

2021



# LGBTQ+ Youth in Orange County Community Needs Assessment



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# EXECUTIVE SUMMARY

## INTRODUCTION

LGBTQ+ youth of color experience rampant discrimination and stigma from their own ethnic community, the LGBTQ community, and other racial/ethnic groups. However, most available data only report the experiences of LGBTQ+ youth of color at a national level that may not be applicable to people who have a connection with Orange County, CA. The purpose of the Community Needs Assessment is to better understand the needs of LGBTQ+ youth of color in our Orange County community in order to advocate, create, and push for change.

## VIET RAINBOW OF ORANGE COUNTY

Viet Rainbow of Orange County (VROC) is a grassroots organization based in Orange County, California that builds community and mobilizes intergenerationally. We primarily work with LGBTQ+ Vietnamese Americans and their loved ones through research, education, and advocacy, while also strengthening collective power alongside other communities working towards liberation.

VROC is grounded in values of equity, healing, joy, and social justice and strives to create a world where everyone has the resources and agency to thrive with dignity.

## KEY FINDINGS

Through the analysis of our survey data, we identified that:

1. LGBTQ+ youth in Orange County are identifying themselves as part of the LGBTQ community in their early adolescent years.
2. Cisgender youth, binary gender youth, and monosexual youth are experiencing better social and health outcomes compared to transgender, non-binary, and polysexual youth.
3. Most individuals have access to health insurance, but may be wary of providers

who have not demonstrated competency in providing gender affirming and non-discriminatory care.

4. Trans youth do not know or have access to trans-affirming health services.

### **WHERE DO WE GO FROM HERE**

Our recommendations on where we can begin to address LGBTQ+ youth needs and close wellness gaps are (in no particular order):

1. Improve access to health care at the community and systems level.
2. Increase services, programs, and resources for LGBTQ+ youth.
3. Identify factors impacting the state of LGBTQ+ youth health.

# METHODS

## RESEARCH QUESTIONS

1. What are the community health needs of LGBTQ+ youth in Orange County?
2. What is the state of queer youth health?
3. What can we all do to foster wellness among LGBTQ+ youth in Orange County?

## RESEARCH DESIGN

The survey consisted of questions from validated scales from past public health surveys and studies as listed: the 2015 U.S. Transgender Survey ( James et al., 2019), The Daily Heterosexist Experiences Questionnaire (Balsam et al., 2013), the Social Anxiety Scale for Adolescents (La Greca & Lopez, 1998), the Brief Hopelessness Scale (Mustanski & Liu, 2013) and the Gender Minority Stress Scale (Testa et al., 2015). These scales were included to evaluate (1) physical health, (2) social health, (3) mental health, (4) school experiences, and (5) school community health. Categorizing health in this way helped us identify and address needs in key social institutions such as schools and healthcare settings.

In addition to the health scales, we designed queer-affirming demographic questions with extensive options for identification. Participants were able to check multiple boxes for questions asking for race, gender, sex, sexual orientation, and sexual attraction. These measures were applied to acknowledge and respect the multifaceted diversity of identities in the community.

To ensure that the survey met the needs of our target population, we conducted a pilot survey study. We held focus groups with local LGBTQ+ youth, asking them to help assess the survey and allowing them an opportunity to add their own questions and voice their concerns. Their input allowed us to clarify terms, simplify questions, and remove unnecessary questions.

The final design for the survey featured over 100 structured questions such as “How would you rate your general health?” The survey also included statements like “I don’t expect to live a very long life.” that participants could agree or disagree with. The estimated time for survey completion was about half an hour.

## DATA COLLECTION

We distributed our survey between December 2020 and January 2021 on social media. We shared the survey on the VROC Facebook and Instagram pages, and individual research and administrative team members shared the survey on their social media pages. We also recruited from VROC's youth programs for both the focus groups and survey. We connected with local QTPOC-led organizations who helped recruit participants through their social media and email listservs.

LGBTQ+ youth between the ages of 14-25 who work and live in Orange County were eligible to participate in the needs assessment. Upon completion of the survey, participants received \$25 gift cards.

Two months of data collection and recruitment yielded a final sample size of 116 after excluding surveys with incomplete responses.

# FINDINGS

## DEMOGRAPHICS

Our survey pool only included LGBTQ+ youth from the Orange County community.

- Majority of participants identified as women (49%) or non-binary (multiple) gender identities (31%).
- 14% of participants identified as transgender.
- 32% of participants identified as polysexual while 22% of participants identified as monosexual.
- Majority of participants identified as Asian (55%) or Hispanic/Latino/a/x (26%).
- 77% of participants fall within the ages of 18-25 while 23% within 14-17.
- Most participants have a Bachelor's degree (44%) or have completed less than high school (20%).

Table 1. Demographics

Gender	Percentage of Participants
Woman	49%
Other/Multiple Gender ID*	31%
Man	20%
<b>Assigned Sex at Birth</b>	
Female	77%
Male	22%
Prefer not to answer	1%
<b>Trans/Cis</b>	
Cisgender	84%
Transgender	14%
Prefer not to answer	2%

### Sexual Orientation

Other/Multiple Sex ID*	46%
Bisexual	24%
Gay	13%
Lesbian	9%
Pansexual	8%

### Race

Asian	55%
Hispanic/Latino/a/x	26%
White	14%
Black	1%
American Indian or Alaska Native	2%
Middle Eastern or North African	2%

### Age

18-25	77%
14-17	23%

### Education

Bachelor's Degree or More	44%
Less than High School	20%
Some College	14%
High School/GED	12%
Associate Degree	8%
Prefer not to answer	2%

\* Note: ID stands for identity.



## HEALTH INSURANCE AND HEALTH SERVICES DISCRIMINATION

Health insurance and access to services are key health determinants that influence the health status of individuals and populations. When people do not have health insurance, they are less likely to participate in preventive care and are more likely to delay medical treatment (AHRQ, 2008).

### **95% of participants had some type of health insurance.**

This is higher than the percentage of Orange County residents with health insurance in 2017 (OC's Healthier Together, 2019). A majority (46%) of respondents were covered by employer-based insurance, followed by Medicaid (28%).

### **38% of transgender participants stated that their insurance covered some trans-related services.**

Although, a majority (44%) of transgender participants preferred not to answer this question. This may be the result of a variety of factors such as lack of awareness of their insurance coverage, lack of providers, or under-utilization of trans related services. This theory is reflected in a majority (44%) of transgender participants stating that they do not have a provider, followed by 38% who are unsure if their provider has the knowledge of trans-related care.

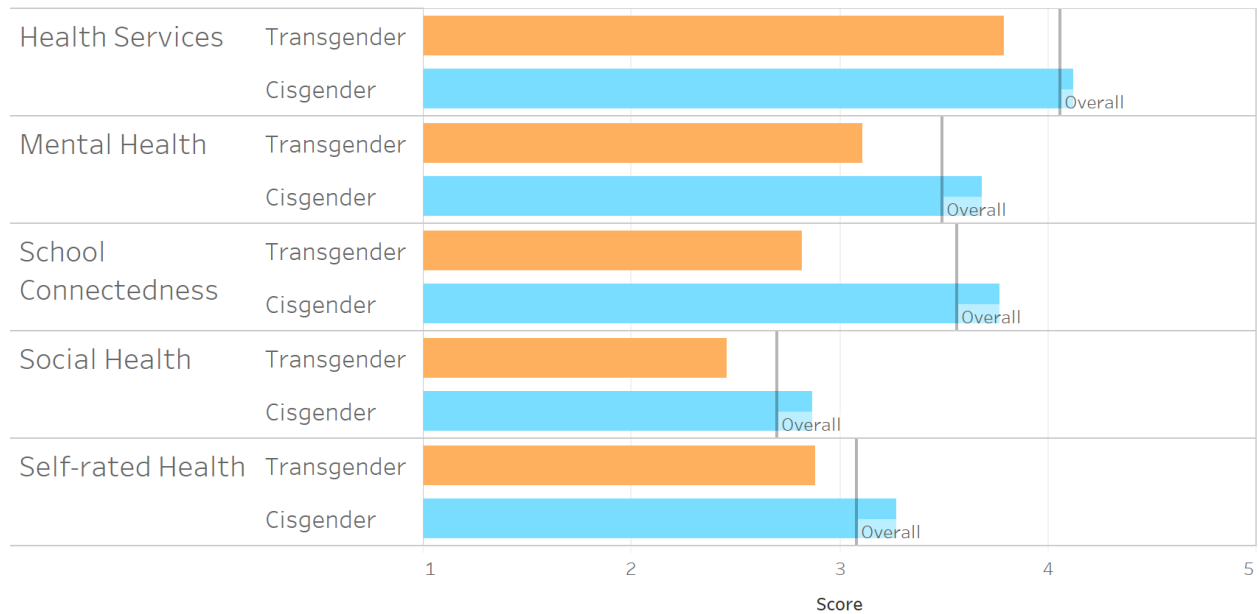
### **1 in 10 participants decided not to seek care because of possible anti-LGBTQ discrimination.**

## HEALTH INEQUITIES

To draw attention to health inequities *within* the LGBTQ+ youth community, we focus on the relationships between gender and sexual orientation with social and health outcomes.

### CISGENDER AND TRANSGENDER WELLNESS GAPS

#### Trans/Cis Scores



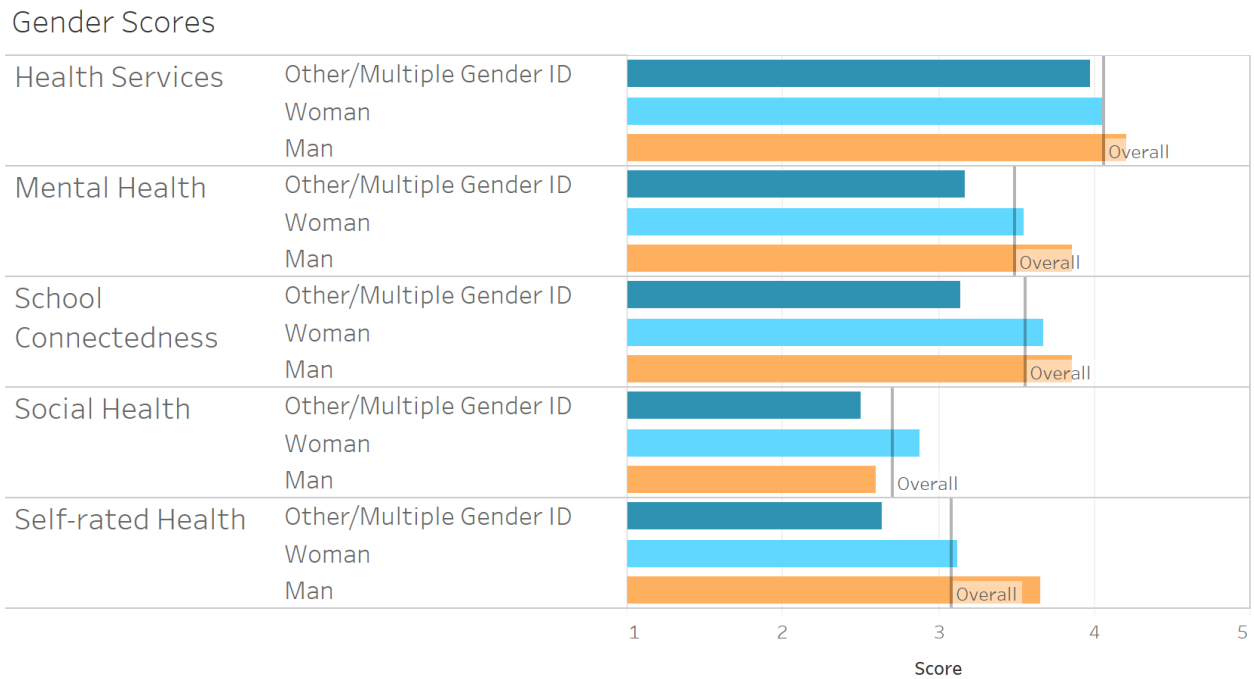
Cisgender youth reported better outcomes across all four categories: mental health, school connectedness, social health, and self-rated health.

**Mental Health:** When accounting for age, education, having health insurance, and heterosexist discrimination, transgender youth reported, on average, about half a point lower in mental health compared to cisgender youth. This means that even when comparing people with the same age, education, health insurance status, and daily hetero experiences, trans people still report higher levels of hopelessness. There is a possible trans health paradox in our sample where there was no statistically significant differences between cis and trans youth for self-rated health, but there was one for mental health.

**School Connectedness:** Similar to mental health, when we controlled for age, education, having health insurance, and heterosexist discrimination, results showed that trans youth reported, on average, almost one point lower in school connectedness compared to cisgender individuals.

The differences for health services and social anxiety were not statistically significant when accounting for sociodemographic characteristics.

### BINARY AND NON-BINARY (MULTIPLE GENDER ID) WELLNESS GAPS



The chart above shows differences in outcomes by man, woman, and non-binary and gender non-conforming participants. Participants who did not identify as strictly men or women were grouped together. For health services, mental health, school connectedness, and self-rated health, we see a gradient where non-binary and gender non-conforming youth report worse outcomes; women report better outcomes; and men reported the best access to health services, mental health, highest levels of school connectedness, and self-rated health.

**Mental Health:** Controlling for age, education, having health insurance, and heterosexist discrimination, multiple gender ID folks reported, on average, about half a point lower in mental health compared to men. This means that comparing across people with the same age, education, health insurance status, and daily hetero experiences, multiple gender ID

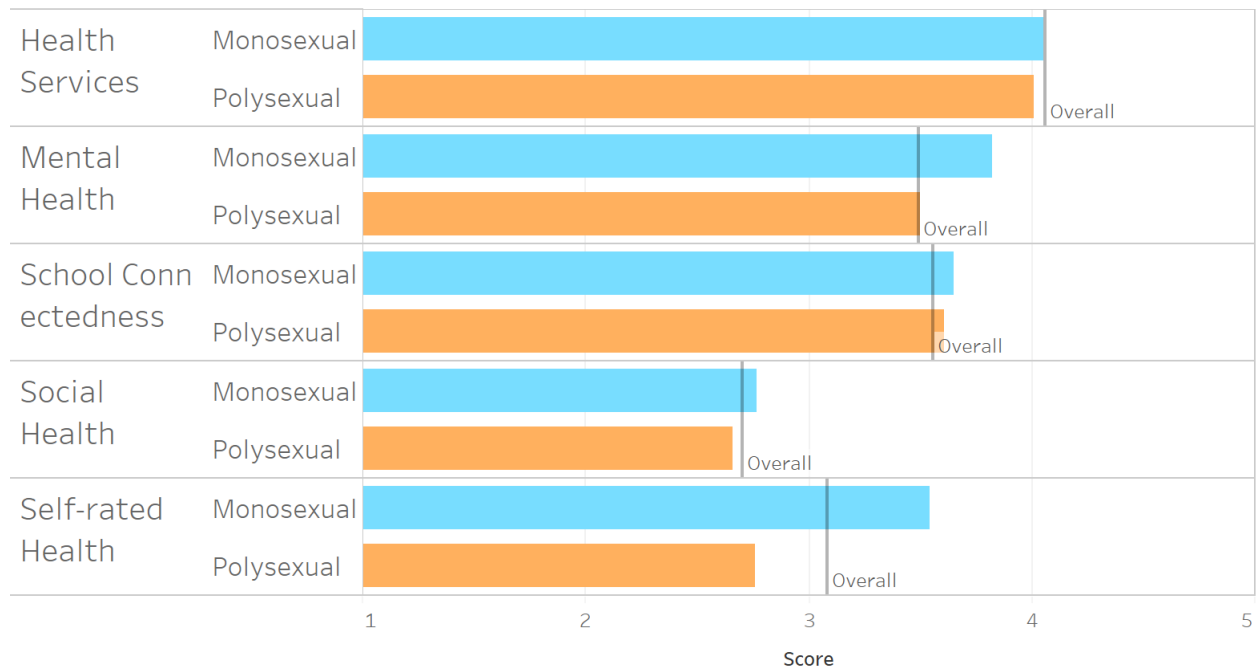
people still report higher levels of hopelessness.

**School Connectedness:** We see similar results for school connectedness as well. Controlling for other variables, multiple gender ID folks reported, on average, more than half a point lower in school connectedness.

**Social Health:** Here, we do not see a difference between men and multiple gender ID people. However, we do see a statistically significant difference in anxiety between men and women such that women reported on average, about half a point higher than men. Basically, controlling for age, education, health insurance, and discrimination, women reported having the least anxiety compared to men and multiple gender ID people.

### SEXUAL ORIENTATION WELLNESS GAPS

#### Sexual Orientation



Overall, monosexual youth reported better outcomes across all categories compared to polysexual youth.

In most cases, these differences were small and not statistically significant when accounting for age, education, having health insurance, and heterosexist discrimination. However, for self-rated health, polysexual people are reported to have 80% less odds of having good health compared to monosexual people. This is the largest difference detected. This result points to the need to better understand other factors impacting

polysexual youths' general health. For example, biphobia and the erasure of bisexual and pansexual people are important considerations for service providers and educators. Even within the LGBTQ community, the "B" is often invalidated with common refrains being "Oh, being bisexual is just a phase." Research also confirms the health inequities between bisexual and pansexual people compared to monosexuals (Friedman et al., 2014).

## CONCLUSION

Through the needs assessment, we identified that:

- Most youth have access to health insurance, however trans youth do not know or have access to trans-affirming health services.
- Cisgender people, binary gender people, and monosexual people are experiencing better social and health outcomes.

These key findings indicate a need to invest in the state of queer youth health in Orange County. This leaves us to answer: What can we all do to foster wellness among LGBTQ+ youth in Orange County? Below are several recommendations on where we as stakeholders can begin to address LGBTQ+ youth needs and close wellness gaps.

### IMPROVE ACCESS TO HEALTH CARE AT THE COMMUNITY AND SYSTEM LEVELS

- Increase community education on available health services at the state and federal level & insurance coverage for services related to transitioning.
- Conduct evaluations on healthcare systems in Orange County to identify how the systems can be responsive to the needs and safety of LGBTQ+ youth.
- Incorporate trans specific healthcare in medical education curriculums.
- Require routine cultural humility and bias training for educators, healthcare providers, and other service delivery professionals.
- Develop mechanisms to ensure healthcare systems and professionals are held accountable to providing gender affirming care that embraces the sexual diversity of the communities they serve.
- Establish a digital directory of current LGBTQ-affirming providers, healthcare organizations and systems, and insurance policies.
- Conduct institutional assessments using the [Healthcare Equality Index](#).

### INCREASE SERVICES, PROGRAMS, AND RESOURCES FOR LGBTQ+ YOUTH

- Incorporate queer and trans-affirming sex education in school curriculums.
- Develop peer to peer education programs where youth can learn how to build healthy relationships to themselves and others.
- Provide support for grassroots efforts to implement and evaluate programs designed for the LGBTQ+ youth community in Orange County.

### IDENTIFY FACTORS IMPACTING THE STATE OF LGBTQ+ YOUTH HEALTH

- Conduct research to assess facilitators and barriers to social and health outcomes for trans youth, non-binary and gender non-conforming youth, and polysexual youth in Orange County.

## MEET THE TEAM

The VROC research committee is composed of academics, community members, and researchers. This research would not have been possible without the energy, expertise, and time of our volunteers that make up this team.

### VROC RESEARCH COMMITTEE MEMBERS

- Brit Cervantes (they/them)
- Uyen P. Hoang, MA, MPH (she/they)
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## GLOSSARY OF TERMS

**LGBTQ+:** An acronym for “lesbian, gay, bisexual, transgender and queer.”

**Cisheteronormative:** A pervasive system of belief (on an individual, systemic, and ideological level) that being cisgender and heterosexual (straight), and associated ways of being in the world (life-path, material desires, family/kinship structures, political/social goals, etc.) are the default, and “normal.”

**Gender Identity:** Our deeply held, internal sense of self as masculine, feminine, a blend of both, neither, or something else. Identity also includes the name we use to convey our gender.

**Sex:** Also referred to as assigned sex at birth. Used to label a person as “male” or “female” (some US states and other countries offer a third option) at birth, this term refers to a person’s external genitalia and internal reproductive organs. When a person is assigned a particular sex at birth, it is often mistakenly assumed that this will equate with their gender; it might, but it might not.

**QTPOC:** Acronym for queer trans people of color.

**Sexual orientation:** Our sexual orientation and our gender are separate, though related, parts of our overall identity. Gender is personal (how we each see ourselves), while sexual orientation is interpersonal (who we are physically, emotionally and/or romantically attracted to).

**Transgender (trans):** Sometimes this term is used broadly as an umbrella term to describe anyone whose gender identity differs from their assigned sex. It can also be used more narrowly as a gender identity that reflects a binary gender identity that is “opposite” or “across from” the sex they were assigned at birth.

**Cisgender (cis):** Refers to people whose Gender identity aligns with their assigned sex at birth (cis- from Latin, meaning, “on this side [of].” In contrast to trans, from the Latin root meaning “across,” “beyond,” or “on the opposite side [of]”).

**Latinx:** A person of Latin American origin or descent (used as a gender-neutral or non-binary alternative to Latino or Latina)

**Binary Genders:** A system that constructs gender according to two discrete and opposite categories: boy/man and girl/woman. It is important to recognize that both cisgender and

Transgender people can have a gender identity that is binary.

**Non-Binary:** An umbrella term for gender identities that are not exclusively masculine or feminine.

**Monosexual:** Those that express attraction to only one gender.

**Polysexual:** Those that express attraction to multiple genders.

**Heterosexual (hetero):** The non-scientific term used to describe heterosexuals; the colloquial term used to designate someone as “not queer.” First used in gay communities as slang to go straight, was to stop engaging in any form of queer sex and romantic behavior.

**Gender non-conforming:** A broad term referring to people who do not behave in a way that conforms to the traditional expectations of their gender, or whose gender expression does not fit neatly into a category. While many also identify as transgender, not all gender non-conforming people do.

**Biphobia:** Biphobia is prejudice, fear or hatred directed toward bisexual people. It can include making jokes or comments based on myths and stereotypes that seek to undermine the legitimacy of bisexual identity.

## READER GUIDE FOR RESEARCH FINDINGS

### Health Services Access

- **Definition:** Whether participants have access to important health services. Services include having a usual place of healthcare, having a main healthcare provider, having health insurance, and being able to get prescriptions on time.
- **How to Interpret:** The scale was 1 through 5. A lower score indicates less access to health services. A higher score indicates more access to health services.

### Mental Health

- **Definition:** How much hopelessness participants are experiencing.
- **How to Interpret:** The scale was 1 through 5. A lower score means worse mental health (i.e., greater feelings of hopelessness) while a higher score means better mental health.

### School Connectedness

- **Definition:** The level of connectedness/sense of belonging that participants feel towards their school environment, teachers, staff, and peers.
- **How to Interpret:** The scale was 1 through 5. A lower score indicates lower feelings of connection to school. A higher score indicates higher feelings of connection to school.

### Social Health

- **Definition:** The level of social anxiety that participants experienced recently.
- **How to Interpret:** The scale was 1 through 5. A lower score means worse social anxiety while a higher score means moderate to no social anxiety.

### Self-Rated Health

- **Definition:** The participants' state of general health.
- **How to Interpret:** The scale was 1 through 5. A higher score means better general health while a lower score means worse general health.

## Statistically Significance

- **Definition:** Whether a result from analyzing the data was likely to have happened by chance or due to a specific factor.
- **How to Interpret:** If statistically significant, a result was unlikely to have happened by chance and may be due to something else. If not statistically significant, a result was likely to have happened by chance.

## Accounting for/Controlling for...

- **Definition:** Holding something constant in the data analysis.
- **How to Interpret:** If we only want to see whether gender influences an individual's mental health, we would control for age, education level, and heterosexist discrimination. This means that we are looking to see if trans people have different mental health outcomes compared to cis gender people who are the same age, have the same education level, and have the same discrimination experiences as them.

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