online, psychoeducational intervention effectively reduces internalized binegativity by:

- Dispelling negative bisexual stereotypes with research evidence;

- Asking participants to identify external sources of their binegative beliefs;

- Affirming bisexuality through a video and writing exercise to express support for

  a bisexual person; and

- Affirming bisexuality through bi-affirming images and presenting positive

  aspects of being bisexual (Israel et al., 2018).

Together, through building bisexual-inclusive communities, dispelling myths about

bisexuality, and directly supporting bisexual people with interventions to reduce

internalized binegativity, the health and wellbeing of bisexual people can begin to flourish.

LGBTQ CALIFORNIANS &

HEALTH CARE

ACCESS

Long wait times and long distances traveled pose a major barrier to accessing needed health care.

LGBTQ Californians and Health Care Access

Physical and mental health care access are intimately intertwined for LGBTQ people. Historically, LGBTQ people have experienced tremendous disparities with regard to accessing health care. LGBTQ people also experience delays in receiving health care due to the inability to find LGBTQ affirming providers, transportation challenges, taking time off work, and/or high out of pocket costs. When these delays happen, they can negatively impact both physical and mental health. In the #Out4MentalHealth Community Survey (CS), respondents were asked about their ability to access health care. Specifically, the survey asked them whether they were insured and, if insured, what types of insurance they have. The survey also asked them about timely access to care.

When analyzing the full CS sample, it is important to note that a large number of Youth (12-17) responded with "I don't know/unsure" to questions about their health insurance status and other survey questions related to health care access. This circumstance made it difficult to parse out meaningful differences when further analyzing the health care access data by sexual orientation, gender identity, race, ethnicity, or other categories. Although there may be interesting differences in health care access between LGBTQ youth and non-LGBTQ youth, this survey is not the correct instrument to measure those differences. Therefore, the analysis in this section reflects respondents ages 18 and over.

Rates of Uninsured

Whether or not a person is insured is an important indicator of their ability to access health care. As stated in *Mapping the Road to Equity: The Annual State of LGBTQ Communities*, for a "variety of reasons—higher rates of poverty and unemployment, coupled with the inability to get coverage through a spouse's health insurance—LGBTQ people have historically had higher rates of uninsurance than the general population" (O'Brien et al., 2018). Thanks to a number of measures in the Patient Protection and Affordable Care Act (ACA), including Medicaid expansion, subsidies on the individual health insurance market, and guaranteed issue,[11] the uninsured rate among LGBTQ people dropped by 25% during the first year of implementation alone (Baker et al., 2014). In an analysis of insurance rates between 2011-2014, the UCLA Center for Health Policy Research found that the rates of uninsured LGB people in California were similar to that of the general population (Wolstein et al., 2018). This study followed the expansion of Medi-Cal to low-income adults in California.

CS respondents reported higher rates of being insured when compared to the UCLA Center for Health Policy Research (Wolstein et al., 2018), with just 6% of respondents indicating that they do not have health insurance and an additional 5% who did not know their health insurance status (see Figure 18). With the differences in sampling

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[11] Guaranteed issue ended the practice of denying health insurance to people with pre-existing conditions and created a requirement that health plans must permit people to enroll regardless of health status, age, gender, or other factors that might predict the use of health services.

methodology, it is impossible to directly compare the results of these surveys: the results

could mean that the uninsured rate among LGBTQ Californians has decreased over the

past several years, or it could indicate that CS respondents are disproportionately likely to

be insured compared to the California LGBTQ population overall. The CS did find that

Monoracial POC and Multiracial POC reported higher rates of being uninsured (11%) than

Monoracial White respondents (5%), strongly suggesting there are disparities that still need

to be addressed.

Figure 18. Do You Have Health Insurance?
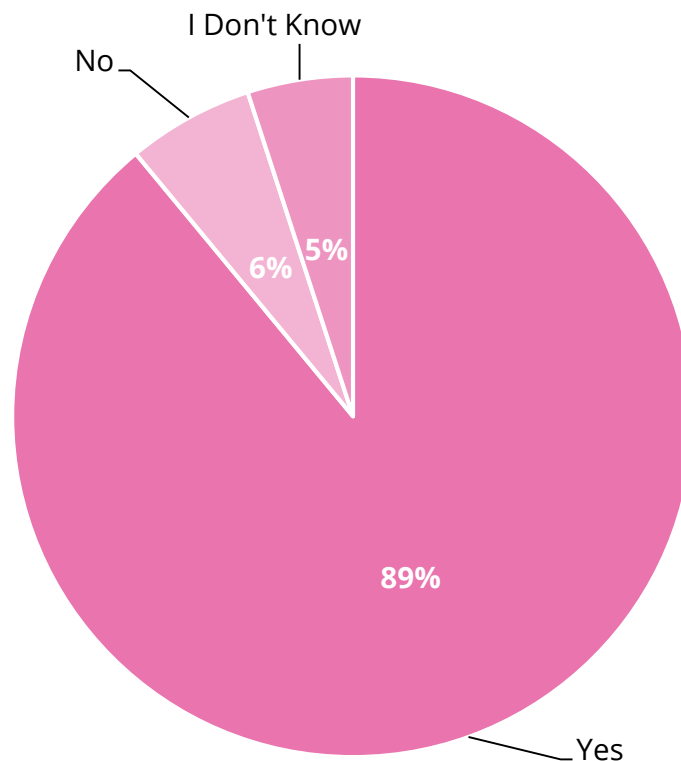
CS participants who reported they were uninsured were asked to indicate the primary reason they are without insurance. The most frequently reported reasons were:

- I am currently unemployed (22%).

- I can't afford to pay the premiums (21%).

- I lost Medi-Cal eligibility (13%).

- My employer doesn't offer health insurance coverage (10%).

Despite California's efforts to make health insurance affordable and accessible to more people, many LGBTQ Californians still struggle to pay for health insurance premiums and cost sharing.

Delaying Care

Lack of insurance, however, is likely not the biggest barrier to accessing health care for LGBTQ Californians. Addressing cost barriers alone will not close all LGBTQ health disparities. The previously mentioned UCLA study also examined health care utilization, and found that LGB individuals were more likely to delay care than their heterosexual counterparts (Wolstein et al., 2018). Qualitative findings in *Mapping the Road to Equity* suggest that LGBTQ Californians' are experiencing discrimination and harassment within the health care system (O'Brien et al., 2018). Negative experiences could be driving some LGBTQ people to delay health care. For example, a recent study from NPR, the Robert

Wood Johnson Foundation, and Harvard School of Public Health (2017) found that fear of discrimination does affect LGBTQ individuals' willingness to seek medical care. Specifically, the study found: "18% of LGBTQ Americans say they have avoided going to a doctor or seeking health care out of concern that they would be discriminated against or treated poorly because of their LGBTQ identity" (p. 12).

Types of Health Insurance

Employer-based coverage (self or spouse) was by far the largest source of health insurance for CS respondents, with 50% indicating this as their only form of insurance. Over a quarter (28%) of respondents indicated that Medi-Cal and/or another government provided health care (e.g. Medicare) was their only form of insurance.

The dependence on employer-sponsored health insurance underscores the importance of employment protections for LGBTQ Californians. Because health care and employment are coupled in the United States, LGBTQ people who experience employment discrimination are doubly impacted: both losing access to income, as well as health care. These numbers also underscore the importance of the expansion of Medi-Cal to cover low-income Californians, and the imperative to continue expanding access to the remaining uninsured (e.g., undocumented immigrants, seniors, and people living with disabilities).

Differences by Race/Ethnicity

The CS findings suggest meaningful differences in the rates of uninsurance among racial/ethnic subgroups. Black/African American respondents were slightly more likely to be uninsured while Latinx/Hispanic respondents were more than twice as likely to be uninsured compared to White respondents.

The CS findings also suggest differences between racial/ethnic subgroups based on the types of insurance respondents have. Black/African American (54%), Latinx/Hispanic (36%), and Multiracial (26%) respondents were more likely to report having Medi-Cal compared to White (14%) or Asian/Asian American (15%) respondents, and were less likely to report having employer-sponsored coverage (see Table 6).

Table 6. What type of health insurance do you have?				
	Medi-Cal	**Employer-sponsored**	**Covered CA**	**Other/Multiple**
Asian/Asian American	15%	64%	11%	11%
Black/African American	54%	17%	2%	27%
Latinx/Hispanic	36%	44%	7%	13%
Multiracial	26%	11%	11%	19%
White	14%	53%	11%	22%

Health Insurance and Mental Health Coverage

The CS asked respondents about their health insurance coverage for mental health services. Despite the gains in mental health coverage through the Affordable Care Act implementation, there is still work to do to ensure Californians have meaningful access to mental health care. The fulfillment of mental health parity means that all health plans sold in California are required to cover mental health services. Yet, 27% of CS respondents indicated that they did not know, or were not sure if their health insurance covers mental health services. In addition, for those respondents (73%) who reported they did have mental health coverage, 34% also noted they had some type of cost sharing, and 25% noted they had limited visits. Uncertainty about coverage, cost sharing, and limited visits can create barriers for people wanting to access needed mental health care.

Fortunately, California regulators have recognized the need to strengthen mental health parity laws and provide more clarity and protections for consumers. Currently, there are efforts underway in California to address parity issues and strengthen enforcement of parity, through the Medi-Cal Healthier California for All initiative[12] as well as updates and potential changes in the budget, legislature, and by health care regulators. This is incredibly important, given that 73% of CS respondents reported wanting mental health services in the past year.

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[12] For more information, please visit the Department of Health Care Services website: https://www.dhcs.ca.gov/provgovpart/pages/medi-calhealthiercaforall.aspx

Timely Access to Care

California law protects timely access to health care. Specifically, the Knox Keene

Health Care Service Plan Act (1975, 2019), established that the Department of Managed

Health Care (DMHC) set regulations to ensure that health plan enrollees receive health care

services in a timely manner. These regulations are set by type of appointment (urgent and

non-urgent appointments) and by specialty (primary care, mental health, specialists,

ancillary providers, and diagnostic services). According to DMHC (2020b),

> *"The Knox-Keene Act requires health plans to maintain provider networks that are*
>
> *sufficient to ensure that all covered health care services are readily available to each*
>
> *enrollee consistent with good professional practice. In addition, section 1300.67.2.2 in*
>
> *title 28 of the California Code of Regulations requires health plans to monitor and*
>
> *maintain networks sufficient to provide enrollees access to covered health care services*
>
> *within specific time-elapsed standards"* (para. 1).

These regulations govern network adequacy, and how well health plans are doing at

delivering accessible health care to patients. Table 7 outlines California's current Timely

Access to Care regulations.

Table 7: California Timely Access Regulations for Appointment (DMHC, 2020a)	
Urgent Appointments	**Wait Time**
For services that do not need prior approval	48 hours
For services that do need prior approval	96 hours
Non-Urgent Appointments	Wait Time
Primary care appointment	10 business days
Specialist appointment	15 business days
Appointment with a mental health care provider (who is not a physician)	10 business days
Appointment for other services to diagnose or treat a health condition	15 business days

CS respondents were asked to indicate, for different providers, how long they had to wait to have their appointment from the time they first attempted to schedule the appointment. Over a third (36%) of respondents reported that they waited longer than 10 business days for a primary care appointment with almost a quarter (24%) waiting longer than 15 business days. For mental health services over half (55%) waited longer than 10 days for an appointment with a mental health provider and almost 60% waited longer than 10 days to see a psychiatrist.

In general, 41% of respondents reported waiting more than 15 days to see a specialist. For some specialties, including transition-related surgery care, a greater number

of respondents reported lengthy wait times. For example, 48% of respondents reported

that, in the past year, they had to wait longer than 10 days for a gynecology appointment,

with 30% reporting they had to wait longer than 15 days. Among respondents who had a

non-recurring endocrinology appointment in the past year, 39% had to wait longer than 15

days for an appointment. Finally, 72% of respondents seeking appointments with surgeons

for transition-related care waited longer than 15 business days.

In addition to regulating the timeliness of appointments, DMHC requires insurers to

"provide access to a primary care provider or a hospital within 15 miles or 30 minutes from

where enrollees live or work" (DMHC, 2020a). If they cannot do so, they must have an

alternate access plan approved by DMHC, the Department of Health Care Services (DHCS),

or the Department of Insurance (DOI)—whichever agency regulates their plan. During the

2018 #Out4MentalHealth Town Halls, particularly in rural areas, participants frequently

reported having to travel long distance to access affirming health care. This trend was

particularly pronounced among transgender participants.

Over 40% of CS respondents reported traveling long distances to see both physical

and mental health providers, including gynecologists, proctologists, therapists, and

psychiatrists. While approximately 40% of all respondents reported traveling farther than

30 minutes to see a counselor or therapist, several subpopulations reported issues in even

greater numbers: 52% of Latinx/Hispanic respondents reported traveling longer than 30

minutes and 58% of Rural respondents reported traveling longer than 30 minutes to see a

mental health provider.

In order to explore further the possible disparities that transgender individuals experience when trying to access care, the CS asked respondents: "In the past year, have you received gender transition-related mental or physical health care within California?" For those who stated "yes," the CS asked questions regarding travel to both general and transition-related health care services. This subgroup of respondents reported they traveled anywhere from 31 minutes to having trips that required an overnight stay in order to access services. Almost half (44%) of respondents had to travel farther than 30 minutes to see their primary care provider. Of these respondents, 16% of respondents reported traveling longer than an hour.

Network adequacy and provider shortages likely have a big impact on LGBTQ health disparities. Other studies have found that high numbers of LGBTQ people delay medical care, despite having health insurance. Long wait times and long distances traveled pose a major barrier to accessing needed health care. These barriers are especially challenging for those LGBTQ people who do not have access to reliable transportation or whose jobs do not provide time off for appointments.

Recommendations

Addressing LGBTQ mental health inequities means we have to address barriers to health care access in general. The following are #Out4MentalHealth's recommendations as

to how the state can improve access to LGBTQ-affirming health care and address health inequities.

- Having health insurance is important to ensuring access to health and mental health care. The number of LGBTQ people with health insurance coverage has improved with the implementation of the ACA and 100% coverage is an attainable goal in the short-term. To achieve full coverage of all LGBTQ Californians the state should:

- Expand Medi-Cal to include all income-eligible Californians, including undocumented immigrant adults.

- Provide greater affordability assistance through Covered California to help low- and middle-income Californians pay for health insurance. The CS found that the cost of health care continues to be the greatest barrier for people who are currently uninsured. Providing premium assistance, and lowering or providing assistance for cost-sharing, will help LGBTQ Californians access needed health care.

- Support LGBTQ employment programs, such as Transgender Economic Empowerment Programs, to ensure that more LGBTQ Californians are fully employed. The CS found that employer-sponsored insurance was the largest type of health coverage for LGBTQ respondents. High levels of unemployment or underemployment threaten LGBTQ Californians' ability to access health care.

- California must improve the quality of health insurance by strengthening mental health parity.

- Clarify the definition of parity to ensure Californians have access to mental health care regardless of the plan in which they are enrolled.

- Enhance enforcement of mental health parity requirements. This includes regular monitoring of compliance with requirements, improve transparency about mental health coverage, and strengthen corrective action plans and penalties for non-compliance with mental health parity requirements.

- Provide public education for consumers about mental health parity policies. The CS found that many people do not know the extent to which their health insurance covers mental health services. Mental health coverage should be transparent and easily accessible for consumers, and more work needs to be done to increase awareness of the availability of these services.

- To further increase accessibility of mental health services, state and local governments must work together to increase the number of LGBTQ-affirming providers.

- At the state level, this means ensuring the Workforce Education and Training (WET) funds include equity measures. These can range from ensuring that providers from historically underserved communities, such as LGBTQ communities, are prioritized for loan repayment programs, to implementing

requirements that all funded programs demonstrate LGBTQ cultural competency as a requirement to receive funding.

- At the local level, counties should use WET and other funds to provide LGBTQ cultural competency trainings for their county and contracted mental health providers. Counties should identify LGBTQ knowledgeable individuals, both on staff and within the community at large, who can provide trainings and ongoing technical assistance for continuous improvement in the quality of LGBTQ mental health care.

- Partner with LGBTQ-serving organizations to provide on-site mental health services, support mental health workforce training for LGBTQ people with lived experience, and fund community-defined practices to address LGBTQ mental health.

- Increase support for LGBTQ knowledgeable Peer Support Specialists, who fill important gaps in providing mental health services.

- Increase funding statewide for mental health workforce development programs.

- Increase enforcement of network adequacy regulations, as they relate to accessing mental health providers and counselors.

- Enhance network adequacy protections to ensure that health plans contract with available LGBTQ-affirming providers.

BARRIERS TO

MENTAL HEALTH SERVICES

"I **cannot afford** the mental health services that I want or need."

Barriers to Mental Health Services

One of the original goals of the Mental Health Services Act (MHSA) was to increase access to mental health services (California Department of Mental Health, 2005). In 2012, research from the California LGBTQ Reducing Disparities Project identified a number of barriers to accessing mental health services experienced by LGBTQ respondents (Mikalson et al., 2012). Respondents to the CS were offered the same list of barriers identified from the 2012 research, as well as additional barriers identified during the #Out4MentalHealth Town Halls and Round Tables in 2019. This section discusses the desire for mental health services, and the barriers to accessing mental services for LGBTQ respondents.

Wanting Mental Health Services

Respondents to the CS were asked, "Within the past year, have you wanted mental health services?" Almost three-quarters of CS participants (73%) answered "yes" to this question. For some subgroups, the rates were even higher:

- GQNB: 85%

- Transgender: 84%

- Pansexual: 83%

- Bisexual: 81%

Respondents who reported they had wanted mental health services were then asked what services or support had they needed or wanted in the past year. The top service chosen was "Individual Counseling/Therapy," with almost all (95%) indicating they had needed or wanted this in the past year. Unfortunately, close to half (44%) who wanted or needed this service reported they did not receive it. Below are the top six mental health services or supports CS participants as a whole reported they wanted/needed in the past year, but did not receive.

Services Wanted in the Past Year, but Not Received

- Individual Counseling/Therapy.

- Peer Support Group (in-person or online).

- Western Medical Intervention (e.g., medication such as antidepressants, hormone treatment, etc.).

- Couples/Family Counseling.

- Counseling/Therapy or Other Services Directly Related to a Gender Transition.

- Group Counseling/Therapy.

There was also one distinct difference for the Trans Spectrum subgroups. "Counseling/Therapy or Other Services Directly Related to a Gender Transition" was the #1 and #2 service wanted/needed, but not received by the Transgender subgroup and GQNB subgroup, respectively. Almost two-thirds (61%) of Transgender and nearly three-quarters

(74%) of GQNB respondents who reported wanting/needing this service, were not able to access it.

General Barriers

CS participants were given a list of barriers individuals may face when wanting mental health services or support. They were asked to indicate whether each item on the list had been a barrier for them in the past year. Participants could respond to each item as: "Not a barrier," "Sometimes a barrier," or "Always a barrier." For this report, the barriers have been ranked first by frequency for the category "Always a barrier," and then with the frequencies for the categories "Sometimes a barrier" and "Always a barrier" combined.

With the exception of Youth (12-17), the top "Always a barrier" for all subgroups, as well as the sample as a whole, was, "I cannot afford the mental health services that I want or need." This was also the top barrier when combining "Sometimes a barrier" and "Always a barrier." For Youth, the top barrier in both lists was, "I feel ashamed to seek out mental health services." Below are the top six general barriers participants reported facing in the past year by "Always a Barrier" and then by "Sometimes" and "Always a Barrier" combined. The ranking is from the entire sample.

Always a Barrier

- I cannot afford the mental health services that I want or need.

- I feel ashamed to seek out mental health services.

- The wait time to be seen by a mental health service provider was too long.

- I am concerned that my mental health care will not be kept confidential.

- I do not have transportation to mental health services.

- I had a harmful or traumatic experience in the past with mental health services.

Sometimes & Always a Barrier

- I cannot afford the mental health services that I want or need.

- The wait time to be seen by a mental health service provider was too long.

- I feel ashamed to seek out mental health services.

- The provider hours did not work with my schedule.

- I am concerned that my mental health care will not be kept confidential.

- The mental health services I need are offered too far away for me to get to.

In addition to the "Sometimes & Always a Barrier" list, certain subgroups reported different barriers and rates than the sample as a whole. Notably, Rural and Superior Region subgroups indicated "There are no mental health services in my neighborhood/on my reservation" as ranking #2 and #3, respectively. For the Older Adult subgroup, "I was not eligible for the services I need/want" and "I have chronic physical health problems which limit my ability to access services" tied at the #3 ranking. Finally, five subgroups indicated, "I

had a harmful or traumatic experience in the past with mental health services" as one of their top six barriers. These included the Emerging Adult, Adult, Transition-Age Older Adult, and Queer subgroups, as well as respondents specifically residing in the Bay Area Region.

LGBTQ minors obviously have less personal agency and access to resources, particularly if they do not have parental support for their identities. This may explain why Youth (12-17) participants in the CS survey reported different barriers and/or had a different ranking than the sample as a whole. Below are the top six "Always" and "Sometimes" barriers for Youth ranked in the order of "Always a barrier":

Barriers for Youth (12-17)

- I feel ashamed to seek out mental health services.

- I am concerned that my mental health care will not be kept confidential.

- My parent(s) / guardian(s) will not give permission for me to have mental health services.

- There are no mental health services at my school / college.

- I cannot afford the mental health services that I want or need.

- I do not have transportation to mental health services.

LGBTQ-Specific Barriers

LGBTQ people not only experience similar barriers to seeking services as heterosexual cisgender people, they also experience LGBTQ-specific barriers directly related to their sexual orientation and/or gender identity. With the exception of Youth (12-17), the top "Always a Barrier" for all subgroups, as well as the sample as a whole, was: "I do not know how to find a mental health service provider that is LGBTQ competent." For Youth, the top barrier was: "I am afraid that my sexual orientation or gender identity will not be kept confidential." Below are the top six LGBTQ-specific barriers participants reported experiencing in the past year by "Always a Barrier" and then by "Sometimes" and "Always a Barrier" combined. The ranking is from the entire sample.

<div align="center">

Always a Barrier

</div>

- I do not know how to find a mental health service provider that is LGBTQ competent.

- (ranked equally)

  - I am concerned that my provider would not be supportive of my LGBTQ identity or behavior.

  - I cannot find a provider I am comfortable with who is also LGBTQ knowledgeable.

- I am afraid that my sexual orientation or gender identity will not be kept confidential.

- I am concerned that my provider would not be supportive of my LGBTQ identity or behavior.

- There are no LGBTQ knowledgeable mental health services in my neighborhood / on my reservation.

Always & Sometimes a Barrier

- I cannot find a provider I am comfortable with who is also LGBTQ knowledgeable.

- I do not know how to find a mental health service provider that is LGBTQ competent.

- I am concerned that my provider would not be supportive of my LGBTQ identity or behavior.

- There are no LGBTQ knowledgeable mental health services in my neighborhood / on my reservation.

- There are no LGBTQ knowledgeable mental health services at my school / college.

- I am afraid that my sexual orientation or gender identity will not be kept confidential.

Almost all subgroups had the same LGBTQ-specific barriers for "Sometimes" and

"Always a Barrier" combined, although they sometimes fell in a different order. The one

exception is that the Emerging Adult, Adult, and Transition-Age Older Adult subgroups

included, "Several of the 'out' providers I would visit are in the same social circle as me (e.g.,

attend the same social events)" as one of their top six LGBTQ-specific barriers.

SUICIDE

78%

of those 12 to 24 have ever considered suicide.

Family, societal, and religious pressure may encourage parents to take actions which are ultimately harmful to their LGBTQ child out of a misguided belief these actions are protective. **Parents need to be educated what actions are harmful**, and which are helpful, to raising a mentally healthy LGBTQ child.

Suicide

Research has shown that LGBTQ people are more likely to consider, plan, and/or attempt suicide than their straight and cisgender counterparts (Almeida et al., 2009; Russell & Fish, 2016). The primary reason for this increased likelihood is that LGBTQ people are exposed to a number of minority stressors related to their sexual orientation and/or gender identity, including family rejection, prejudice, discrimination, and violence. These stressors can create or exacerbate feelings of social isolation, anxiety, and depression, leading to increased thoughts of, planning, and attempting suicide (Almeida et al., 2009; Movement Advancement Project [MAP], 2017; Russell & Fish, 2016). In addition, LGBTQ people are not one monolithic community and, therefore, many individuals experience simultaneous layers of intersectional oppression (both within and outside LGBTQ communities), such as racism, heterosexism, cissexism, ableism, sexism, and others. These additional experiences of oppression and minority stress further create and/or exacerbate negative mental health outcomes, including thoughts of, planning, and attempting suicide (McConnell et al., 2018).

The CS sought to better understand the current experience of suicide behaviors among LGBTQ Californians and asked respondents a series of suicide related questions. All respondents were asked: *Have you ever considered suicide?* Anyone who answered "yes" to this question were then asked the following additional questions:

- Have you considered suicide in the past year?

- In the past year, did you ever make a suicide plan?

- In the past year, how many times did you attempt suicide?

- If a respondent reported at least one attempt: Did any attempt result in injury, poisoning, or overdose that had to be treated by a doctor or nurse?

- Did you seek out any type of mental health services or support _before_ your most recent experience of considering or attempting suicide?

- Did you seek out any type of mental health services or support _after_ your most recent experience of considering or attempting suicide?

The remainder of this section outlines key findings from these questions.

Have You Ever Considered Suicide?

When asked, "Have you ever considered suicide?" 70% of all CS respondents, and 67% of those 18 and older, answered "yes." For comparison, the 2018 California Health Interview Survey (CHIS) found that "only" 13% of Californians 18 and older indicated they have ever considered suicide (UCLA Center for Health Policy Research, 2018). More concerning than the 70% rate for the general CS sample are the even higher rates among specific CS subgroups, including Pansexual (84%), Trans Spectrum (83%), and Rural (80%) respondents. Figure 19 identifies all the CS subgroups that reported the highest rates of ever considering suicide.

Figure 19. Subgroups: Highest Rates of "Ever Considered Suicide"
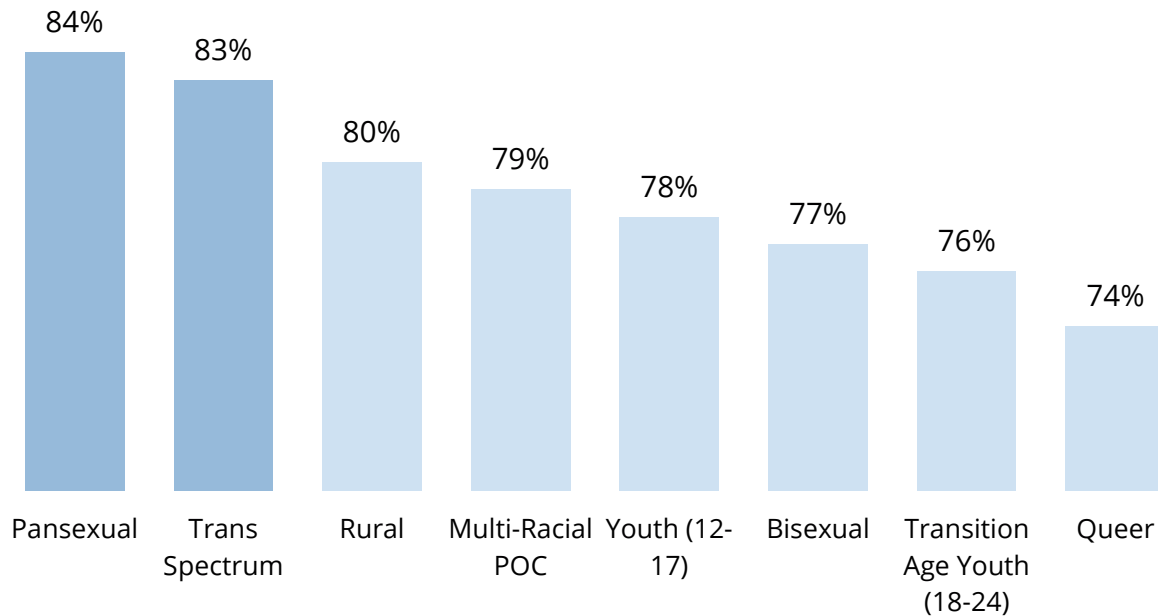
For the remainder of this section, the reader should keep in mind that the findings reported below are from the subsample who answered "yes" to the question: "Have you ever considered suicide?" and not from the entire CS sample.

Considering, Planning and Attempting in the Past Year

Over half (57%) of CS respondents who had ever considered suicide, indicated they had considered suicide in the past year. In addition, almost a quarter (24%) reported making a suicide plan, and 17% attempted suicide at least once in the past year (see Figure 20).

Figure 20. Respondents Suicide Behaviors in the Past Year
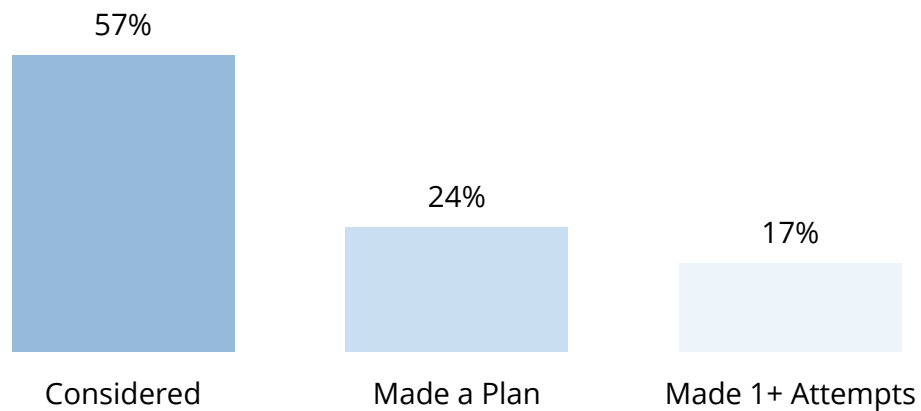
Sexual Orientation. Figure 21 shows rates of considering, planning, and attempting suicide within the past year by identified sexual orientation. Pansexual and Bisexual respondents reported higher rates of considering suicide, making a suicide plan and attempting suicide in the past year when compared to both the overall CS sample and other sexual orientation identities.

Figure 21. Respondent Rates of Suicide Behavior in the Past Year by Sexual Orientation
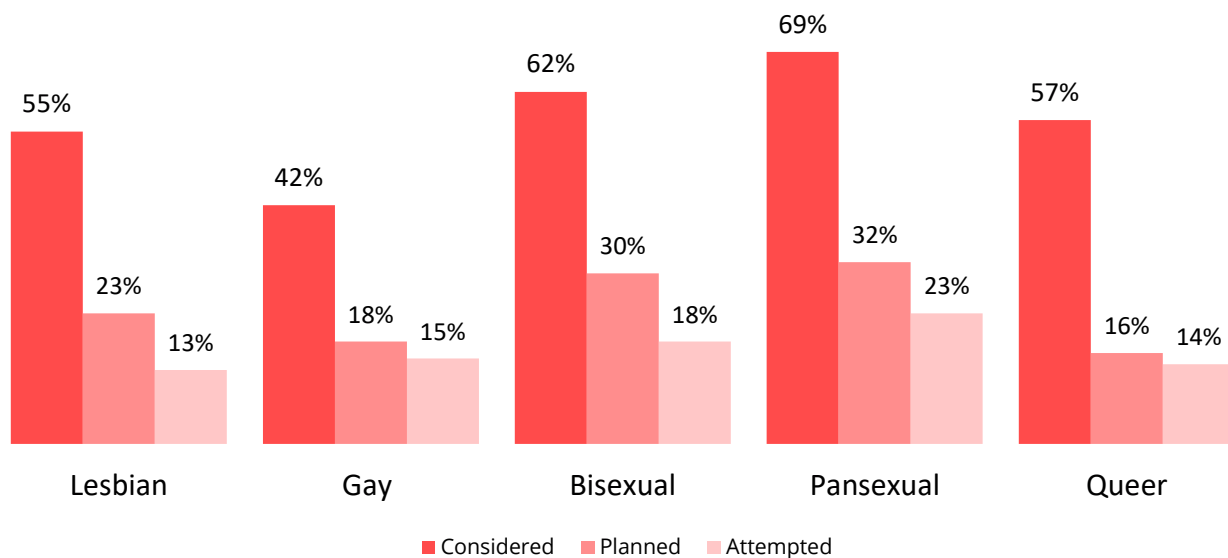
Gender Identity. Consistent with previous research (Haas et al., 2014; Virupaksha

et al., 2016; Toomey et al., 2018), Trans Spectrum respondents reported higher rates than

LGBQ Cisgender respondents of considering suicide (66% vs. 48%), making a suicide plan

(29% vs. 19%) and attempting suicide one or more times (22% vs. 12%) in the past year. The

Trans Spectrum subgroup was analyzed further by looking at Genderqueer/Nonbinary

(GQNB) respondents as a separate subgroup from (binary) Transgender respondents. As

Figure 22 shows, GQNB respondents were more likely than Transgender respondents to

have considered suicide in the past year, although Transgender respondents did report

comparatively higher rates of planning and attempting suicide. These findings suggest that

LGBTQ suicide prevention efforts need to focus on both Transgender and GQNB

individuals.

Figure 22. Respondents Considering, Planning and Attempting
Suicide in the Past Year by Gender Identity
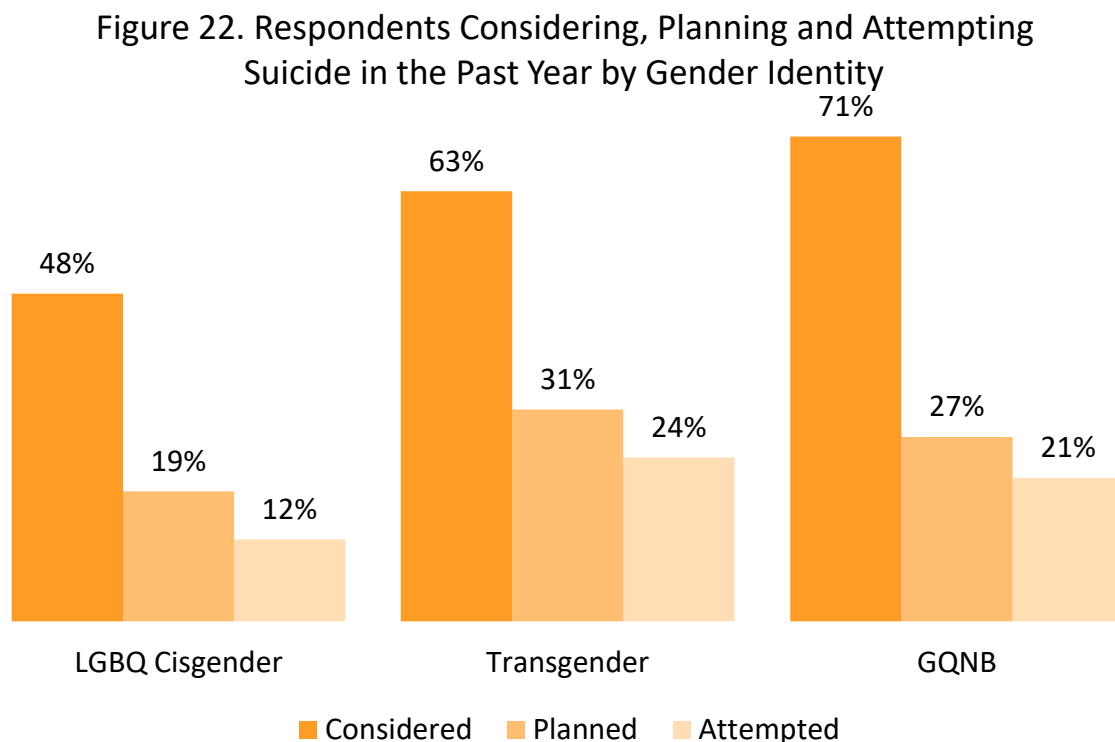
Urban vs. Rural. Research has found that people living in rural areas have higher

rates of suicide due to geographic isolation, declining economic opportunities, mental

health stigma and a lack of access to mental health services (Clay, 2014). These issues are

amplified for LGBTQ rural residents who may face higher levels of sexual orientation

and/or gender identity discrimination and victimization compared to their urban

counterparts (MAP, 2019). In addition, rural LGBTQ people often have less access to LGBTQ

support services. CS findings suggest that LGBTQ Rural individuals are at much higher risk

for suicide behaviors than their Urban counterparts (see Table 8).

| Table 8. Suicide Behaviors in the Past Year - Rural & Urban Respondents		
In the past year have you...	**Rural**	**Urban**
Considered suicide	68%	56%
Made a suicide plan	31%	23%
Attempted suicide	26%	16%

Race/Ethnicity. As previously discussed in the *Racism and Heterocissexism* section of

this report, QTPOC experience simultaneous systemic oppressions, such as racism,

heterosexism, and cissexism, that have negative impacts on their well-being and mental

health (Balsam et al., 2011; Meyer, 2010). In the CS, both Monoracial POC and Multiracial

POC respondents reported higher rates of considering, planning and attempting suicide

within the past year than did Monoracial White respondents (see Figure 23). The findings

also suggest that Multiracial POC respondents are more likely to consider suicide in the

past year. According to Johnston & Nadal (2010), multiracial POC individuals may

experience further mental health stressors due to monoracism,[13] multiracial

microaggressions, and traditional racism that serve to invalidate their racial identity.

Essentially, they may receive messages that "being multiracial is substandard or different"

(p. 127).

---

[13] Monoracism refers to a social system of psychological inequality where individuals who do not fit monoracial categories may be oppressed on systemic and inter-personal levels because of underlying assumptions and beliefs in singular, discrete racial categories (Johnston & Nadal, 2010)

Figure 23. Considering, Planning and Attempting Suicide in the
Past Year by Race/Ethnicity Subgroups.
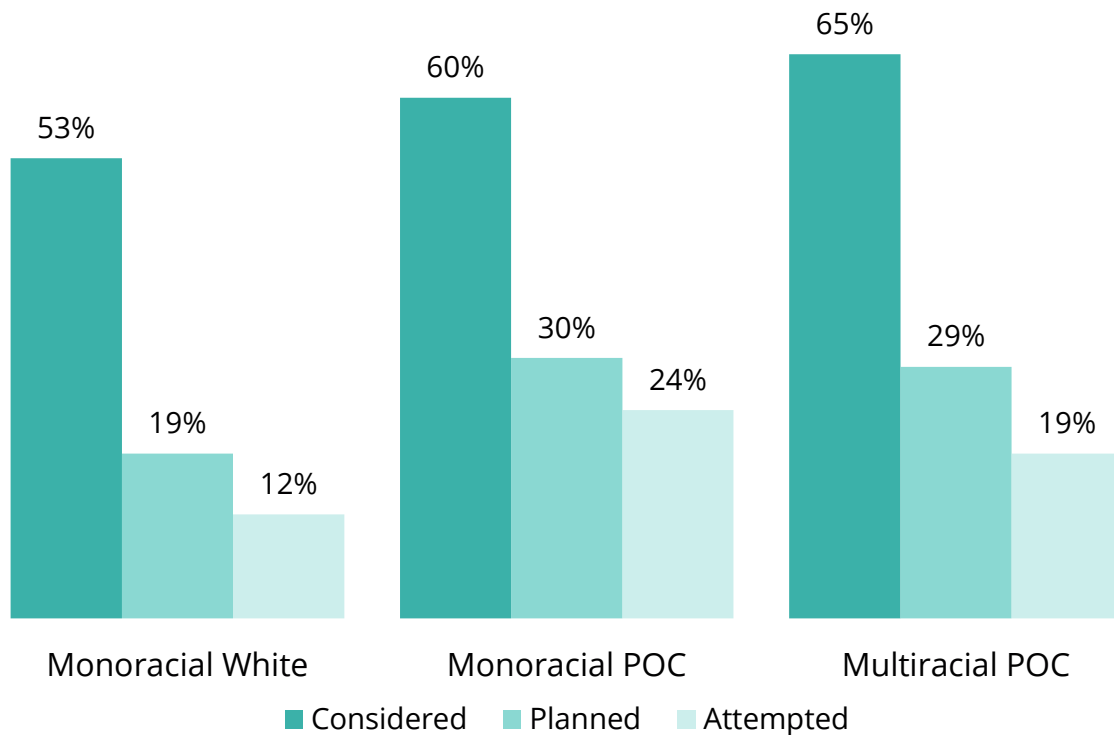
Age. There is a wealth of research showing that LGBTQ youth are generally at higher

risk for suicide behavior than their heterosexual counterparts. The youth and young adults

responding to the CS were no exception. LGBTQ Youth (12-17), Transition Age Youth (TAY;

18-24), and Emerging Adult (25-34) respondents were more likely to have considered,

planned and attempted suicide in the past year compared to respondents who were 35

years or older. Alarmingly, 79% of Youth (12-17) reported they had considered, 43%

reported they had made a plan, and 29% reported they had attempted suicide at least once

in the past year. These rates are much higher than all other age groups (see Figure 24).

As mentioned above, CHIS found in 2018 that 13% of Californians 18 years and

older indicated ever considering suicide (UCLA Center for Health Policy Research, 2018).

Further, results of the 2017 National Survey on Drug Use and Health indicated that .06% of

American adults (18 years and older) made at least one suicide attempt in the past year.

Finally, the 2017 Youth Risk Behavior Survey (YRBS) found that 7.4% of youth in grades 9-12

reported that they made at least one suicide attempt in the past year. While these studies

are not completely comparable, findings from the CS strongly suggest that LGBTQ

individuals across the age spectrum have significantly higher rates of considering, planning

and attempting suicide than the general population.[14]

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[14] Note: questions across surveys may be asked differently. The subsequent State and National data referred to in this section only reflects those surveys with questions most closely matching those asked in the CS.

Figure 24. Considering, Planning and Attempting Suicide
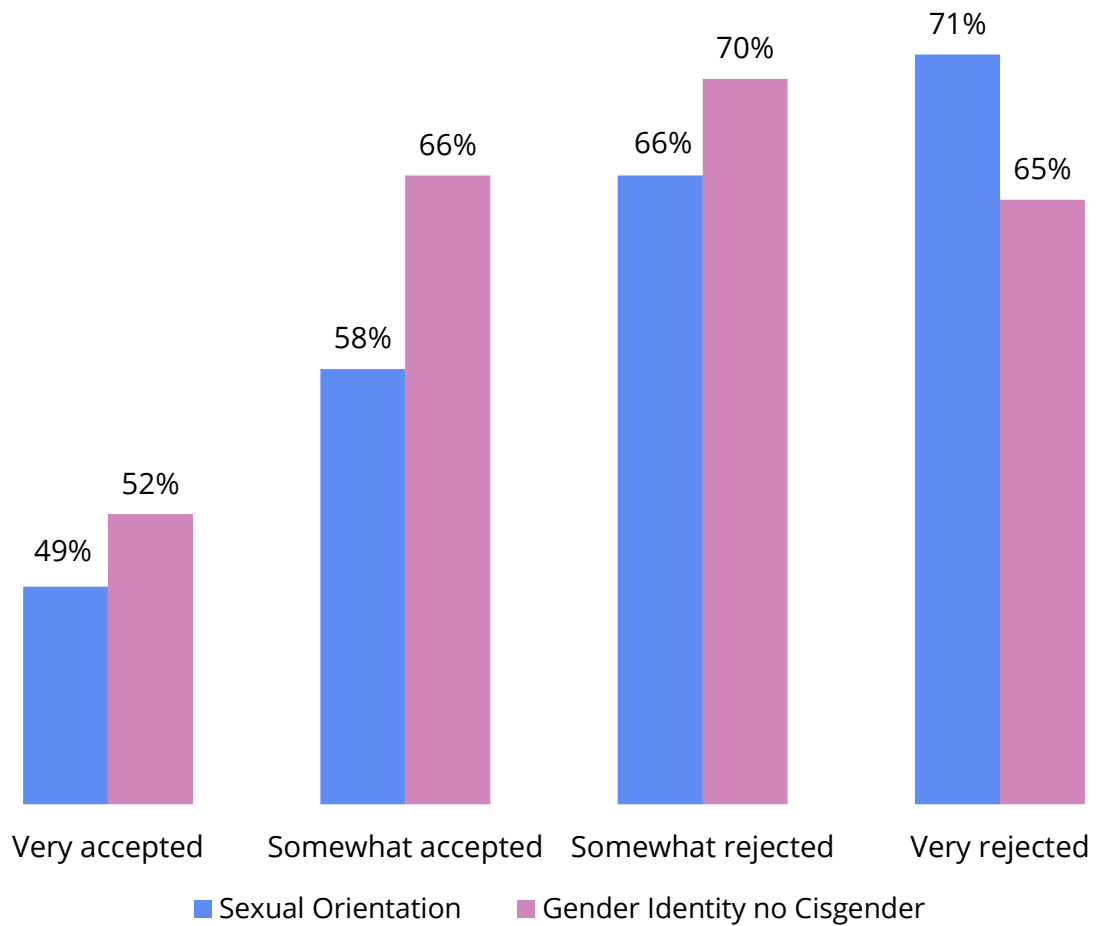in the Past Year by Age
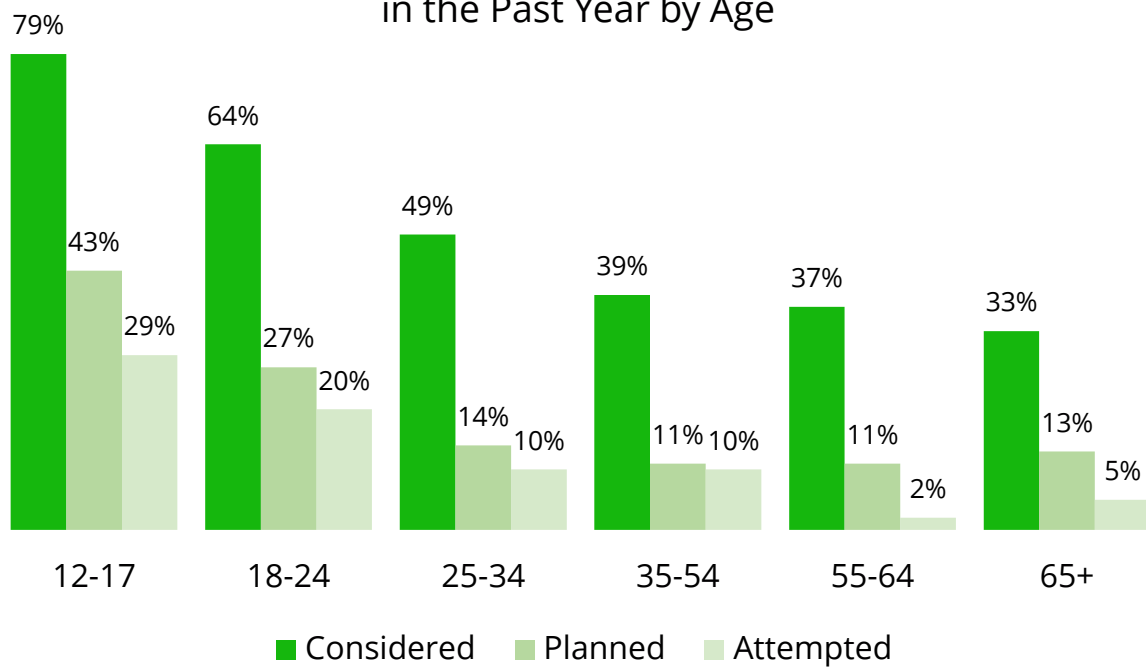
Family rejection. Research has documented that LGBTQ youth who experience

high levels of family rejection are more likely to have negative mental health outcomes,

including an 8 times higher rate of suicide attempts than LGBTQ youth who experience

little to no family rejection (Ryan, 2009). With this in mind, CS findings were analyzed by

reported degree of family acceptance or rejection for all CS respondents who indicated

they had considered suicide in the past year. Figure 25 shows the percentage of

respondents who considered suicide in the past year also experienced family rejection.

When analyzed by sexual orientation, the trajectory is in alignment with previous research.

In other words, those who reported higher degrees of family acceptance also had lower

rates of considering suicide in the past year (49%) than those who reported higher degrees

of family rejection (71%). This suggests that, across the age spectrum, family rejection

places LGBQ individuals at higher risk for considering suicide.

The trajectory for Trans Spectrum respondents, however, looks very different. What

remains similar to the sexual orientation findings is that Trans Spectrum respondents who

experienced greater family acceptance also reported lower rates of considering suicide in

the past year than those who experienced less family acceptance and greater family

rejection. Nonetheless, the remaining trajectory is somewhat level, with a slight peak (70%)

for those who reported their family of origin was "somewhat rejecting." Note, also, that

those who reported "somewhat accepting" and those who reported "very rejecting" families

had similar rates of considering suicide in the past year (66% and 65% respectively). These

findings suggest that, for Trans Spectrum individuals, any amount of family rejection—

including only minimal acceptance—creates a similar (rather than increasing) risk of

considering suicide.

Figure 25. Ever Considered Suicide by Degree of Family
Acceptance or Rejection

Needing medical attention. Respondents who reported at least one suicide

attempt in the past year were asked: "Did any attempt result in injury, poisoning, or

overdose that had to be treated by a doctor or nurse?" A little over a quarter of these

respondents (27%) indicated at least one of their attempts required medical treatment. The

subgroup reporting the highest rate of needing medical attention for attempts made in the

past year were Veterans (75%), although the sample was relatively small. Other subgroups

reporting higher rates of needing medical treatment were Adult (53%), Emerging Adult

(44%), and Rural (44%).

Although only 15% of Youth (12-17) respondents reported needing treatment by a

doctor or nurse for at least one attempt in the past year, this finding is still concerning—

particularly when compared to their heterosexual counterparts. For example, the YRBS is

given to high school students every other year. Although it is not a direct comparison to the

CS, the YRBS findings are disaggregated by state and include findings by sexual orientation.

Results from the 2017 YRBS found that only 2.5% of heterosexual students in California

required medical attention for a suicide attempt within the past year, as compared to 8% of

LGB-identified students. These findings suggest that LGBTQ youth are at higher risk of

needing medical attention after a suicide attempt.

Seeking Mental Health Services Before and After a Suicide Attempt

The CS asked if participants sought mental health services before their most recent

suicide attempt. Less than half of all respondents (48%) who ever considered suicide

reported seeking mental services before their most recent suicide attempt. Rural

individuals reported the lowest rate (35%) of seeking mental health services prior to their

most recent suicide attempt, followed by Gay men (40%), Youth (40%), Transition Age Older

Adult (40%), and LGBQ Cisgender individuals (41%). The subgroups who reported the

highest rates of seeking care prior to their most recent attempt were Emerging Adult (55%),

Trans Spectrum (56%), and Queer individuals (60%).

The CS also asked participants if they sought mental health services after their most

recent suicide attempt. In this case, more than half of all respondents (60%) who ever

considered suicide reported seeking mental services after their most recent suicide

attempt. In fact, rates of seeking mental health care services *after* the most current attempt

had a reported increase for all subgroups. Those who reported the highest rates of seeking

services after their most current suicide attempt were the Queer (72%), Emerging Adults

(70%), and Transgender (69%) subgroups. The lowest rates of seeking services were

reported by those Questioning their Sexual Orientation (37%), Older Adults (45%), and

Youth (47%).

Recommendations

Results of the CS indicate that LGBTQ Californians are reporting high levels of

suicide behavior, both over their lifetime and in the past year. In addition, the rates of

seeking mental health services both before and after a suicide attempt are relatively low,

particularly considering the serious implications of an individual attempting suicide. The

following recommendations identify ways for increasing LGBTQ sensitive and culturally

affirming services to prevent suicide behavior—and increase well-being—across LGBTQ

communities.

Train Mental Health Service Providers

Mental health service providers must continue to receive and access training on LGBTQ issues, specifically the impact of minority stress and intersectional oppression. LGBTQ people do not comprise one monolithic entity. Rather, each person comes to treatment with their own experiences of minority stress and intersectionality. Mental health service providers in general, and at least those who specialize in working with LGBTQ clients, should be capable of addressing LGBTQ minority stressors, including heterosexism, cissexism, monosexism, trans-negativity, and religious exclusivism, as well as racism, sexism, classism, ableism, and ethnocentrism, which are pervasive in our society. Training should include a module on addressing one's own implicit biases that, directly or indirectly, contribute to continued marginalization of LGBTQ people. Providers should seek this training from professionals and not depend on their clients as educators.

Educate Parents About Family Rejection and Acceptance

As stated previously in this section, research has documented that LGBTQ youth who experience high levels of family rejection are more likely to have negative mental health outcomes, including an 8 times higher rate of suicide attempts than LGBTQ youth who experience little to no family rejection (Ryan, 2009). Research also indicates that family acceptance of LGBTQ youth can reduce negative outcomes (Ryan et al., 2010).

Most LGBTQ youth are raised by heterosexual and cisgender parents. These parents may have little to no positive knowledge regarding how to affirmingly raise an LGBTQ child. Family, societal, and religious pressure may encourage parents to take actions which are ultimately harmful to their LGBTQ child out of a misguided belief these actions are protective. Parents need to be educated what actions are harmful, and which are helpful, to raising a mentally healthy LGBTQ child. #Out4MentalHealth recommends that schools disseminate LGBTQ education resources to all parents at the same time other parent education resources are provided. In addition, school counselors should be well-versed in the needs of LGBTQ students, and be available as a resource to their families, if needed.

Collecting Sexual Orientation and Gender Identity (SOGI) Data

In 2017, 4,323 people died by suicide in California (California Department of Public Health, 2019). Under current California law, there is no requirement to collect or report sexual orientation or gender identity in the *California Electronic Violent Death Reporting System (CEVDRS).* Therefore, it is unknown how many LGBTQ individuals die by suicide in California each year. In addition, almost all of what is known about suicide behaviors in LGBTQ communities' concerns thoughts of suicide and suicide attempts, and is based on self-report.

#Out4MentalHealth recommends the legislature pass, and the Governor sign, a bill requiring the collection of SOGI data for the CEVDRS. Such a bill (AB 650) was introduced in 2019, but was placed on suspension. As stated in the bill, justifying the need for SOGI data:

"This data can be an effective tool to evaluate and develop appropriate prevention efforts,

and the data can facilitate the evaluation of state-based prevention programs and

strategies."

LGBTQ
REFUGEES
& ASYLUM
SEEKERS
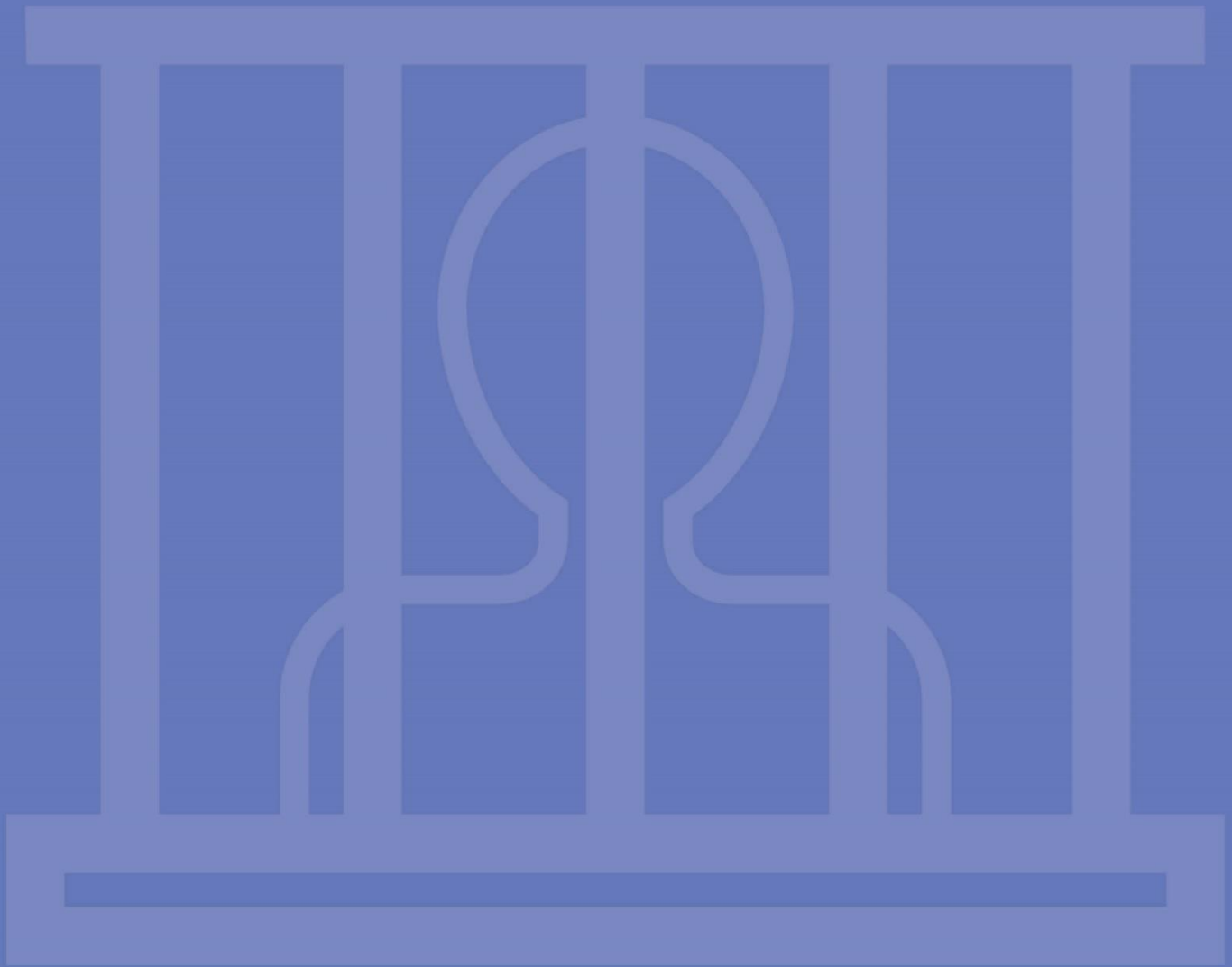
"There's a sense that this [severe depression] is environmental — or at least exacerbated by the detention center environment. You never hear about a history of mental illness, **but rather how horrible the detention centers are**."

LGBTQ Refugees and Asylum Seekers

People migrate to other countries for a variety of reasons and do so voluntarily or involuntarily. Some seek employment, education, or reunification with family. While others are displaced due to incredible violence, persecution, war, and human rights violations in their home countries (The UN High Commissioner on Refugees [UNHCR], 2019). In the United States, immigrants, non-immigrants, undocumented immigrants, refugees, and asylum seekers are distinct groups with different legal statuses:

- *Immigrants* are typically those who have been granted permanent residency either by obtaining a green card or becoming naturalized citizens.

- *Non-immigrants* are those who have obtained temporary approval to reside in the United States (e.g. student or work visa, etc.,).

- *Undocumented immigrants* reside in the United States but have not been granted the legal right to remain in the United States.

- *Refugees* have been granted asylum in another country and have been approved to resettle in the United States.

- *Asylum seekers* are people who seek asylum in the United States and who have not yet been granted protected status.

The experiences among these five groups differ considerably. A full discussion of these differences is beyond the scope of this report. Therefore, this section focuses on the

particular experiences of LGBTQ refugees and asylum seekers, as defined above, with

additional information on how the current political climate is impacting immigrants

generally.

In 2019, #Out4MentalHealth held a virtual Town Hall with advocates and providers

who have expertise and experience with LGBTQ immigrants, refugees, and asylum seekers

in California. Their input, as well as a review of the current literature, informs this section.

All quotes in this section are from the participants in the Refugees & Asylum Seekers Virtual

Town Hall.

"It's difficult to separate that experience of sexuality and the immigrant experience because they

can't actually be disentangled."

The Number of Refugees and Asylum Seekers Worldwide

UNHCR (2019) indicated that in 2018 there were over 70 million people displaced

worldwide, with two-thirds of them coming from five countries: Syria, Afghanistan, South

Sudan, Myanmar, and Somalia. Almost 26 million displaced people were refugees and

another 3.5 million were asylum seekers. A significant proportion of asylum seekers are

now coming out of Central America due to pervasive persecution, war, poverty and hunger

(Restrepo et al., 2019). Knowing how many of those seeking asylum are LGBTQ people is

challenging. This is partly due to failures of immigration officials to track the number of

those who have been granted asylum due to persecution for sexual orientation and/or

gender identity (Portman & Weyl, 2013; Tabak & Levitan, 2014; Gruberg et al., 2019). In

addition, LGBTQ asylum seekers and refugees may fear disclosing their sexual orientation

and/or gender identity to immigration officials for fear of further rights violations and

persecution based on their LGBTQ identity (Tabak & Levitan, 2014).

Why LGBTQ People Seek Asylum

Although there has been improvement in the treatment of LGBTQ people across the

world, many seek asylum due to threat of imprisonment, violence, or death due to their

sexual orientation and/or gender identity (Tabak & Levitan, 2014). Same-sex romantic or

sexual behavior is criminalized in more than 75 countries, with 13 of those countries

implementing the death penalty for those who are found guilty (LGBT Asylum Project,

2019).

Penalties for same-sex romantic or sexual behavior between men include

imprisonment (varying between 1 month to life in prison), physical punishment (e.g. lashes,

hard labor, etc.), fines, mandatory counseling, and banishment (Human Rights Watch,

2019). Same-sex behavior between women carries comparable punishments, although

often to a lesser degree. Similarly, transgender people in many parts of the world face legal

restrictions on gender identity and expression. As of June 2019, at least nine countries had

explicit laws criminalizing cross-gender expression (Human Rights Watch, 2019). Beyond

the criminalization of same-sex behavior and transgender expression, LGBTQ people

across the world also face violence and persecution within the larger society (Tabak &

Levitan, 2014). Many LGBTQ migrants have reported leaving their home country after

experiencing violence at the hands of neighbors, partners, or family (Human Rights Watch

2016; 2018a; 2018b). As a result, they migrate to countries with more affirming state

policies and environments.

Anti-Immigration Rhetoric and Policy in the United States

Refugees and asylum seekers, regardless of sexual orientation or gender identity,

are leaving violent and persecuting environments in the hopes of improving their lives.

Many believe that the United States will be a welcoming place for them, and that there are

benefits for settling here. Currently, however, anti-immigration rhetoric and policies are on

the rise under the Trump administration. As Town Hall participants stated:

"We always have to be in response mode. A tweet can change everything."

"The attacks by our [federal] government never seem to end"

In the past few years, the Trump administration has:

- Forcibly separated at least 2,608 children from their parents (ACLU, 2019).

- Expanded the detention of asylum seekers without expanding the capacity to adequately house and care for asylum seekers (Spagat & Merchant, 2019).

- Repeatedly threatened mass Immigration and Customs Enforcement (ICE) raids on immigrant communities (Bojorquez, 2019).

- Implemented discriminatory bans and extreme vetting on migrants from Muslim-majority countries (National Immigration Law Center, 2019).

- Continuously reduced the number of authorized refugee resettlements (Alvarez, 2019).[15]

- Established a new "third country rule," creating greater barriers to asylum seekers. [16]

- Proposed new changes to the *public charge* rule,[17] placing barriers to seeking needed services.

In addition, thousands of asylum seekers are being turned away at the southern border of the United States, and often forced to live for extended periods of time in Mexico while they wait for their asylum cases to be heard. For LGBTQ asylum seekers, having to

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[15] The Trump administration has currently set the number of authorized refugee resettlement at only 18,000 for 2020, and will only allow refugees to resettle where both state and local jurisdictions consent to receiving them. This the lowest number of refugee resettlement allocation in the history of the United States (Alvarez, 2019).

[16] The "third country rule" states that asylum seekers who pass through another country on their way to the United States *must* apply for asylum in that country—and be rejected by that country— before they are eligible to apply in the United States. This is the case even if they are in similar danger in the "third country" as they were in their country of origin (Williams, 2019).

[17] See "The fear of public charge" section for further information.

wait in Mexico or other countries may subject them to additional anti-LGBTQ harassment,

violence and persecution (Fry & Hennessy-Fiske, 2019). If they are not turned away, they

may be placed in detention facilities which are overcrowded, under serviced, and can place

them at additional risk of harm from both fellow detainees and staff (discussed further

below).

LGBTQ Identity & Persecution

The particular experiences of LGBTQ asylum seekers are extremely variable by

culture of origin, religion, sexual orientation, gender identity, as well as other factors.

LGBTQ individuals may face more hurdles, tasks, and barriers than their non-LGBTQ

counterparts when attempting to seek asylum in the United States. In addition, they may

face discrimination or rejection from fellow asylum seekers or from within their own

cultural community due to their sexual orientation and/or gender identity, as noted by

Town Hall participants:

"There was an LGBTQ cohort in the Caravan,[18] that had to split out from the main group due to

violence and harassment from the main group members."

---

[18] See: Romo (2018) for information on the LGBTQ caravan cohort.

"LGBTQ is very stigmatized 'back home.' There's a lot of scoffing and derogatory

language."

Seeking asylum is a complex process[19] which forces people into a position of proving they are at-risk for violence and persecution in their home countries. When an LGBTQ individual requests asylum based on LGBTQ persecution, they must prove two things: 1) their sexual orientation and/or gender identity, and 2) that they have a well-founded or reasonable fear of persecution in their home country because of their sexual orientation and/or gender identity.

Proving you are LGBTQ. The UNHCR includes LGBTQ identities under the heading of *particular social group* (PSG). A PSG is a group of people who share a common, immutable characteristic that the members of the group cannot or should not be required to change (UNHCR, 2003). But proving one is LGBTQ must include more than just self-identification, and depends on the attitudes and biases of the asylum adjudicator towards LGBTQ people. As Town Hall participants noted, who is being placed in adjudicator positions has changed for the worse:

---

[19] See: American Immigration Council (2018) for more information on seeking asylum in the United States.

"The asylum interviews at the border were traditionally held by experienced asylum

workers—but now the administration is sending workers from DC, who are not as

understanding."

LGBTQ asylum seekers may be asked to prove their LGBTQ identity by answering

questions about their sexual behavior (Turk, 2013), presenting a marriage certificate

proving they are in a same-sex marriage, affidavits from former partners proving a same-

sex relationship (Immigration Equality, 2015a), and/or providing evidence proving

membership in an LGBTQ organization (LGBT Freedom and Asylum Network, 2019).

Transgender asylum seekers must provide affidavits from doctors and mental health

professionals describing the individual's transition steps (Immigration Equality, 2015b).

These requirements are particularly difficult for those LGBTQ asylum seekers who, for the

very reasons they are seeking asylum, needed to hide their LGBTQ identity in their home

country (Turk, 2013).

Proving you are persecuted. After proving their LGBTQ identity, LGBTQ asylum

seekers must document how this identity will lead to persecution in their home country.

They must provide evidence of their country's anti-LGBTQ laws. In the absence of anti-

LGBTQ laws, then they must provide proof of official state sanctioning of, or unwillingness

to stop, anti-LGBTQ persecution (LGBT Freedom and Asylum Network, 2019). They must

also provide evidence that they are personally at risk. This may be more complicated for

some LGBTQ asylum seekers. For example, bisexual individuals may have difficulty proving

their risk of persecution if they are married to a different sex person. In this case, asylum

adjudicators may deny their claims for asylum simply because they do not (currently) have

a same-sex spouse—and therefore their risk for persecution is diminished (Immigration

Equality, 2015a). In addition, according to Immigration Equality (2015b), asylum

adjudicators may deny risk of persecution based on expected and stereotyped

appearances:

> If the applicant is a "flaming queen," it may be easier for the adjudicator to picture
>
> the applicant being gay-bashed on the street or abused by policemen than if the
>
> applicant looks like a professional athlete. If the adjudicator can't tell that the
>
> applicant is LGBTQ, the adjudicator may question how the applicant's compatriots
>
> could tell. (11 Immigration Basics: Challenging Asylum Cases, para. 15)

Detention for LGBTQ Asylum Seekers

"Mental health conditions should not be thought of as inherent to immigrants and

refugees, or even caused by [the experience of migrating,] but by the environment...in detention"

Unhealthy conditions. A 2019 report by the Office of the Inspector General of the

U.S. Department of Homeland Security (OIG) found immediate risks to the health and

safety of detained people including unsafe and unhealthy conditions of facilities (e.g., food

safety issues, dilapidated and dirty facilities, etc.), inadequate medical care, a lack of

outdoor recreation, and a lack of detainee access to clothing and hygiene items (Kelly,

2019). Participants in the Town Hall, some of whom have spent time in detention centers

for their work, provided additional details:

"LGBTQ asylum seekers were placed under the charge of the 'cops' and

were housed separately from others in the Caravan by sheriffs. They were

left in their cells 22 hours a day, while cishet[20] detainees [who were

housed elsewhere] had plenty of time outside...Some detainees in this

situation were on the verge of signing deportation papers just to escape

this environment."

A decent meal is only provided once a week, unless the person purchases more food [from

the Commissary] ... There is work available, but many can't work and the pay is extremely

low, so many live on scraps between their weekly meal. ...The food is often moldy and there

are maggots in the food."

"The detention centers are making money off of asylum seekers...they try to charge

detainees for everything...phone calls cost $20 for 6 minutes."

---

[20] *Cishet* is a term for people who are both cisgender and heterosexual

"Some people have been detained over 2 years in these conditions."

Overmedication. Of particular note, Town Hall participants spoke about people in detention being psychiatrically misdiagnosed and overmedicated on a regular basis. In addition, there is no follow through after a person is released, leaving many asylum seekers at risk for withdrawal and other negative physical and mental health outcomes.

"There was heavy medication used—you could hear it in their voices, they sounded drugged and it was difficult to understand them or for them to understand what was being said to them."

"There was something in their eyes...like they weren't really there."

"Misdiagnosis and very heavy meds to keep detainees docile."

"There is no support of medical transition plans after release for detainees who were given medications in detention."

Barriers to services.

"Being inside a detention center is the barrier."

One Town Hall participant noted that the local detention center has been making it more difficult for service providers to reach out to people in detention.

"Instead of just knowing a person's name, now you need to know their bunk number—which basically means they [the person in detention] need to contact the provider and know that services are available."

The participant went on to explain that bunk numbers can change more than once while a person is in detention, so even if a service provider is able to initially make contact, they may lose contact when the person is assigned a different bunk number. The detention center also created additional barriers to providing services once contact was made.

"The 2 hours outside their cells were not consistent, so it was very difficult to schedule appointments or services."

"You have to be very careful in the detention centers. You have to talk in code because there are

so many people around."

Abuse. LGBTQ asylum seekers face greater risks for abuse within detention facilities

than their straight and cisgender counterparts. They experience higher rates of

harassment, physical/sexual violence, isolation and solitary confinement, lack of

recognition of their identity, and other abuses (International Detention Coalition, 2016).

They may experience victimization from both detention center staff and fellow detainees.

In particular, transgender individuals in detention are frequently subjected to sexual abuse

and harassment. They are also frequently housed based on their birth sex, rather than

their gender identity, or are placed in solitary confinement, presumably for their own safety

(National Immigrant Justice Center, 2016). Trans women in immigration detention have also

reported many instances of invasive strip searches performed by male guards, which is in

violation of ICE's own 2015 Transgender Care Memorandum (Human Rights Watch, 2016).

Moreover, transgender individuals in detention often do not have access to transition-

related or other necessary medical care (Center for American Progress [CAP] & MAP, 2016).

Town Hall participants spoke of these and other abuses experienced by LGBTQ

people in detention. As mentioned earlier, LGBTQ people in detention were kept in their

cells for 22 hours out of the day, while their heterosexual and cisgender counterparts were

given much greater freedom. There are also media reports that LGBTQ asylum seekers in

detention are being put in solitary confinement after reporting incidents of sexual

harassment and assault (Moore, 2019). One Town Hall participant spoke about retaliation

by detention center guards:

> *"We've heard of officer retaliation, such as solitary confinement, used against lesbian and bi women and trans men on the pretense that they were organizing. They were also not allowed to hug or give comfort to each other—even though this was allowed for the cishet detainees."*

Solitary confinement can have severe impacts on one's mental health. Grassian (2006)

notes that such isolation can increase anxiety, hallucinations, paranoia, self-harm, and

nightmares in individuals with no prior mental illness. Town Hall participants were clear

that this, and all other facets of detention, were harmful to the mental health of LGBTQ

asylum seekers.

> *There's a sense that this [severe depression] is environmental—or at least exacerbated by the detention center environment... You never hear about a history of mental illness, but rather how horrible the detention centers are."*

> *"A lot of detainees were suffering from PTSD before detention and detention made it worse."*

Barriers Outside of Detention

Stigma and fear. Current anti-immigrant and marginalizing policies and tactics

create anxiety, despair and a mistrust of government among all immigrant communities

(Valle, 2019). Town Hall participants noted high levels of PTSD, depression, and anxiety

among LGBTQ refugees, asylees and asylum seekers,[21] yet they may not seek or accept

mental health care. Not only is there often stigma around seeking mental health services

within their ethnic community, but LGBTQ people may have experienced harmful mental

health care in their home country.

"There's stigma…especially because in some cultures mental health care is actually used against

LGBTQ people."

"There's a lot of mental health stigma and queer and trans stigma, so there's a cautiousness

about seeking mental health services because so many people have been taken advantage of in

their home countries or here."

---

[21] Asylees are those who have been granted asylum by the United States and are allowed to resettle. Asylum seekers are those who are still waiting for the United States to process their claim for asylum. If they are not in detention, then they are out on bond or parole. For information on bond and parole for asylum seekers, please visit https://www.humanrightsfirst.org/resource/parole-vs-bond-asylum-system

"Our communities fear being re-traumatized in care."

Wait lists and other barriers. LGBTQ refugees and asylees who choose to seek mental health services still face barriers. Town Hall participants pointed out the difficulties of navigating the system and finding a competent provider:

"Providers not understanding both queer and Latinx is a barrier."

"The need to shop around and have to spend a long time trying to find an appropriate provider—and then wind up on a long wait list...Lack of knowledge how to access appropriate services...They aren't able to leave work to seek services... and there's also often a language barrier."

"And then there are long wait lists and a continuing process of looking for that one provider who is culturally competent. There are issues of not knowing how to access services. We all know how disjointed the system is."

"There are obstacles to enrolling in county mental health. There was one person, for

instance, who had planned to be seen in [city #1] but had to enroll in [city #2] for counseling.

He got enrolled in services, but overall that process took a month with [agency] support. For

people without that support, and just arriving to the United States, it can be near impossible

to enroll in county services. There needs to be a system of support for people who

get out of detention."

The fear of public charge. The United States government defines a *public charge* as an

individual who is, or who may be expected to be, primarily dependent upon public

programs. The public charge test may be done by an immigration official at the time of

entry into the United States or when a person requests a change to their immigration

status. Not everyone entering the United States or applying for legal status is subject to a

public charge test. Those who are required to undergo the public charge test and do not

pass the assessment, are not allowed to enter the United States, or obtain legal residency if

they have already entered the country.[22] In October, 2019, the Trump Administration

greatly expanded the number of public programs that can be considered for the public

charge test. At the time of this writing, the United States Supreme Court has allowed the

changes to the public charge regulations to be implemented, despite that there are still

legal challenges pending court review. The Department of Homeland Security announced

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[22] See Puhl, Quinn, and Kinoshita (2018) for information on the public charge test including who is exempt.

that the new rule goes into effect on February 24, 2020 (Immigrant Legal Resource Center,

2019).

The proposed changes to the public charge assessment include:

- Adding public programs like Medicare/Medicaid, food Supplemental Nutrition

  Assistance Program (SNAP), and Section 8 housing vouchers to the list of

  considerations of public benefits usage;

- Redefining a public charge as someone who uses one or more of the above benefits

  for more than 12 months aggregate within a 36-month period (e.g. two benefits in

  one month counts as two months);

- Allowing the consideration of income, limited English proficiency, and physical and

  mental health conditions in the public charge test (National Immigration Law Center,

  2018).

Despite not applying to all immigrants—including refugees and asylum seekers—the

proposed changes to the public charge rule have led many immigrants in the United States

to question whether they can safely access public services without posing a risk to their, or

a family member's, immigration status and continued residency in the United States. Given

the issues and confusion surrounding the proposed changes to the public charge rule,

many immigrants therefore fear accessing public physical and mental health services.

Town Hall participants spoke about a "chilling effect" even before the new public charge

rules were announced, and the drop in using mental and physical health services by all immigrants, including refugees and asylum seekers.

"There are less [Latinx] patients coming in to receive services. People are afraid of accessing services, for physical or mental health, for fear of public charge. This even affects people with permanent residency who fear being deemed a 'burden on the U.S. government'."

"We've been hearing scary things like: 'Ok, if I seek services, will it affect my pursuit of documentation, services, or jobs down the road?'"

"I fear for my trans women community members in this climate. Living at the intersection of LGBTQ, immigrant, and person of color, there are layers of fear to interacting with government at any level."

Recommendations

"I wish the system was prepared to care about this population."

"Providing support to one asylum seeker takes a village; for a group of asylum seekers it takes a city."

"Having a network of agencies to support the person is the best strategy for asylum

seekers/refugees. Sending someone to legal services is not the end of the story."

When asked what can be done to support LGBTQ immigrants, refugees, and asylum

seekers, Town Hall participants offered a number of recommendations, including:

1. Expand Medi-Cal to *all* undocumented people, including adults over the age of 25.

2. Remove barriers to accessing services for undocumented immigrants, including fear

    of detention or deportation.

    "A model that could offer anonymity and *consistency of care would be great!"*

3. Provide education to immigrant, refugee, and asylee communities to help combat

    mental health stigma.

4. Eliminate detention for LGBTQ asylum seekers, if not all asylum seekers.

5. Find sponsors for LGBTQ asylum seekers and support sponsors in their work.

"When an individual is in detention, a way to get out is to have a sponsor. The ability to

stay with LGBTQ community members is much more welcoming."

"Sponsors need support and should be provided with a network of services for the person they

are sponsoring."

- Individuals should consider sponsoring a detained asylum seeker who is

    eligible for bond or parole.[23]

- If sponsorship is not a viable option, individuals should consider supporting

    sponsors in their commitment. This could be through financial donations,

    social support, or legal assistance.

For more information on sponsoring asylum-seekers or their sponsors visit:

- **Freedom for Immigrants**

    freedomforimmigrants.org/sponsor-freedom

- **Asylum-Seekers Sponsorship Project**

    asylumsponsorshipproject.org

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[23] Sponsors are United States citizens and legal permanent residents who are willing to provide food, shelter, clothing, medical care, legal support to asylum seekers for at least six months to one year (Asylum-Seekers Sponsorship Project, 2019).

LGBTQ SEX WORKERS

"You either get into your job **because you chose it** [or like] most people in every kind of job, which is that you get into this work by circumstance, and that it was the **best opportunity you had in the moment**."

LGBTQ Sex Workers

Sex work is the exchange of sexual services for money or goods, including food, transportation, and lodging. There are many types of sex work, including street sex work, escort services, porn films, stripping, performing over web cam, and gogo dancing. Sex workers can be subject to criminalization, abuse, harassment and stigma due to a lack of sex positive cultures and negative perceptions about the legitimacy of the work. The stigma related to sex work is pervasive; much of which is rooted in a paternalistic desire to protect people, historically female identified people, from exploitation (Wahab, S., 2002).

With the biased idea that all sex workers are victims, societies have historically taken an abolitionist perspective by enacting laws to regulate or ban all forms of the sex commerce in one way or another, albeit different laws exist for different types of sex work. For example, in the United States stripping and dancing are usually allowed (although there is still stigma) but are highly regulated (e.g., establishing the age at which one can either work at or attend such venues). Similarly, participating in the adult film industry is legal for those over age 18. On the other hand, exchanging sex acts for money in private (such as street sex work) is banned in most of the United States (only Nevada offers a partial exception).

Due to both the criminalization and stigma of sex work many sex workers remain underground and conceal the type of work they do (Weitzer, 2018). Therefore, it is unknown exactly how many sex workers there are in the United States. In addition, much

of the research conducted about sex workers relies on convenience samples from jails,

clinics and treatment programs. Further complicating the issue is that sex work is often

conflated with sex trafficking making the data gathered even less reliable (Sawicki, et al.,

2019). Even less is known about the number of LGBTQ sex workers, or about LGBTQ sex

workers in general.

In Town Halls and Round Tables that #Out4MentalHealth held across California in

2018, participants frequently expressed concern about the health and well-being of sex

workers, including LGBTQ sex workers. They also expressed concern for the continued

criminalization of sex work, particularly in light of the Federal legislation: *Stop Enabling Sex*

Traffickers Act and *Allow States and Victims to Fight Online Sex Trafficking Act*, frequently

referred to as SESTA-FOSTA. The below comments were previously included in *Mapping the*

Road to Equity: The Annual State of LGBTQ Communities (O'Brien et al., 2018, p. 28).

"The fact they took ads off Craigslist and Backpage puts our communities at risk,

especially trans women and people who don't have documentation.

This is making sex work more dangerous by pushing people back out onto the streets."

"Sex workers are being forced back into street-based sex work.

It increases the risk of violence, criminalization, [and] police surveillance."

In light of community concern for the well-being of sex workers and to expand on the #Out4MentalHealth recommendation to decriminalize sex work in California (O'Brien et al., 2018), #Out4MentalHealth staff members held a virtual Town Hall in 2019 with LGBTQ sex workers to learn about their own experiences and needs. The following section discusses the particular experiences of LGBTQ sex workers, their mental health, issues relevant to their lives, and their recommendations for supporting sex worker health and well-being.

Current literature on sex workers in general, and LGBTQ sex workers specifically, is scarce. Therefore, this section only includes a review of current literature where it was publicly available. Quotes in this section are from participants who attended the Sex Worker Virtual Town Hall.

Reasons for engaging in sex work

"You either get into your job because you chose it…[or like] most people in every kind of job, which is that you get into this work by circumstance, and that it was the best opportunity you had in the moment."

Societal perceptions of sex work in the United States continuously assumes that people enter the sex trade involuntarily. Yet, participants in the Town Hall noted that people enter sex work for a variety of reasons, many of which are consistent with why people enter into mainstream economies. They explained that sex workers enter the

profession due to economic need and opportunity, from invitations by community

members, friends, and role models, intimacy and fun, schedule flexibility, pursuit of social

justice, and self-esteem.

"I got into sex work because it was fun for me. We enjoyed the intimacy and connection that we

have, and it was an opportunity to showcase a body and a type of person that we don't typically

see in traditional porn. I saw so much porn and none of it showed healthy portrayals of sex that

wasn't cishet,[24] or positive."

Many people enter sex work because it can be a profitable industry with flexible

hours and can also provide time for other endeavors, like raising children, going to school,

or holding another job. Others enter the profession because they are pushed out of

mainstream economies due to discrimination and harassment, leaving them with

increasing risks for poverty and homelessness. Employment protections for LGBTQ people

are inconsistent depending on geography. As of this writing, 26 states have no specific laws

prohibiting discrimination based on sexual orientation or gender identity (Movement

Advancement Project, n.d.). The lack of employment protection creates economic insecurity

and poverty as LGBTQ people face higher costs for housing, health insurance, unfair

taxation and others (CAP & MAP, 2014).

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[24] "Cishet" is a term used among LGBTQ people to refer to cisgender heterosexual people.

Moreover, transgender individuals experience employment discrimination and harassment at higher rates than their cisgender counterparts. Transgender individuals who lose a job due to anti-transgender bias are three times more likely to enter the sex work trade (National Center for Transgender Equality, n.d.). Despite the fact that California employment law prohibits discrimination based on sexual orientation and gender identity, discrimination still exists. This may be particularly true for LGBTQ people who do not match the white, cisgender, and heterosexual norms of appearance, behavior, and gender identity. Appearance-based discrimination is pervasive in the United States and employment law has failed to address the issue (Mahjan, 2007).

In addition to job discrimination, LGBTQ people may face rejection from their family of origin. Family rejection can directly lead to less, or no, family financial and social support, which further exacerbates factors that contribute to homelessness and poverty. All combined, many LGBTQ people face reduced economic options which then leads them into choosing sex work. However, this does not mean their choice is involuntary as one Town Hall participant noted:

"I know people who experienced family rejection and entered sex work urgently because of that, and that is totally different from my experience. But both experiences are choice-based and different from trafficking."

Some of the Town Hall participants argued that capitalism systemically creates

coercive environments within which individuals may be left with no other option but sex

work to survive. The argument continues that lack of other options is further influenced by

racism, sexism, heterocissexism,[25] nativism, and other systems of oppression. Testimonies

from participants in the Town Hall acknowledged these influences and nonetheless

indicated that, even under varying levels of economic strain, they *chose* to be a part of this

industry and found personal and financial benefits to sex work that were unavailable in

other economies.

"I was 25 and working multiple minimum wage jobs and struggling to pay rent...I saw my

queer women friends doing sex work and feeling empowered and setting their own hours and

making better money than I was making. This encouraged me to try something else because my

minimum wage job wasn't cutting it."

Consequences of conflating sex work with trafficking

"If the greater community could understand that consensual sex work is not human trafficking."

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[25] The term heterocissexism is used in this report to exemplify the intersectionality of sexism, heterosexism, and cissexism

Sex trafficking[26] is the use of force, fraud, or coercion to compel someone to provide

sexual services for profit.[27] Sex work is frequently conflated with sex trafficking, with the

biased presumption that people do not choose to enter the sex trade by choice. As noted

above, Town Hall participants stated that people enter into sex work by choice for a variety

of reasons, some of which are consistent with people entering mainstream economies.

"With human trafficking, it's not as if sex workers want it to happen—trafficking makes it more

dangerous for us! … Human trafficking in the sex trade does exist, and some victims of

trafficking consider themselves sex workers, but we shouldn't penalize sex workers and we

should provide support no matter what."

While sex work is distinct from sex trafficking in terms of both consent and choice,

they do share "transactional sex"[28] in common. Due to this commonality, the work and

experiences of sex workers are heavily impacted by laws intended to combat sex

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[26] Note: Sex trafficking is a form of human trafficking, which is defined as "the use of force, fraud, or coercion to compel a person into commercial sex acts or labor or services" (Polaris, 2012).

[27] According to Federal Law, force, fraud, or coercion do not need to be evident in cases where a minor engages in a sex act in exchange for things of value (money, food, shelter, drugs, etc.). Under these laws, minors engaged in sex work are considered victims of sex trafficking, and any adults who compels or patronizes such activities can be tried for sex trafficking. However, this differs greatly from the language used in research (survival sex) to describe especially LGBTQ youth engaged in transactional sex (consensually or not) and may differ from the actual stated experiences and needs of youth consensually engaged in transactional sex.

[28] Transactional sex: any sexual act or service provided in exchange for something of value, including money, housing, food, transportation, or services. This term is extremely broad and does not imply a presence or lack of consent in transaction. It is used here to describe a commonality between human trafficking and consensual sex work.

trafficking. These laws are typically written without consideration of sex worker well-being,

and thereby create unintended consequences in the lives of sex workers. Anti-trafficking

laws are seen as legitimate pathways to eradicate sex work, because such laws are rooted

within a neo-abolitionist[29] framework that sees all sex work as involuntary and views sex

workers as victims and are, therefore, essentially trafficked (Sex Worker Project, 2007;

Chuang, 2010; Vanwesenbeeck, 2017). These laws, which on their face seek to protect

human trafficking victims, are grown out of a false notion that sex work is a direct pipeline

to human trafficking.[30]

Conflating sex work and human trafficking sets the stage for further criminalization

of sex work—ultimately jeopardizing working conditions for sex workers (Schreter et al.,

2007). For example, in 2018, Congress passed a combined Senate and House of

Representatives bill—Allow States and Victims to Fight Online Sex Trafficking Act of 2017—

frequently referred to as SESTA-FOSTA (referencing both the Senate and House versions of

the bill). SESTA-FOSTA, specifically, amends section 230 of the Communications Decency

Act of 1996 to state that protections for online companies do not extend to "websites that

unlawfully promote and facilitate prostitution" (Allow States and Victims to Fight Online Sex

Trafficking Act of 2017, 2018).

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[29] Neo-abolistionism represents a reframing of the abolition movement, one which connects sex work explicitly with human and sex trafficking and that seeks to criminalize the purchasing of sex rather than the selling of sex (Vanwesenbeeck, 2017).
[30] See Chuang (2010) for a discussion on the historical connection between sex work and anti-trafficking laws in the United States.

The stated intent of this legislation was to prosecute sex traffickers, as well as web-based companies whose platforms were being used by sex traffickers. One of the immediate effects of this legislation was to push sex workers offline, where they had been using online platforms to screen potential clients, as well as share important health and safety information with each other. The reduced ability to screen clients and share health information places sex workers at increased risk of violence. In particular, the legislation pushes sex workers to engage in riskier forms of sex work, like street-based sex work, where they may face more frequent and more severe violence from both clients and law enforcement.

"...in the context of SESTA-FOSTA the impacts are severe [for workers who are less privileged].

We've lost the ability to advertise on sites that were taken down.

Survival sex. Minors cannot legally consent to sex in the United States. Under U.S. anti-trafficking laws, force, fraud, or coercion do not need to be evidenced in cases of transactional sex with a minor.[31] In other words, all minors who engage in transactional sex can legally be considered victims of sex trafficking in the United States, whether or not they are choosing to engage in sex work. While this law does protect young people, particularly

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[31] See: Trafficking Victims Protection Act; Trafficking Victims Protection Reauthorization Act; Justice for Victims of Trafficking Act

from being arrested for engaging in sex work, it fails to address the contexts and needs related to why homeless LGBTQ youth engage in transactional sex (Murphy, 2016).

LGBTQ youth are overrepresented in the homeless population. One report estimates that LGBTQ youth have a 120% higher risk of homelessness than their non-LGBTQ counterparts (Voices of Youth Count & Chapin Hall, 2017), while another study showed that LGBTQ youth are 40% of the homeless youth population (True Colors United, 2019). Facing a loss of home, social connections, and economic resources, LGBTQ youth left to fend for themselves may enter into sex work out of need. Sometimes this is referred to as *survival sex*.[32] However, it is a term used primarily in research and social service environments, and not by or among youth. Research is lacking to understand how LGBTQ youth understand and describe their own engagement in transactional sex, and how their own understandings of their experiences shapes their desire for specified services. Further research is needed to inform advocacy on sex worker rights and anti-trafficking prevention, and anti-trafficking response from the perspective of LGBTQ youth engaged in transactional sex.

The Whorearchy

Participants in the Town Hall made it clear that while sex work is a useful umbrella term for a large variety of practices, forms of sex work are treated differently under the law

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[32] Survival Sex: The trade of sex for the provision of a basic necessity, such as housing or food.

and entail different levels of risk. The differential treatment creates what Town Hall

participants referred to as a "whorearchy". As one participant explained, there is:

"...a multilayered "whorearchy," as it's often called, where there are more privileged sex workers

who don't have to stress about their daily survival, but that this is at the expense of other

workers locked out of those echelons of the trade."

The whorearchy has been created because of sexism, patriarchal views on female

sexuality, the patch-work criminalization of sex work, societal expectations of what is

beautiful and "normal," and societal views on gender identity. Sex workers in the

whorearchy who face discrimination based on their bodies, transness, and queerness (e.g.,

Trans sex workers, sex workers of color, and sex workers with less "mainstream" bodies)

may be given fewer job opportunities and may have to work in riskier parts of the industry

to make a living.

"'Eventually, I ended up in a massage parlor where friends were working, but the job didn't last

long because the manager was worried about me as a trans woman being a security risk."

"Regarding the whorearchy, I'm a pierced person of size and gender nonconforming. So to be

working in mainstream queer porn, I'm not always top choice as people who fit a different

description or a classic model. My choices are limited because I don't fit a certain thing....I don't

see people with my struggles as the face of sex work."

A lack of work-place protections, either based on appearance, sexual orientation, or gender identity, directly benefits sex workers whose bodies meet industry beauty standards, which are shaped by sexism, cissexism, racism, and ableism.

"I know sex workers who worked themselves through school. I know someone who paid her way

through college and became a CPA through stripping, but that wasn't an option for me...[As a

trans person] my body had limited marketability at the time I was dancing, so I could not get a

job as a stripper because clubs wouldn't hire me, and that affected my finances, so school was

not an option when trying to survive."

Violence

Content warning: the following section includes violent stories shared by Town Hall participants.

Violence against sex workers is pervasive regardless of sexual orientation or gender identity. Sex workers are at high risk for physical, sexual and psychological violence including, but not limited to, harassment, assault (verbal, sexual, or physical), rape, robbery, and having one's possessions destroyed (World Health Organization et al., 2013). Many participants in the Town Hall shared stories of violent and traumatic experiences. Of note, participants emphasized that while they shared histories of violence, many of these

incidents occurred *outside* of the context of their sex work. Although they mentioned

violent interactions with clients, police, and healthcare providers, they also made it clear

that they have been targeted in their personal lives, as well.

"I've survived multiple sexual assaults outside of the sex trade, in my personal relationships. And

I've survived IPV[interpersonal violence], some of which occurred as a sugar baby, but mostly

outside of the sex trade."

Some clients take advantage of the illegality of sex work. In the following two

instances, one client took advantage of the HIV criminalization law[33] and another took

advantage of the sex worker's homelessness. In these cases, the participants described

extreme circumstances where they were forced to provide sexual acts and their

vulnerability was taken advantage of.

"I had HIV positive listed on my ad, and I had a client who threatened to report me to police if I

didn't give the money back—so he kept me having sex with him for a whole week because I didn't

know what to do."

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[33] Under a 2017 reform of prior HIV criminal statutes, a person can be criminally prosecuted only if
they intentionally seek to infect another person with HIV (Equality California, 2017).

"When... [I'm] homeless and have to do sex work in order to try to get a roof over my head or

keep the roof of a sugar daddy or sugar mama over [my] head, it adds a level of pressure or

coercion to the mix. I had to leave situations where abuse happened and they knew I didn't have

much choice but to be under that roof, and they took advantage of that vulnerability."

Sex workers frequently experience violence not only from their clients, but also within

institutional structures that are intended to protect them, such as police and health care

systems (Sawicki et al., 2019). These violent experiences lead to a reduced reporting of

sexual and physical assault by sex workers. Moreover, when sex workers report crimes of

victimization, they are at risk for further violence and the potential to be arrested for

engaging in sex work as a result of reporting the context in which the violence was

perpetrated.

Town Hall participants recounted experiences of being further victimized by these

institutions. One participant explained that she went to the police station to report a

physical assault, she was again physically assaulted *by* the police officers she was seeking

help from. This story and the following quotes highlight why sex workers might avoid

seeking help:

"I've heard multiple stories of [sex workers] being revictimized by the cops."

"You can't go to law enforcement when something bad happens."

Another participant recounted the following experience within a health care institution:

"I was sexually assaulted by a male Nurse Practitioner in a public clinic …. That was before I

started doing sex work, but that experience of being assaulted by an NP that I trusted, at a time

when I was seeking hormones for the first time to start transition, that made me distrust

providers in general. The provider who assaulted me kept their job."

Law enforcement

"More than any other institution, law enforcement is the *problem"*

As mentioned above, sex worker relationships with the police is one of mistrust and

fear. Not only do police officers enforce anti-sex work laws, which threatens a sex worker's

economic well-being, but they also subject sex workers to extra-judicial violence. Sex

workers report incidences of profiling, strip searches, sexual assault, physical assault, and

verbal harassment by police officers (Sankofa, n.d.), but have little recourse due to the

relative social status and protection given to police officers. Participants in the Town Hall

expressed this deep distrust and told of the dangers in going to the police for help.

"More than any other institution, law enforcement is a formidable foe of most any sex worker I

know. By the time I started doing street sex work…I already knew many queer and trans sex

workers who had been assaulted by police officers and who had spent time in jail just for being

who they were and trying to survive by doing street based sex work. Where I was fortunate and

privileged enough not to encounter law enforcement that way, I knew that I couldn't go to them

for protection. When I was homeless later and got sexually assaulted and robbed, it was out of

the question to call police."

As a result, sex workers develop support and protection networks of their own. For example, one Town Hall participant noted that "bad date lists" can help sex workers avoid violent and manipulative clients. Sex workers have also found that, because of a lack of supportive social structures, they have to learn to stand up for themselves.

"I've learned to advocate for myself because no one else will do it for you. I think more often than

not, we don't go to law enforcement first, because you're not sure whether they will believe you

or if something worse will happen, so a lot of sex workers I know, we don't go to the established

places."

California has recently made strides to improve the likelihood that sex workers will report experiences of violence and victimization to the police. Historically, police and prosecutors have used condoms to prosecute people suspected of engaging in illegal sex work. This practice created a health crisis for sex workers who were being given free condoms by health agencies, but feared carrying them due to the possibility of prosecution

and incarceration (Wurth et al., 2013). As a result, many sex workers carried few or no condoms—putting them at increased risk for sexually transmitted diseases. In addition, sex workers have also been reticent to report being a witness to, or victim of a crime, out of fear of being incarcerated for prostitution.

In an effort to increase the safety of sex workers' interactions with police, and encourage the reporting of crimes, California recently passed the Immunity from Arrest Law (SB 233). This law intends to end the practice of police using possession of a condom as probable cause for arrest and protects sex workers from prosecution should they be a witness to, or are a victim of, a felony (Riquelmy, 2019). Nonetheless, entrenched distrust of police can take time to address, and sex workers remain apprehensive about their relationships with law enforcement. As one Town Hall participant noted:

"But even with [The Immunity from Arrest Law] in place, I wouldn't be surprised if many sex workers don't report to law enforcement for fear of their own safety, and that speaks volumes to how we have been criminalized and how it endangers our safety by empowering violent people posing as clients and partners."

Healthcare providers

Sex workers deserve healthcare like any other Californian. For sex workers, it is difficult to find care providers that are affirming of all aspects of their identities. As such, it is important that physicians, nurses, mental health professionals, and other providers

understand the contexts of their patients' lives while providing care. Unfortunately, many

providers have negative views regarding sex work and these judgments may adversely

affect their provision of care. For LGBTQ sex workers, and especially LGBTQ sex workers of

color, the need for culturally competent care makes it even harder to find a provider who

can truly be supportive.

Culturally competent care with sex workers requires, at a minimum, that providers

question their personal and societal sex-negative ideas about the merits and morals of sex

work, in addition to challenging their own implicit biases about race, ethnicity, sexual

orientation, and gender identity. Mental health providers, in particular, need to be able to

consider the intersection of identities on a sex worker's personal experience when

providing services (Sawicki et al., 2019), as a Town Hall participant stated:

"It's not just me being a sex worker, it's me being Latino, it's being queer, and having Native

[American] background to this continent. I need a mental health provider who can support me in

all of these ways. I went to a therapist and I'd start with sex work and I'd see them respond and

their change in demeanor, and that means they will talk to you differently. I need a good

provider who will acknowledge their biases beforehand."

Providers need training in how to provide culturally appropriate care and build trust

with clients who are sex workers. Understandably, many sex workers do not come out to

their providers for fear of discrimination.

"A lot of sex workers don't come out to their providers as sex workers because a lot of providers

discriminate and it makes it unsafe for us."

"Bring people with lived experience as sex workers to trainings and don't speak for sex workers if

you don't have that experience."

There are also barriers to finding those providers who are supportive. As one participant

shared:

"Providers aren't allowed to list that they are supportive of sex workers. There's a mucky area

with SESTA-FOSTA because it looks like listing that you provide sexual services, and a lot of

providers aren't willing to do that."

Participants also talked about providers withholding care unless the person agrees

to quit sex work. Withholding healthcare on the requirement that a person quit their

current profession would be unheard of in other contexts, but participants agreed this

happens frequently.

"A lot of providers do not *provide [HIV] positive services once they find out someone is a*

sex worker."

"When I woke up [in the emergency room] the specialist came and asked the standard question.

And before I said anything, she said: 'We already know you're a prostitute. We tested you for STIs,

and you're positive for HIV.' And at that point, I didn't know it's illegal for her to do that...without

my consent....I asked: 'What is my treatment plan?' And she said that because of my unstable

lifestyle as a prostitute, that they don't recommend treatment until I quit prostitution and enter

mental health services. But at that point I wasn't ready to quit, because sex work was the only

thing keeping me alive..."

Decriminalization

As mentioned in the introduction, the criminalization and regulation of sex work

finds its roots in an abolitionist framework; one that is championed by both Evangelical

conservatives and feminist anti-sex work scholars. Conservatives typically oppose sex work

on moral grounds targeting the sale and purchase of sex, while feminists oppose sex work

because they see it as inherently degrading, abusive, and violating of human rights (Davis,

2015). Regardless, both viewpoints have combined together to create laws prohibiting and

regulating sex work. These laws are often enacted without consideration for sex workers'

rights (Wagenaar, 2017). Participants in the Town Hall were adamant that sex workers

should be involved whenever laws, regulations, or services are developed that affect sex

workers.

"Anything that involves sex workers, sex workers should be there in the

decision-making process."

"More than anything, actual sex worker input on solutions is the single most effective way

to do good to improve sex worker circumstances."

While criminalization of sex work typically takes the form of prosecuting the sex

worker, Sweden has developed an approach intended to reduce sex trafficking and

eradicate sex work by heavily prosecuting buyers of sexual services instead of those who

are selling sex (Amnesty International, 2016). This approach, dubbed the *Nordic Model*, has

been adopted in various forms throughout Europe. Town Hall participants strongly

disagree with this approach, stating that criminalizing clients ultimately harms sex workers.

"There are a lot of partial decriminalization models that shift the criminal focus to clients, and

that's bullshit and doesn't keep sex workers safe"

"Shifting criminalization to clients makes sex workers unsafe, because now our clients

have strong cause to not be on record seeking sex work, which makes it harder for us to screen

and protect ourselves. If any aspect of the trade is criminal, sex workers get punished."

"If you shift criminality to the clients, it also makes it unsafe for sex workers and

maintains the idea that sex work is criminal and stigmatized."

Notably, attempts to implement the Nordic Policy in the United States have been

unsuccessful (Davis, 2015).

Although many call for the criminalization of sex work, research shows that

criminalization has actually done very little to limit or eradicate the sex work industry.

Despite the proliferation of laws, one comparative study in Europe found that anti-sex work

policies had been ineffective at reducing the number of sex workers or eradicating the sex

work industry. Instead, these policies reduced the rights of sex workers and resulted in

increased exploitation (Wagenaar, 2017).

Decriminalizing sex work would remove criminal penalties for engaging in

transactional sex. The posited benefits from decriminalization include:

- Providing increased agency for sex workers;

- Allowing sex work to be considered under traditional employment law;

- Reducing the incidence of HIV and other sexually transmitted diseases;

- Reducing the incidence of violence and exploitation of sex workers;

- Increasing positive health outcomes for sex workers; and

- Increasing the likelihood that sex workers will seek protection from law

  enforcement when victimized (Benoit, et al., 2019; Marshall, 2016).

Moreover, Marshall (2016) argues that decriminalization does not negate anti-trafficking

laws and that sex workers may be in a better position to help identify sex-trafficking victims

and perpetrators.

Town Hall participants voiced their support of decriminalization. One participant,

who had multiple experiences of violence while doing sex work, stated:

"I could have avoided all of these experiences with those problem clients if I had had more

resources to begin with... If I were able to screen my clients effectively... if I had been mentored

by a sex worker who took me under their wing... if there wasn't criminalization of sex workers

who could teach me the ropes who could today just be charged with pandering or pimping for

doing that. If sex work weren't criminalized, I could have probably avoided all of those

experiences."

Conclusion and Recommendations

#Out4MentalHealth supports the full decriminalization of sex work (O'Brien et al., 2018). Removing legal prohibitions and penalties on sex work is the best way to improve the health and well-being of sex workers in California, including LGBTQ people.

However, decriminalization alone cannot address all of the health inequities and violence experienced by sex workers. The experience of violence among sex workers, especially that which is perpetrated by the police, those who are sworn to protect, and health care professionals who swore to do no harm require specific interventions. Communities need policies that hold police officers accountable for any discriminatory behavior toward sex-workers, including their lack of follow up on reports of violence and other crimes. Under decriminalization, police officers should be required to attend trainings that relate to sex work laws and sex worker rights (Marshall, 2016).

Health care professionals, including physicians, nurses, mental health professionals, and other providers, should seek to understand the contexts of their patients' lives while providing care. This also means addressing their negative views regarding sex work and suspending judgements that may adversely affect their provision of care. In addition, they must seek to provide culturally appropriate care to sex workers, especially for sex workers of color. This at a minimum should include questioning personal and societal sex-negative ideas about the merits and morals of sex work, in addition to challenging their own implicit biases about race, ethnicity, sexual orientation, and gender identity.

Mental health providers, must consider the intersection of identities on a sex

worker's personal experience when providing services. Funding should be allocated to train

mental health and other providers, on how to provide culturally affirming care to sex

workers. Such training should require participants to address personal implicit biases

about sex work and question negative ideas about the merits and morals of sex work.

St. James Infirmary | stjamesinfirmary.org

St. James Infirmary is a **peer-based occupational health and safety clinic** that provides much

needed services to current and former sex workers, their partners and children, living and working

in the San Francisco Bay Area, regardless of gender identity or sexual orientation. St. James

provides clinical and mental health services, clinical case management, acupuncture, and massage,

as well as community and engagement and training services.

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Appendices

Appendix A: Methodology

Virtual Town Halls

#Out4MentalHealth hosted two virtual Town Halls in July 2019, on the topics of LGBTQ Refugees and Asylum Seekers and LGBTQ Sex Workers. Key informants were invited to participate in the virtual Town Halls based on their expertise and/or personal lived experience with the topics discussed. Town Hall participants were asked about current and emerging issues in the health of their communities. Each Town Hall lasted two hours and was recorded for the purpose of accurately capturing participants' words and perspectives.

The LGBTQ Refugees and Asylum Seekers Town Hall had three participants, and an interview phone call using the same questions was conducted afterward with a fourth key informant referred to #Out4MentalHealth staff. Information learned from the additional phone call is folded in with information from the other Town Hall participants. The LGBTQ Sex Work Town Hall had six participants.

Each Town Hall recording was transcribed and scrubbed of identifying information. The qualitative information gained from these Town Halls was used to inform the literature review, findings, and recommendations in this Report, particularly for the LGBTQ Refugees and Asylum Seekers and LGBTQ Sex Workers sections of the Report.

The #Out4MentalHealth LGBTQ Community Survey

#Out4MentalHealth implemented an online survey covering topics related to LGBTQ mental health and well-being between March 5 - May 30, 2019 using Qualtrics Survey Software (Qualtrics, Provo, UT). The online survey was distributed in both Spanish and English. The English version was released on March 5, 2019. A Spanish language translation of the survey was made available on April 9, 2019.

The survey included several modules intended to understand the demographics, health services access, and experiences seeking and receiving mental health support for LGBTQ Californians. The following list provides an overview of the demographic sections and health modules in the #Out4MentalHealth Community Survey (CS). Not all participants answered all modules, such as modules specifically designed for bisexual+ respondents or for people of color. There were 125 questions in the survey.

Demographics	
Zip code	Education
Age	Employment
Race / Ethnicity	Income
Gender identity	Housing
Sex Assigned at Birth	Deaf and hard of hearing

Intersex	Childhood religion and affiliation
Sexual Orientation	Relationship status
Asexuality	U.S.- or Foreign-born
Health Insurance	Military Service
Student status	

Health Modules
Bisexual needs assessment
Discrimination at the intersections of race, sexual orientation, and gender identity
Outness and experiences of acceptance/rejection
Discrimination and distress
Insurance, service access, and service use
Community supports
Lifetime and past year suicide history
Barriers to seeking and receiving services
Tobacco use

The Community Survey URL was distributed by organizations throughout California

using email, social media, dating apps, paper fliers, blogs, and the news media. In addition

to an unpaid snowball sampling method, #Out4MentalHealth paid for boosted posts on

Facebook, Instagram, and Grindr. Grindr4Equality donated free advertising to share the CS

with users through its broadcasts. The Spanish language version of the survey was accompanied by a Spanish-language social media campaigns to increase outreach and awareness of the survey opportunity in Spanish.

The California LGBTQ Health and Human Services Network also received a grant from CalMHSA to partner with Gender Justice LA and the Trans Latina Coalition to support state and local outreach for survey participation. The CalMHSA grant to Gender Justice and the TransLatin@ Coalition specifically funded in-person events where tablets were available to complete the survey in exchange for a $10 gift card.

Incentives

Adult participants who completed the survey were given the opportunity to enter a gift card raffle. The raffle included five $50 gift cards, ten $25 gift cards, and twenty-five $10 gift cards. As respondents age 17 and under cannot legally participate in raffles, $5 gift cards were offered to the first 500 participants age 17 and under. Due to a security breach explained further in the screening methods below, the youth incentive was closed on March 7.

Response & Screening

A total of 4,655 online survey responses were recorded between March 5 - May 30, 2019. Of these, 2,874 responses (62%) were valid and screened into the final survey sample. Below are the methods used to screen recorded responses for valid entries.

1. CS responses included several entries potentially from Bots during the first two days of the survey period (March 5 - March 7), that targeted the youth incentive of $5. Quality assurance checks during the first few days of the CS release identified the potential phishing problem, and in response the #Out4MentalHealth team implemented a CAPTCHA[34] on both the CS and the Incentive Modules. To maximize data integrity, all responses collected prior to the CAPTCHA implementation on March 7, 2019 at 3:30pm (n = 902, 19.4% of recorded responses) were not included in data analysis.

2. Responses were designated as "ineligible due to insufficient data" where only one question was answered. There was a total of n=600 (12.9%) filtered out due to insufficient data.

3. Respondents were screened out of the sample if they answered "No" to the first question, "Are you a resident of California, even if you are currently living elsewhere (e.g. attending college or serving in the military)?" (n = 262, 5.6%).

4. Data flagged by the Qualtrics online survey platform as "Spam" (n = 17, .01%) were filtered out of the sample.

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[34] CAPTCHAs are programs that help distinguish between human and computer input. They are used to thwart SPAM and automatic data extraction from websites.

The Sample

In total, there were n=2,874 valid responses recorded in the CS. All survey

respondents identified as members of LGBTQ communities. Demographic data for the CS

sample are below. In brief, a majority of the sample were assigned female at birth (68.6%),

under the age of 34 (68.9%), residents in urban areas (94.1%), and monoracial White

(50.2%). With regards to gender identity and sexual orientation, 40% of the sample

identified among a Trans Spectrum (genderqueer, nonbinary, transgender, trans man,

trans woman, two spirit, or questioning) and 39.5% identified as Bisexual or Pansexual.

Demographic Recoding

In some cases, responses to demographic questions needed to be recoded for the

purpose of statistical analysis or easy representation of the data. Recodings are explained

here.

Age. Respondents chose their age from a drop-down menu with options 12 to 100

years of age. Respondents were then grouped into six categories: Youth (12-17), Transition

Age Youth (18-24), Emerging Adult (25-34), Adult (35-54), Transition Age Older Adult (55-64),

and Older Adult (65+).

Gender Identity. Gender identity responses are represented in two ways

throughout this Report. Either the responses are shown descriptively with all demographic

options (Woman/girl, Man/boy, Genderqueer, Nonbinary, Transgender, Trans Man, Trans

Woman, Two Spirit, Questioning) or, for the purposes of analysis, the above nine gender

identity groups were consolidated into three groups (Cisgender, Genderqueer/Nonbinary,

and Transgender). Respondents who recorded identities as Two-Spirit (n=37) or

Questioning (n=113) could not be assumed to be Nonbinary or Transgender, and did not

have enough respondents for standalone gender groups, so these respondents were not

included in subsequent group comparison analyses.

The two-part Gender Identity and Sex Assigned at Birth questions allowed those

who selected "Man/boy" for gender identity and "Female" for sex assigned at birth to be

analyzed as Trans Men, and those who selected "Woman/girl" for gender identity and

"Male" for sex assigned at birth to be analyzed as "Trans Women" in order to identify

community trends by lived experience while still honoring current gender identity.

Sexual Orientation. For the purpose of analyses, sexual orientation responses

were recoded as follows: Any respondent who recorded a gender identity as "Woman/girl"

and who selected "Gay" as a sexual orientation was recoded for analysis purposes as

"Lesbian."

Race/Ethnicity. Respondents had the following race/ethnicity options: Asian or

Asian American; Black, African American, or African Descent; Latinx, Latino/a or Hispanic;

Middle Eastern or North African; Native American, First Nation, or Alaskan Native; Native

Hawaiian or Pacific Islander; White; and Another Not Listed (Please Specify).

Respondents who selected "Another Not Listed," and who provided a write-in

response that was categorizable as a distinct racial/ethnic group were recoded (i.e.

recategorizing Irish as White). Respondents who wrote ethnic identities that were not

descriptive enough to categorize within an existing race group (i.e. Indian, where the

response could not be distinguished between Asian Indian or Native American without

further information) were left as "Another Not Listed." Respondents who provided write-in

data that are not race/ethnicities were maintained "Another Not Listed" (i.e. Human; Race is

a social construct). People who selected multiple racial categories were recoded as

"Multiracial."

Race/ethnicity is represented three ways throughout the Report. For descriptive

purposes, valid percent data are presented in the Report for each race/ethnicity selection.

In some sections of the report, we analyze data by race/ethnicity 3-ways (Multiracial People

of Color, Monoracial People of Color, and Monoracial White). In other sections of the

report, we summarize data with maintaining individual race/ethnicity selections (African

American/Black; Latinx or Hispanic; White), and Multiracial is included as a separate group

for the purpose of analysis.

Survey Response Rates

On average, participants completed 80% of the survey. There were some response

rate differences by Race/Ethnicity and by Age group. For example, Multiracial People of

Color (POC) and Monoracial POC completed significantly less of the survey than Monoracial

White respondents. Youth (12-17) and Older Adults (65+) completed significantly less of the

survey than respondents aged 18 to 64 years old. Survey completion differences by

demographics also revealed Age and Race/Ethnicity interactions, whereby Monoracial

White Youth completed more of the survey (84% completion rate) than Monoracial POC

Youth (67% completion rate), while Multiracial POC Youth completed slightly more of the

survey than Monoracial POC Youth (74% vs. 67%, respectively). Additionally, Monoracial

White Older Adults (65+) completed more of the survey (92%) than Monoracial POC Older

Adults (69%) and Multiracial POC Older Adults (62%). Overall, Monoracial White

respondents recorded an 81% survey completion rate and Monoracial People of Color

recorded a 66% survey completion rate.

In sum, while survey response rates reflected here are relatively high (> 60% even

when examined by subgroups where differences were observed), research has historically

underrepresented communities of color. Some cite reasons for differential representation

as mistrust of researchers and sampling bias (Jang & Vorderstrasse, 2019). In addition,

although web-based surveys tend to enhance survey access among underrepresented

communities, race may be a predictive factor in survey completion rates (Jang &

Vorderstrasse, 2019). Thus, there is an ongoing need for survey design that considers the

recruitment nuances amongst people of color, youth and older adults. For the current CS,

#Out4MentalHealth utilized various methods known to increase cross-cultural and

intergenerational participation, including community of color-oriented advertising and local

events with communities of color. However, the current survey may have benefited from

additional methods to prevent survey attrition, including the ability to offer incentives

without fraudulent interference. Methods to reduce survey attrition among people of color,

multiracial people, youth, and older adults are especially important given

#Out4MentalHealth's concern for the increased burden of health disparities carried by

these specific groups.

Analysis Plan

The data collected as part of the CS were analyzed by members of the

#Out4MentalHealth Survey Research Team, which included #Out4MentalHealth staff and

research partners Dr. Seth Pardo at the San Francisco Department of Public Health, Dr.

Tania Israel and doctoral student Kristina Esopo at UC Santa Barbara, and Dr. Luis Parra at

the University of Southern California. Only #Out4MentalHealth staff had access to and

processed any sensitive data for the purpose of processing participant incentives. Each

member of the research team made unique contributions in the preparation of the Report.

Bisexual Needs Assessment. Data gained from the Bisexual Needs Assessment

Module were used to assess the mental health needs of non-monosexual respondents.

Participants accessed this module if they either reported a bisexual sexual orientation

identity, or reported attractions to more than one gender, regardless of recorded identity

label.

Approximately 42% of the total sample (n = 1,321) met these inclusion criteria. Data

for eligible bisexual respondents were analyzed using IBM SPSS Statistics Version 26 (2019).

The majority of survey responses were summarized with frequency counts and sample

proportions. For more complex intra- or inter-group comparisons and relationships

between variables, statistical tests were conducted. Demographic data were compiled for

sexual orientation, gender identity, age, and race/ethnicity.

Outcome variables of interest included interactions with other bisexual people, anti-

bisexual experiences, social support, internalized binegativity, and suicide. These were

analyzed and summarized using proportions and frequency counts. Some outcome

variables were also analyzed by demographic subgroups (e.g. interactions with other

bisexual people split by gender identity). In specific circumstances, statistical group

comparisons were made or relationships between variables were explored. All data were

examined statistically with a significance level set at $p < .05$. Thus, for the summary of

results here, any result indicated as "significant" had a p-value less than .05; that is, the

difference or relationship was found to be due to factors other than chance.

Appendix B: Abridged List of Resources Online LGBTQ Clearinghouse

The following table identifies some of the organizations throughout California that serve

the health, community, and legal needs of LGBTQ Californians or advocate for policy

change on their behalf. This list is only a brief snapshot of the available resources

throughout California. Additional resources are listed on the #Out4MentalHealth website:

Out4MentalHealth.org, under the "Resources" tab. The online clearinghouse includes a

regularly updated list of National, State, and county LGBTQ-serving organizations and

resources.

Organization	Website	Region Served	Population Served
American Institute of Bisexuality	americaninstituteofbisexuality.org	National	Bisexual
API Equality - Los Angeles	apiequalityla.org/	Los Angeles	POC
API Equality - Northern California	apiequalitync.org/	San Francisco Bay Area	POC
California Commission on Aging	ccoa.ca.gov/	California	Elders
California Latinas for Reproductive Justice	californialatinas.org/	California	POC
California Pan-Ethnic Health Network	cpehn.org/	California	POC
California Partnership to End Domestic Violence	cpedv.org/	California	Domestic Violence Survivors

California Rural Legal Assistance	crla.org/	California	LGBTQ
Center of Excellence for Transgender Health	prevention.ucsf.edu/transhealth	National	Transgender
Children's Hospital Los Angeles - The Center for Transyouth Health and Development	chla.org/the-center-transyouth-health-and-development	Los Angeles	Youth
Community United Against Violence (CUAV)	cuav.org/	San Francisco Bay Area	LGBTQI Anti-violence
Courage Campaign	couragecampaign.org/	California	LGBTQ Advocacy
Equality California	eqca.org	California	LGBTQ Advocacy
Familia: TQLM	familiatqlm.org/	National	POC
Gay and Lesbian Medical Association	glma.org	National	LGBTQ
Gender Spectrum	genderspectrum.org/	California	Transgender Youth
Genders and Sexualities Alliance Network	gsanetwork.org/	California, National	Youth
Latino Equality Alliance	latinoequalityalliance.org/	Los Angeles	POC
Nat'l Center for Lesbian Rights	nclrights.org	National	LGBTQ
National Black Justice Coalition	nbjc.org/	National	POC
National Queer and Trans Therapists of Color	nqttcn.com/	National	POC

Cal Voices *(a continuation of NorCal Mental Health America)*	calvoices.org/	California	LGBTQ Advocacy
Our Family Coalition	ourfamily.org/	Alameda and San Francisco	Families
PFLAG	pflag.org/	National	Families
Racial and Ethnic Mental Health Disparities Coalition	remhdco.org	Sacramento	POC
Transgender Law Center	transgenderlawcenter.org	National	Transgender/GQNB
Trevor Project	thetrevorproject.org/	National	Youth

Appendix C: #Out4MentalHealth Fact Sheets

#Out4MentalHealth produced fact sheets to distribute to the general public, community members, providers, county staff, and policy makers. The most recently created fact sheets are included in this report:

1. The Who, What, Where, and How of Mental Health Services

2. Adverse Childhood Experiences and LGBTQ Communities

PDF versions of these fact sheets, and all others, can be found by visiting

www.out4mentalhealth.org

Who Can Provide What Specific Mental Health Services

The chart indicates which providers are generally permitted to provide a service. Individual providers do not always offer every service their profession allows. The scope of services offered by individual providers is generally determined by education and experience level, employer type, specific job descriptions at the organization, whether they are contracted or receive grant funds to provide specific services, and the types of payments they are able to accept.

Mental Health Service	Types of Providers		
Clinical Assessment and Diagnosis	Primary Care Provider / Psychiatrist / Nurse Practitioner / Physician's Assistant / Psychologist / Licensed Marriage and Family Therapist (LMFT) / Licensed Clinical Social Worker (LCSW) / Licensed Professional Clinical Counselor (LPCC)		
Medication Support	Primary Care Provider / Psychiatrist / Nurse Practitioner / Physician Assistant		
Therapeutic Individual and Group Counseling	Psychologist / Licensed Marriage and Family Therapist (LMFT) / Licensed Clinical Social Worker (LCSW) / Licensed Professional Clinical Counselor (LPCC) / Associate Professional Clinical Counselor (APCC) / Associate Clinical Social Worker (ACSW) / Licensed Marriage and Family Therapist Intern (LMFTI)		
Case Management and Advocacy	Associate Clinical Social Worker (ACSW) / Associate Professional Clinical Counselor (APCC) / Licensed Marriage and Family Therapist Intern (LMFTI) / Master of Social Work (MSW) / Personal Services Coordinator (PSC) / Peer Advocate		
Peer Support	Personal Services Coordinator (PSC) / Peer Advocate / Community Group Facilitator		
Life Skills and Coaching	Master of Social Work (MSW) / Personal Services Coordinator (PSC) / Peer Advocate / Life Coach / Pastor/Spiritual Leader		

*A Physician Assistant has prescribing authority but prescribes medication as an "agent" of the supervising physician

*Psychologists have doctorates but are not medical doctors and must be licensed before providing mental health care

*LMFTI, ACSW, and APCC must be supervised by a licensed mental health clinician (LMFT, LCSW, or LPCC)

*APCC and LPCC are not permitted to provide couples or family counseling without obtaining additional training, supervision, and written confirmation from the California Board of Behavioral Sciences

*MSW are also able to facilitate group counseling

Color Key: **LESS** Experience/Training/Education/Licensure **MORE**

Where and How of Accessing Mental Health Services

The following is a list of places and ways that you can access mental health services in your community using different financial sources, provider types, and points of entry.

College Campuses: Students frequently pay for mental health services as a part of their "student fees" each semester. Support can generally be accessed via the campus health center for no additional cost to the student.

Community Based Organizations (CBO): Services are frequently _free, low-cost, or sliding scale_ for the client. Services can range from highly specialized to a broad continuum of care. CBOs with mental health services are sometimes contracted with counties, receive grants, or fundraise in order to provide support in their local communities.

County Behavioral/Mental Health Services: The majority of public mental health services in California are implemented at the county level, either directly or by contracting with CBOs. Some services are Medi-Cal specific but many are available to anyone who qualifies for a particular program. Your county's website will have more information.

Employee Assistance Plans (EAP): Depending on the plan coverage, some EAPs provide direct mental health support via phone or local contracted providers or can help you locate services in your area.

Health Centers and Medical Groups: Many health centers and medical groups, particularly Federally Qualified Health Centers (FQHC) offer a full range of comprehensive services. You can find out what mental health services your health center or medical group provide by checking their website or contacting their general inquiry phone line.

Health Insurance Plans: Per federal health guidelines in the Affordable Care Act, all health insurance plans _must cover mental health_ services at parity with medical and surgical benefits. This includes privately purchased insurance, employer insurance, all plans through Covered California, and Medi-Cal. You can contact your insurance plan to find out what types of care are covered and access a network provider list. California parity requirements may also allow you to receive _reimbursement for out of network providers_ in order to preserve continuity of care.

Hospitals and Emergency Room: If you are experiencing a _mental health crisis and need immediate intervention_, medical providers at your local emergency room can assess you for risk of harm and help you get access to care through a 72 hour hold at the hospital for stabilization, followed by a transfer to inpatient psychiatric care if needed. If you disclose that you may harm yourself or another person, medical doctors in most hospital departments have the capacity to assess for harm and a responsibility to get you access to appropriate care.

K-12 Schools: Many schools offer prevention and early intervention support to youth. Additionally, students with specific diagnoses can access individualized services on campus with a 504 Plan or Individual Education Plan (IEP).

Private Practitioners: Many mental health providers in private practice will accept specific insurance plans. They are often also open to accepting sliding scale payments based on need. When you find a provider you like, it is appropriate to ask about negotiating payment in advance based on your financial capacity.

Psychiatric Facilities: Based on the need assessed during intake, psychiatric facilities can often offer different levels of care, including inpatient care, partial hospitalization, and full-time or part-time intensive outpatient programs. Some psychiatric facilities only accept patients from their particular medical group (i.e. Kaiser, Sutter) based on emergency room or physician referrals. Some psychiatric facilities are private and accept insurance and private payments. There are no longer state-run psychiatric facilities but many counties run public psychiatric facilities. Each psychiatric facility has their own intake and assessment process, availability, and range of services.

#Out4MentalHealth

ADVERSE CHILDHOOD EXPERIENCES AND LGBTQ COMMUNITIES

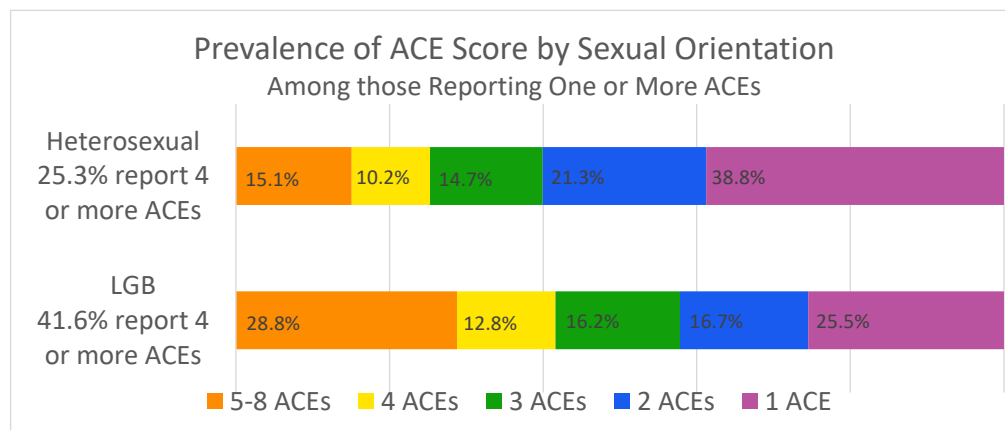**Compared to straight counterparts, LGB individuals report:**

- Disproportionately higher prevalence of ACEs
- They are more likely to experience patterns of abuse
- High rates of abuse and poly-victimization by parents
- They are more likely to have experiences of poly-victimization and psychological and/or physical abuse

LGB, Transgender, and questioning adolescents were more likely to have experienced poly-victimization and psychological and/or physical abuse when compared with their straight or cisgender adolescent counterparts.

- Experiences of victimization are common among transgender adolescents and those with high levels of gender nonconformity.
- *Research has revealed that the more gender nonconforming an individual is the more abuse they experience.*

Research shows those identifying as Black or Latino and those with less than a high school education or an annual income below $15,000 were more likely to have more ACEs, with multiracial and gay, lesbian and bisexual individuals carrying the greatest burden.

Prevalence of ACE Score by Sexual Orientation
Among those Reporting One or More ACEs

Heterosexual 25.3% report 4 or more ACEs
5-8 ACEs	4 ACEs	3 ACEs	2 ACEs	1 ACE
15.1%	10.2%	14.7%	21.3%	38.8%

LGB 41.6% report 4 or more ACEs
5-8 ACEs	4 ACEs	3 ACEs	2 ACEs	1 ACE
28.8%	12.8%	16.2%	16.7%	25.5%

Legend: 5-8 ACEs | 4 ACEs | 3 ACEs | 2 ACEs | 1 ACE

What are ACES?

ACES are Adverse Childhood Experiences of traumatic or stressful life events before the age of eighteen. These include *childhood abuse and neglect* (Physical abuse; Sexual abuse; Emotional abuse) and *household dysfunction* (Household member with depression, mental illness, or suicide attempts; Alcohol or drug abuse in household; Incarcerated household member; Violence between adults in the household; Parental divorce or separation).

How do ACES impact adult health?

A person's cumulative adverse childhood experiences have a strong relationship to numerous health, social, and behavioral problems throughout their lifespan, including substance use disorders, more frequent **depressive symptoms, anxiety, and tobacco use**. Greater levels of adversity are also associated with poorer self-rated health and life satisfaction, heart disease, lung cancer, diabetes and many autoimmune diseases, as well as depression, violence, being a victim of violence, and suicide. **The more ACES a person has, the higher the cumulative risk of negative health consequences.**

ACEs are strongly related to the development and prevalence of a wide range of health problems throughout a person's lifespan, including those associated with **substance misuse.** Research has demonstrated a strong relationship between ACEs, substance use disorders, and behavioral problems. When children are exposed to chronic stressful events, their brain development can be disrupted. As a result, the child's cognitive **functioning or ability to cope** with negative or disruptive emotions may be impaired. Over time, and often during adolescence, the child may **adopt negative coping mechanisms**, such as substance use or self-harm. Eventually, these unhealthy coping mechanisms can contribute to disease, disability, and social problems, as well as premature mortality.

i ii iii iv v vi vii viii ix x xi xii

[i] **Polyvictimization** refers to having experienced multiple victimizations such as sexual abuse, physical abuse, bullying, and exposure to family violence. The definition emphasizes experiencing different kinds of victimization, rather than multiple episodes of the same kind of victimization http://polyvictimization.org/about-polyvictimization/

[ii] Mersky, J. P., Topitzes, J., & Reynolds, A. J. (2013). Impacts of adverse childhood experiences on health, mental health, and substance use in early adulthood: a cohort study of an urban, minority sample in the U.S. *Child abuse & neglect*, *37*(11), 917-25.

[iii] United States Substance Abuse and Mental Health Services Administration https://www.integration.samhsa.gov/clinical-practice/trauma#ACE_Trauma_PTSD_Resources

[iv] Center for Disease Control's Adverse Childhood Experiences Study, https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/index.html

[v] Andersen, J. P., & Blosnich, J. (2013). Disparities in adverse childhood experiences among sexual minority and heterosexual adults: results from a multi-state probability-based sample. *PloS one*, *8*(1), e54691.

[vi] https://www.contemporarypediatrics.com/adolescent-medicine/toll-adverse-events-lgbtq-teens

[vii] Disparities for LGBTQ and Gender Nonconforming Adolescents, doi: 10.1542/peds.2017-3004

[viii] https://www.npr.org/sections/health-shots/2018/09/17/648710859/childhood-trauma-and-its-lifelong-health-effects-more-prevalent-among-minorities

[ix] https://acestoohigh.com/got-your-ace-score/

[x] https://www.thelancet.com/pdfs/journals/lanpub/PIIS2468-2667(17)30118-4.pdf

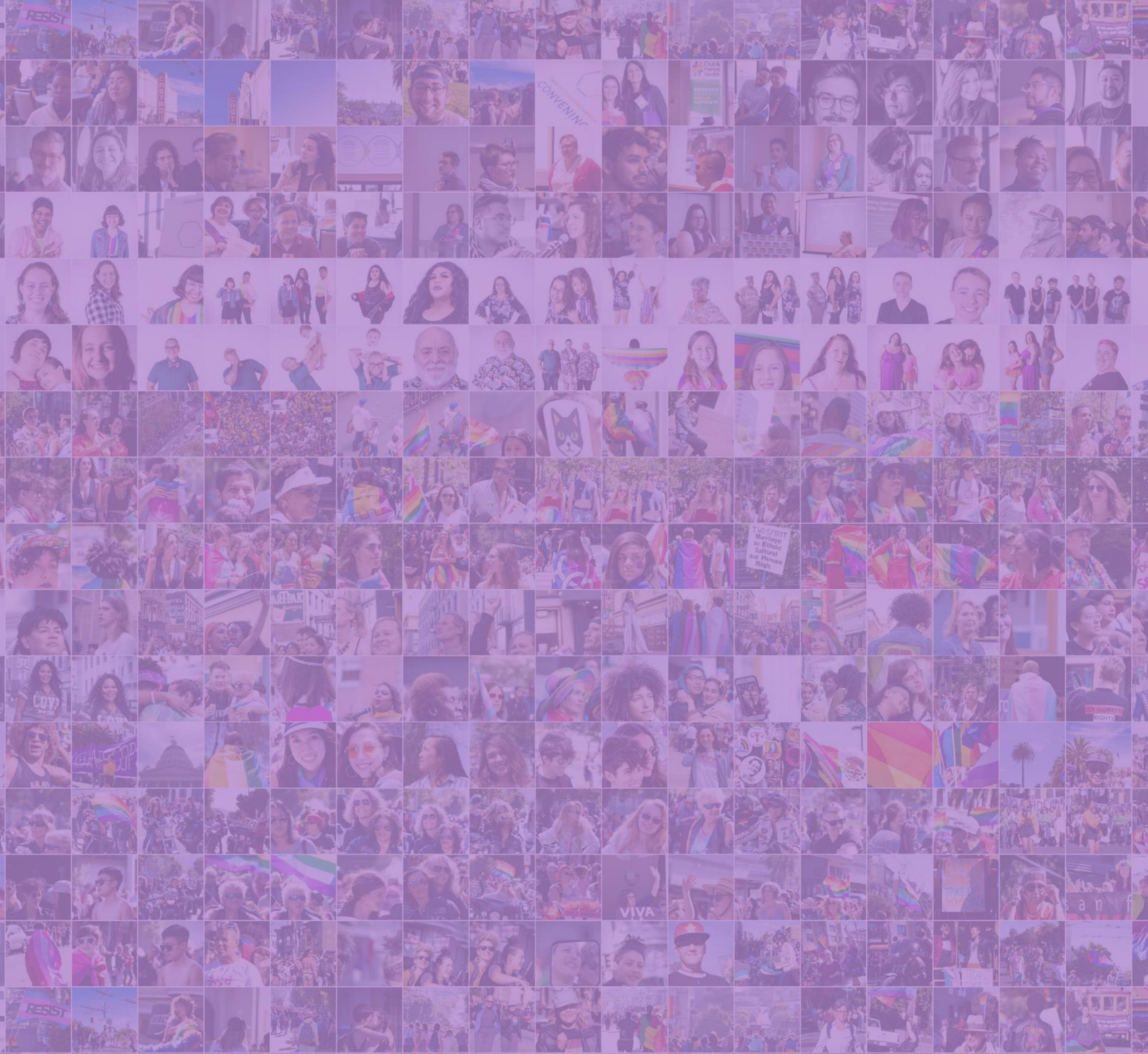[xi] https://www.childtrends.org/wp-content/uploads/2014/07/Brief-adverse-childhood-experiences_FINAL.pdf

[xii] Sterzing, Paul, and Jeffrey L. Edleson. SpeakOut: Polyvictimization Prevalence Rates for Sexual and Gender Minority Adolescents - Online, 2015 [United States]. ICPSR36774-v1. Ann Arbor, MI: Inter-university Consortium for Political and Social Research [distributor], 2018-02-02. http://doi.org/10.3886/ICPSR36774.v1

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LGBTQ
HEALTH AND HUMAN
SERVICES NETWORK

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MHA
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HEALTH ACCESS

MENTAL HEALTH SERVICES ACT
63
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WELLNESS · RECOVERY · RESILIENCE

MHSOAC
Mental Health Services
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