Do You Mind:

Findings from the 2018 Sex Now Survey on the Mental Health of Young Gay, Bisexual, Trans, Two-Spirit & Queer Men & Non-Binary People in Canada

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do you mind!

Table of Contents

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Purpose Statement

The Community-Based Research Centre (CBRC) developed the *Do You Mind?* pilot project in partnership with organizations supporting gender and sexual minority youth in Vancouver, Edmonton and Halifax. Each city's *Do You Mind?* pilot provided participants with opportunities to develop their own mental health promotion projects along with skills-building activities to develop further the capacity of the participants and their communities. In 2021, CBRC will evaluate the *Do You Mind?* pilot to understand better the impacts of community-based mental health interventions and to ensure that they are best responding to the needs of the communities they were designed to support.

This report provides an initial overview of some of the evidence available to support the initiation and pilot of the community mental health leadership program, *Do You Mind?*. *Do You Mind?* is a community mental health leadership program for gender and sexual minority youth interested in being mental health-savvy knowledge holders and advocates. Despite this broader community focus, our report is focused predominantly on young gay, bi, trans, Two-Spirit, and queer (GBT2Q) men and non-binary people because that is the population surveyed in *Sex Now 2018* and thus for whom we have data available. Future research at CBRC will address this gap by collecting critical mental health data among broader sexual and gender minority communities.

When not specifically referring to GBT2Q men and non-binary people as the *Sex Now* survey population, we use the terms "queer and trans" and/or "gender and sexually diverse" to describe the broader communities of interest. When referring to the work of a specific author, we use the terminology that author used to refer to the communities of interest; this might include LGB, LGBT, LGBTQ, LGBTQ2S+ etc.

This report examines data from the *Sex Now 2018* Survey to highlight the mental health of young GBT2Q men and non-binary people in Canada in order to articulate evidence for the necessity of programs such as *Do You Mind?* and support the program's development by identifying recommendations for needed supports. *Sex Now* is Canada's largest and longest running survey of GBT2Q health. The diversity of participants in the 2018 survey cycle was expanded to include gender non-binary populations; however, as this survey was primarily advertised as survey for "guys into guys," many non-binary people may not have participated. Importantly, all women (cis and trans) were not eligible participants for the 2018 survey. Of the data examined

in this report, 95.4% of participants identified their gender as "man" and 4.6% identified their gender as something else. Because of these limitations, the data spoken to in this report cannot specifically refer to experiences with mental health by trans women, all non-binary people, and other gender and sexually diverse populations of women. Of note, 8.9% of all *Sex Now 2018* participants self-identified as Indigenous (59% First Nations, 38% Metis, 3% Inuk) and 42% of those Indigenous participants identified as Two-Spirit. So, when the report refers directly to the *Sex Now 2018* data, we will use the term young GBT2Q men and non-binary people, recognizing the important caveats missed.

While the *Sex Now Survey* has captured data on the experiences of GBT2Q men and non-binary people, we believe that the benefits of a program, such as that being proposed for *Do You Mind?*, would still have a large impact on the mental health of broader queer and trans communities. In this regard, this report uses the language of young queer and trans people in order to speak to the diversity of communities and populations that *Do You Mind?* has the potential to engage with.

In writing this report, it is understood that experiences of gender and sexuality are unique and diverse. Many individuals and communities experience gender and sexuality in ways that do not align with the norms and binary scripts present in the societies they find themselves in. While this report is based on data from *Sex Now 2018*, which utilizes the terminology of GBT2Q men and non-binary people, this report draws on these data with the understanding that the findings are limited in the ways in which they can speak to broader experiences of mental health across gender and sexually diverse populations. This report serves as a starting place from which to support the development of community health programs with the understanding that growth, adaptation, and redefinition are part of developing relevant and appropriate mental health services to these diverse communities of young people.

Introduction

Increasingly, over the last decade, calls for queer and trans liberation have included the understanding that health, and specifically mental health, is a central component in that fight. Gender and sexually diverse populations continue to experience systemic homophobia, transphobia, racism and colonial violence that negatively impacts their mental health. These communities, however, have also developed strong social and community networks of support that function to insulate and alleviate some of the negative impacts that come from living with persistent marginalization. In order for service providers, community organizers, and policy makers to address these health inequities, they must both understand the experiences that contribute to them and the ways that communities support each other.

To understand the complicated ways that gender and sexually diverse populations relate to their own mental health, and the ways that their mental health is impacted by their environments, an understanding of four interrelated theories is recommended: intersectionality, life-course theory, the minority stress model, and socio-ecological theory.

While the word intersectionality was originally developed by Crenshaw, a critical race legal scholar, in the late 80s, the theory behind it has been central to Black feminist scholarship and activism for almost two centuries (Truth, 1851). Intersectionality is a term to describe "the vexed dynamics of difference and the solidarities of sameness in the context of antidiscrimination and social movement politics" (Cho, Crenshaw, & McCall, 2013, p. 787). This framework can be utilized to expose how single axis thinking can undermine "disciplinary knowledge production and struggles for social justice" (Cho, Crenshaw, & McCall, 2013, p. 787). Taking this framework up in considering the current project report, intersectionality is utilized to interrogate the ways in which systems of power constitute regulatory regimes of identity (such as gender, race, age, and sexual orientation), revealing processes that can and do lead to disparities in mental wellness and access to resources. Utilizing intersectionality to make visible the unique relationships between complex identities that inform, and shape people and communities offers opportunities for considering unique sites of not only oppression but also resilience, protective factors, and possible sites of intervention.

Life-course theory has become an integral part of the ways that we understand community and individual health as we age (Institution of Medicine, 2012; Hammack,

2005). Life-course theory looks to understand the ways that events and social factors impact the trajectories of generations or cohorts as they age. By doing so, we see patterns emerge that can provide deeper insight into the experiences of communities. People also engage with life-course theory outside of academic spaces, as can be seen with the explosion of Millennial vs. Gen Z memes. While the terms "Millennial" and "Gen Z" come with a lot of history and assumptions themselves, at the heart of these, often comedic, online representations of cohorts, is the belief that there is a shared experience shaped by events (like the economic downturn in 2008) in people's lives. As this report looks specifically at the data we have on experiences of People of Colour (POC), trans, and Indigenous GBT2Q men and non-binary people who are young (defined as aged under 30), life-course theory is useful in considering the patterns that may be present.

The minority stress model, developed by Brooks (1981) and Meyer (1995, 2003) for sexual minority populations and adapted by Hendricks and Testa (2012) for gender diverse populations, proposes that individuals with minority identities are exposed to a "hostile and stressful social environment" (Meyer, 2003, p. 674) that may lead to high incidences of mental health issues. This model is used to understand how the social environment and external factors that individuals experience impact their mental health, suggesting that discrimination, bias, and prejudice have real implications on the health and well-being of individuals. This model parallels the ideas found in intersectionality and socio-ecological theories but specifically highlights the unique ways that social environments impact the experiences of stress for minority populations, such as queer and trans people.

Socio-ecological theory represents an understanding that individuals are shaped by their interactions with multiple levels of their social environments (McLeroy et al., 1988). These include personal micro interactions that might be represented by one-on-one relationships with other individuals but also include relationships to larger contexts at the meso and macro level such as institutions including schools, hospitals and governments, and overarching systems of culture. Socio-ecological theory positions societal oppression as central to understanding how individuals relate to these various levels of interaction but also looks to understand the strengths and resilience that individuals and communities can draw from them as well. Oppression and strength can be experienced at different levels of interaction with our surroundings (person, family, communities, societal institutions, etc.) and have a direct impact on the health outcomes of individuals and communities, leading to health inequity and sites of resilience.

There is a growing body of research on the health inequities that are experienced by gender and sexually diverse communities in Canada. A meta-analysis of studies on depression and anxiety among lesbian, gay, bisexual and heterosexual people in Canada found that bisexual people represented the highest scores for both depres-

sion and anxiety (Ross et al., 2018). Gay-identified participants in the same meta-analysis still scored higher than their heterosexual peers who scored the lowest for depression and anxiety of all groups in the study. These findings are in line with other research, both in Canada and from around the world, that has found significant differences in mental health outcomes between gender and sexual minority populations and their cisgender and heterosexual counterparts (Ferlatte et al., 2020).

Furthermore, differences in mental health outcomes also exist across sub-populations of gender and sexually diverse communities. For example, mental health disparities exist between trans and non-binary communities and their cisgender peers (D'Augelli et al., 2006; Ferlatte et al., 2020; Greytak et al., 2016; Kosciw et al., 2016). In a study looking at inequities in depression amongst sexual and gender minorities, Ferlatte et al. (2020) found substantial differences between gender identitities, noting that transgender and non-binary individuals reported higher scores of depression than the other sexual minority participants and that transgender women of ethinic minority groups are at higher risk for depression and other adverse health outcomes.

Trans PULSE Ontario, the largest survey of transgender communities in Canada at the time, found 77% of trans people age 16 and over had ever seriously considered suicide and 43% had attempted suicide (Bauer et al., 2013). This study indicated that among those having ever attempted suicide, ⅓ did so when they were less that 15 years of age and another ⅓ between the ages of 15 and 19 years old, indicating the importance of mental health interventions for young trans people. This is also in line with data that have recently been released by Trans PULSE Canada, collected from trans and non-binary people from across the country, that found 56% of respondents described their mental health as fair or poor (The Trans PULSE Canada Team, 2020). Similarly, when compared with their cisgender peers, trans and non-binary participants from *Sex Now 2018* were found to experience significantly higher levels of depression and anxiety symptoms (CBRC, 2020). Other studies of transgender youth in British Columbia found that while transgender youth overall (transgender girls/women, transgender boys/men, and non-binary youth) had a higher risk of reporting psychological distress, trans boys and men, as well as non-binary respondents, were the most likely to report self-harming behaviours (Veale et al., 2017).

There has been a lack of research on the specific mental health experiences of queer and trans people of colour in Canada. The research has been inconclusive on whether or not queer and trans people of colour have worse mental health outcomes than their white peers (Ferlatte et al., 2020; Kertzner, Frost & Stirratt, 2009; Chih et. al, 2020). Regardless of depression or anxiety scores, queer and trans people of colour are likely to experience multiple forms of oppression in the micro, meso and macro spheres of their lives, including racism and settler colonial violence within the LGBTQ2S+ community. Discussions of the queer and trans community in Canada frequently presume a white community, which erases the existence and experiences

of LGBTQ2S+ people of colour (Sadika et al., 2020). This report looks to speak to a broad range of diverse experiences within the LGBTQ2S+ umbrella, specifically to our data among young GBT2Q men and non-binary people of colour.

While research regarding mental health of young queer and trans communities is limited, much of the research points to large disparities in mental health between sexual and gender minority communities and their heterosexual and cisgender counterparts (Bauer et al., 2013; Hottes et al., 2018; King et al., 2008; Taylor et al., 2019). Violence and bullying continue to disproportionately impact these communities and while research exists outlining higher rates of violence, mental health concerns, self-harm, and suicidality amongst young LGBTQ2S+ communities, much of the available research focuses on risk factors as opposed to protective factors and sites of resilience (Pakula, 2016).

Previous *Sex Now* data found that that GBT2Q trans men and non-binary people are more likely to access mental health support services than their cisgender peers (CBRC, 2020). Even still, GBT2Q men and non-binary people experience unique barriers to accessing services such as clinical counsellors, psychiatrists, or social workers (Ferlatte et al., 2019). While online resources, such as www.goodhead.ca and www.mindmapbc.ca, can offer specific resources, there is a gap in availability of local resources that are specifically directed to young people within these communities, particularly in more rural or remote areas. Being able to find an agency that offers mental health services specifically for young queer and trans people can be hard with such services being found mainly in large urban centres. Furthermore, experiences of racist, homophobic or transphobic mental health practitioners, agencies and counselling offices make queer and trans people less likely to access these spaces in the future (Bowers, Plummer & Minichiello, 2005).

Supports for young queer and trans people have often taken the form of school-based interventions such as Gay-Straight Alliances or Gender and Sexuality Alliances (GSAs) (Currie et al., 2012; Toomey & Russel, 2013). School-based organizations, while helping to provide services for a community that is often underserved, may not be the best equipped to address the complex mental health needs of this particular community. School-based interventions such as GSAs work to create safe, caring, and supportive spaces for queer and trans students and their allies in schools. Research demonstrates GSAs are a supportive factor for queer and trans students and are associated with increased emotional safety for LGBQ students (Ioverno et al., 2016), lower rates of suicide among LGBTQ youth (Poteat et al., 2013), less experiences of bullying and higher perceived classmate and teacher support by LGBTQ students (Day et al., 2020); however, these findings are not as strong for LGBTQ students of colour (Baams & Russell, 2020). Nevertheless, GSAs are student-run and teacher supported, meaning that these groups are not offered by trained mental health professionals. While some GSAs are led by school counsellors, it is more common for the staff-lead of the alli-

ance to not be a member of the teaching staff or administration (Mayo, 2015), making these groups important for community and connection but not as sites of complex, direct mental health service.

In addition to school-based programs, support for young queer and trans people's mental health is often individual counselling or other clinical services. While these services offer trained professional mental health providers, research suggests that many queer and trans young people face barriers when wanting to access these supports (Kitts, 2010; McIntyre et al., 2012; Williams & Chapman, 2011). In addition to systems-level barriers, these mental health service providers are often not well-trained or cognizant of appropriate and relevant care for sexually and gender diverse communities (Kitts, 2010; Shipherd & Sloan, 2019). Service providers that do not have education or experience in providing appropriate services to queer and trans communities may engage in homophobic or transphobic practices, whether intentional or not, including asking inappropriate or stigmatizing questions. This lack of awareness can make services unsafe and even potentially harmful for these communities which leaves a large gap in available services for communities with a demonstrated need.

While there is a growing body of research in Canada about the health disparities that sexual and gender diverse communities face, there is still a dearth of research that looks to understand the community factors that support queer and trans young people's mental health. While community connectedness and social networks might act as insulating factors against ongoing experiences of marginalization, oppression and systemic violence (Frost & Meyer, 2012; Kertzner, Frost & Stirratt, 2009; Pakula et al, 2015), more research is needed in this area to further explore the importance of community in supporting the mental health of queer and trans young people.

Methodology

The data were collected as part of the 2018 iteration of the *Sex Now Survey*. *Sex Now* is the principal community-based research project administered by the Community-Based Research Centre (www.CBRC.net/sexnow). It originated as a paper-and-pencil survey done at Pride festivals across British Columbia in 2002 and has grown to become the longest running and largest survey of gay, bisexual, queer and trans men, and Two-Spirit and non-binary people's health in Canada. Since 2010, the study has been conducted nationally. *Sex Now* has become a vital tool for understanding the experiences of GBT2Q men and non-binary people and is used by policy makers, front line service providers, health researchers and community members. Data collected from *Sex Now* is also publicly available through the Our Stats dashboard (www.cbrc.net/ourstats).

The 2018 version of *Sex Now* was conducted in collaboration and with input from GBT2Q men's and non-binary people's communities, and service providers who support them. CBRC hosted a series of consultations to help shape questions to ensure that the survey represented the needs that GBT2Q men and non-binary people identified as central to their health. This included targeted consultation with trans men and Indigenous Two-Spirit stakeholders. CBRC partnered with community organizations from across Canada to survey GBT2Q men and non-binary people on their health experiences. Data were collected in-person at 15 LGBTQ Pride festivals in six provinces across Canada from June-September 2018. Non-heterosexual men, including trans men as well as Two-Spirit and non-binary people, aged 15 years or older attending Pride festivals were eligible to complete anonymous paper-and-pen health surveys in English or French.

Participants were asked questions on topics like anxiety, depression, social support, access to mental health services and feelings of community connectedness. Participants were also asked to answer both the Patient Health Questionnaire-2 (PHQ-2, "Little interest or pleasure in doing things" and "Feeling down, depressed, or hopeless") and the Generalized Anxiety Disorder 2-item (GAD-2, "Feeling nervous, anxious or on edge" and "Not being able to stop or control worrying") to screen for depressive and anxiety symptoms (Kroenke et al., 2007; Löwe et al., 2005). Response options for these two-question screeners were "not at all," "several days," "more than half the days," and "nearly every day." From these questions, two mental health measures

were established: one for depression and one for anxiety. For each measure, the possible range of scores was 0 through 6, with a score of 0 indicating a respondent answered "not at all" to both questions, and a score of 6 meaning the person answered "nearly every day" to both questions. A score of 3 could mean that a participant had either experienced one symptom "nearly every day" or selected "more than half the days" as one response and "several days" as the other response. Based on the literature (Kroenke et al., 2007; Löwe et al., 2005), a cut-off of 3 or higher was used to indicate a possible depression or anxiety disorder.

As indicated above, a number of sub-groups were of interest for this report. Participants could identify with more than one race/ethnicity, so these categories are not mutually exclusive. Participants were defined as a person of colour if they identified with any race/ethnicity other than white. Any participant who identified as Indigenous was included in the Indigenous group and could have also identified as a person of colour and/or white.

Participants were grouped into a trans/non-binary category based on their responses to two survey questions: gender identity and transgender lived experience. The first question, "What is your gender identity?," had three options: "man," "woman," and "neither. I prefer to self-describe as: _____." A participant could only select one answer as a response. As per above, participants were eligible if they did not answer "woman." Those who answered "neither" had an opportunity to provide a written response for how they prefer to self-describe their gender identity; the most common responses to this open text question were "non-binary" or "they/them", followed by "transmasculine" or "FTM", and then "genderfluid". The second question asked was, "Do you have trans experience? (i.e., your gender is different than the sex you were assigned at birth)." A participant could answer either "yes" or "no." Using these two questions, we created a trans/non-binary participant group. The cisgender group is composed of all participants that selected "man" as their gender identity and responded "no" to the question about trans experience. The trans group includes all participants who selected "yes" to trans experience, regardless of their gender identity being man or non-binary, and all participants who responded "neither" man nor woman to the question of gender identity were included in the non-binary group, irrespective of their trans experience. Of note, we intentionally only asked self-identified Indigenous participants whether they were Two-Spirit or not; this report does not distinguish between the experience of Indigenous Two-Spirit and Indigenous non-Two-Spirit participants, which is the focus of a separate stand-alone report.

Table 1. Demographics

	All Participants		POC <30		Trans/NB <30		Indigenous <30	
Racial Identity	**n=3508**	**%**	**n=397**	**%**	**n=206**	**%**	**n=145**	**%**
African, Caribbean, Black	145	4.1	66	16.6	10	4.9	9	6.2
Arab, West Asian	116	3.3	66	16.6	8	3.9	3	2.1
East or Southeast Asian	298	8.5	152	38.3	16	7.8	6	4.1
Indigenous	314	9	24	6.0	32	15.5	145	100.0
Latin American, Hispanic	180	5.1	83	20.9	11	5.3	6	4.1
South Asian	113	3.2	48	12.1	8	3.9	2	1.4
White	2594	73.9	55	13.9	151	73.3	54	37.2
Other	33	0.9	1	0.3	5	2.4	1	0.7
Sexual Orientation/ Identity	**n=3483**	**%**	**n=395**	**%**	**n=206**	**%**	**n=145**	**%**
Gay	2816	80.8	319	80.8	70	34.0	86	59.3
Asexual	33	0.9	2	0.5	9	4.4	2	1.4
Straight	27	0.8	2	0.5	3	1.5	0	0.0
Bisexual	426	12.2	44	11.1	46	22.3	34	23.4
Pansexual	178	5.1	16	4.1	60	29.1	23	15.9
Queer	330	9.5	54	13.7	81	39.3	15	10.3
Heteroflexible	27	0.8	3	0.8	6	2.9	2	1.4
Other	21	0.6	4	1.0	4	1.9	1	0.7
Gender Identity	**n=3479**	**%**	**n=395**	**%**	**n=206**	**%**	**n=144**	**%**
Man	3320	95.4	365	92.4	107	51.9	130	90.3
Other	159	4.6	30	7.6	99	48.1	14	9.7
Age	**n=3487**	**%**	**n=397**	**%**	**n=206**	**%**	**n=145**	**%**
15-17	42	1.2	7	1.8	14	6.8	14	9.7
18-24	664	19.0	187	47.1	126	61.2	84	57.9
25-29	720	20.6	203	51.1	66	32.0	47	32.4
30+	2061	59.1	-	-	-	-	-	-

In total, 3508 people participated in the 2018 *Sex Now* online survey with 40.8% (n= 1426) reporting being under the age of 30 years old. Of those under 30, 19.5% (n=397) identified as a person of colour (POC), 9.9% identified as trans or non-binary (n=206), and 7% identified as Indigenous (n= 145). Of note, 40.7% (n=59) of Indigenous youth participants identified as Two-Spirit. The racial or ethnic identities of white, East or Southeast Asian and Latin American or Hispanic were the most represented in the survey. Demographics are outlined in Table 1.

Descriptive statistics were derived from participants' responses to the 2018 *Sex Now* survey to develop an exploratory analysis on the mental health experiences of GBT2Q men and non-binary people in Canada, specifically to understand better the experiences of youth of colour, Indigenous youth, and trans and non-binary youth. The following section outlines the findings, focusing on the mental health outcomes of these specific participant groups.

Findings

The following section outlines the findings looking at results from the participant group as a whole (n=3508) and three sub-groups of participants under 30 years of age: People of Colour (POC) (n=397), trans and non-binary (Trans/NB) (n=206), and Indigenous (n=145). While these groups are not distinct, differences in findings speak to how variations in positionality and intersections of identity factors may result in differences in mental health outcomes, access to service providers, and connection to community across these sub-groups.

Table 2. Anxiety and Depression Scores

	All Participants		POC <30		Trans/NB <30		Indigenous <30	
Anxiety Score (GAD-2)	**n=3271**	**%**	**n=370**	**%**	**n=190**	**%**	**n=134**	**%**
0	1290	39.4	119	32.2	27	14.2	32	23.9
1	598	18.3	83	22.4	26	13.7	17	12.7
2	755	23.1	79	21.4	36	18.9	35	26.1
3	195	6	26	7.0	17	8.9	15	11.2
4	196	6	28	7.6	33	17.4	13	9.7
5	86	2.6	12	3.2	16	8.4	8	6.0
6	151	4.6	23	6.2	35	18.4	14	10.4
<3	2643	80.8	281	75.9	89	46.8	84	62.7
>3	628	19.2	89	24.1	101	53.2	50	37.3
Depression Score (PHQ-2)	**n=3276**	**%**	**n=370**	**%**	**n=192**	**%**	**n=134**	**%**
0	1510	46.1	137	37.0	34	17.7	38	28.4
1	523	16	76	20.5	26	13.5	21	15.7
2	741	22.6	84	22.7	57	29.7	35	26.1
3	195	6	32	8.6	15	7.8	12	9.0
4	137	4.2	16	4.3	27	14.1	13	9.7
5	67	2	9	2.4	9	4.7	6	4.5
6	103	3.1	16	4.3	24	12.5	9	6.7
<3	2774	84.7	297	80.3	117	60.9	94	70.1
>3	502	15.3	73	19.7	75	39.1	40	29.9

Almost half (46.1%, n= 1822) of all participants in the *Sex Now* survey had a Depression Score of 0 on the PHQ-2, 84.7% (n= 2774) of all participants scored less than 3, and 15.3% (n= 502) scored equal to or higher than 3 indicating the presence of possible depressive symptoms. When looking at just participants who identified as a young person of colour (POC) the number of people who scored less than 3 drops

to 80.3% (n= 297) with 19.7% (n= 73) scoring 3 or higher. Indigenous young people also predominantly scored less than 3 on the PHQ-2, 70.1% (n= 94), but a higher percentage scored 3 or greater at 29.9% (n= 40/134).

The findings from the 2018 *Sex Now* survey suggests that young trans men and non-binary communities face greater mental health outcome disparities in comparison with their cisgender peers (see Table 2 and Figure 1). A larger portion (39.1%, n= 75) of trans men and non-binary-identified participants scored 3 or greater on the PHQ-2. This suggests that more needs to be done to support the needs of trans men and non-binary individuals' mental health in Canada. It should be noted that 60.9% (n= 117) of trans men and non-binary individuals still scored lower than 3 on the PHQ-2 and that the majority of trans men and non-binary respondents are not experiencing depressive symptoms.

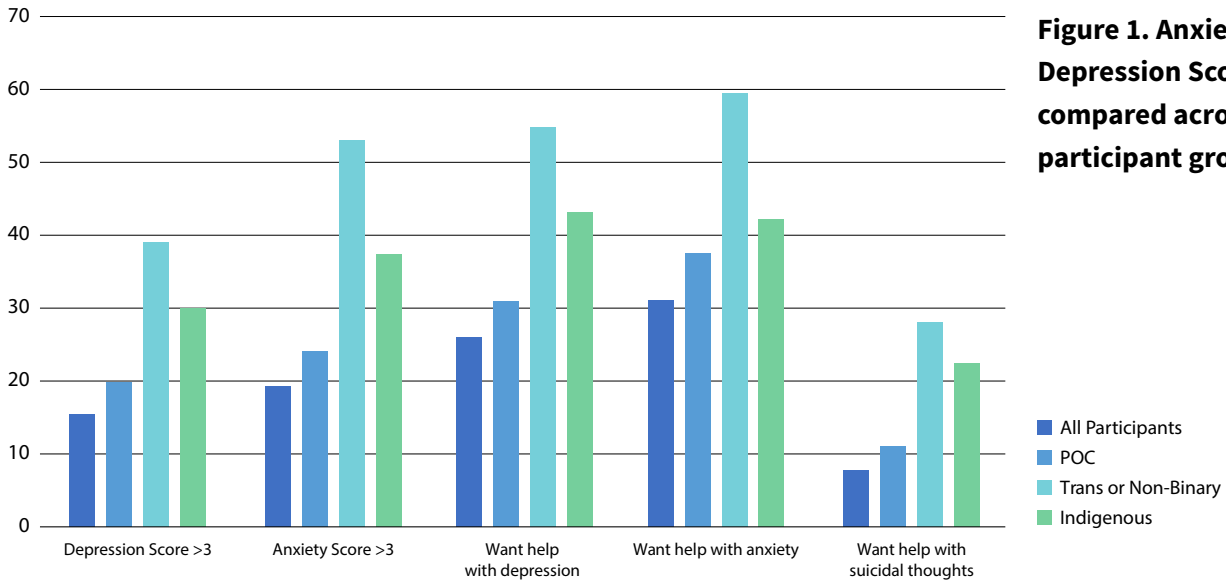


Figure 1. Anxiety and Depression Scores compared across participant groups

Our findings from *Sex Now 2018* shows anxiety as a common experience for participants, but still not something that a majority reported. Of all participants, 80.8% (n= 2643) scored less than 3 on the GAD-2. This dropped to 75.9% (n= 281) for those who identified as people of colour and to only 62.7% (n= 84) among those who identified as Indigenous. Thus 37.3% (n= 50) of Indigenous participants scored 3 or higher, which highlights the particular need for services to support the mental health of this community.

While a majority of participants did not score 3 or higher on the GAD-2 portion of the *Sex Now* survey, a majority of trans men and non-binary participants did. Half (53.2%, n= 101) of trans men and non-binary participants scored 3 or higher, with 18.4% (n=35) scoring themselves a 6 (the highest possible score) on the GAD-2. Again, specific attention needs to be paid to the mental health experiences of trans and non-binary communities in Canada and targeted mental health screening and supports must be produced to address this alarming gap.

Among *Sex Now 2018* participants, the most popular responses when asked what issues participants would like help with were consistent across all three sub-groups and the overall sample. In each group, the largest number of participants chose anxiety, depression, and body image as the issues that they most wanted help with (see Table 3). Suicidal thoughts was the fourth most common response for Indigenous participants, fifth overall, and sixth for people of colour (POC). POC participants identified relationship problems as their fourth most common issue and support in coming out was fifth.

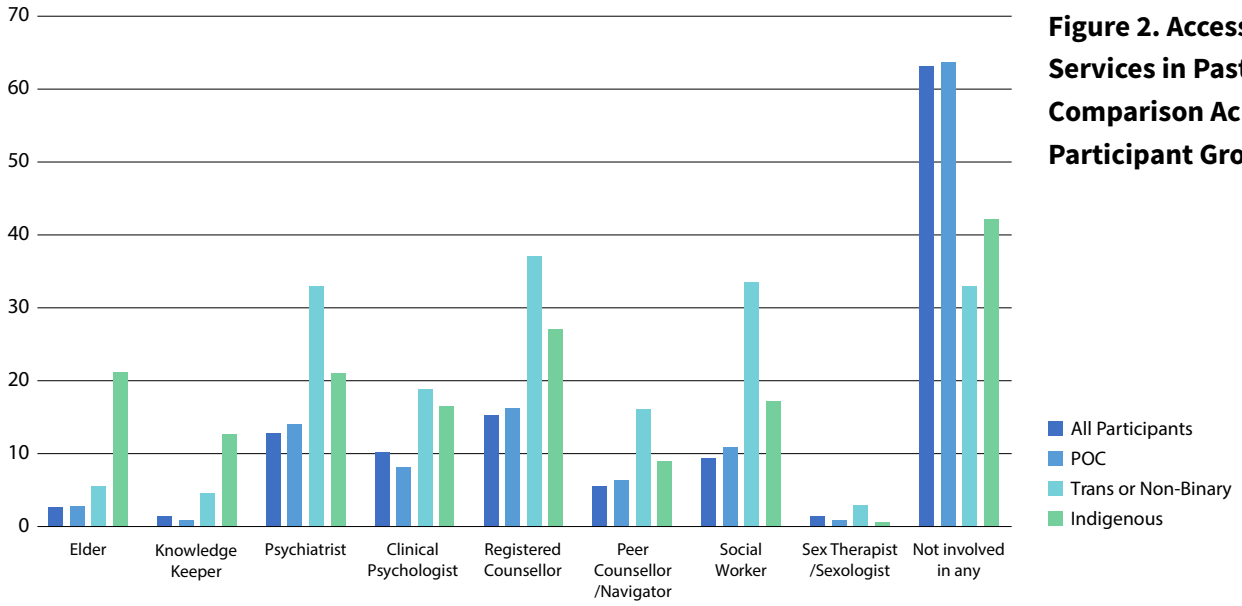


Figure 2. Accessing Services in Past Year Comparison Across Participant Groups

Table 3. Issues identified wanting help with and connection to related services and resources

	All Participants		POC <30		Trans/NB <30		Indigenous <30	
Issues Wanting Help With	**n=3178**	**%**	**n=364**	**%**	**n=189**	**%**	**n=130**	**%**
Depression	820	25.9	112	30.9	103	54.8	56	43.1
Anxiety	984	31	137	37.6	112	59.6	55	42.3
Body Image	621	19.5	109	29.9	83	43.9	41	31.5
Suicidal Thoughts	240	7.6	40	11.0	53	28.0	29	22.3
Resources Accessed in the Past Year	**n=3130**	**%**	**n=350**	**%**	**n=190**	**%**	**n=132**	**%**
Elder	83	2.7	10	2.9	11	5.8	28	21.4
Knowledge Keeper	51	1.6	4	1.1	9	4.7	17	12.9
Psychiatrist	414	13.2	50	14.3	63	33.2	28	21.2
Clinical Psychologist	325	10.4	29	8.3	36	19.0	22	16.7
Registered Counsellor	486	15.5	58	16.6	71	37.4	36	27.3
Peer Counsellor/ Navigator	179	5.7	23	6.6	31	16.3	12	9.1
Social Worker	303	9.7	39	11.1	64	33.7	23	17.4
Sex Therapist/ Sexologist	54	1.7	4	1.1	6	3.2	1	0.8
Not involved in any of above	1984	63.4	224	64.0	63	33.2	56	42.4

Table 4. Connection to Community and Supports

	All Participants		POC <30		Trans/NB <30		Indigenous <30	
Number of People Participants can count on for support	**n=3257**	**%**	**n=353**	**%**	**n=193**	**%**	**n=127**	**%**
0	114	3.5	16	4.5	6	3.2	10	7.9
1	129	4	12	3.4	15	7.9	5	3.9
2-3	920	28.2	105	29.7	54	28.4	37	29.1
4-6	874	26.8	111	31.4	56	29.5	34	26.8
7-9	348	10.7	39	11.0	21	11.1	15	11.8
10+	872	26.8	70	19.8	38	20.0	26	20.5
Satisfaction with connection to LGBT2SQ+ communities	**n=3347**	**%**	**n=360**	**%**	**n=191**	**%**	**n=128**	**%**
No	585	17.5	77	21.4	40	20.9	28	21.9
Unsure	790	23.6	113	31.4	38	19.9	47	36.7
Yes	1841	55	170	47.2	113	59.2	53	41.4
Satisfaction with connection to gay, bi, and queer men	**n=3328**	**%**	**n=364**	**%**	**n=192**	**%**	**n=126**	**%**
No	566	17	72	19.8	58	30.2	26	20.6
Unsure	585	17.6	87	23.9	45	23.4	35	27.8
Yes	2093	62.9	205	56.3	89	46.4	65	51.6

While trans men and non-binary participants were more likely to identify symptoms of anxiety and depression than their cisgender peers, they were also more likely to be connected to mental health supports. About a third of trans men and non-binary participants reported seeing a registered counsellor (37.4%), social worker (33.7%) or psychiatrist (33.2%) in the past year.

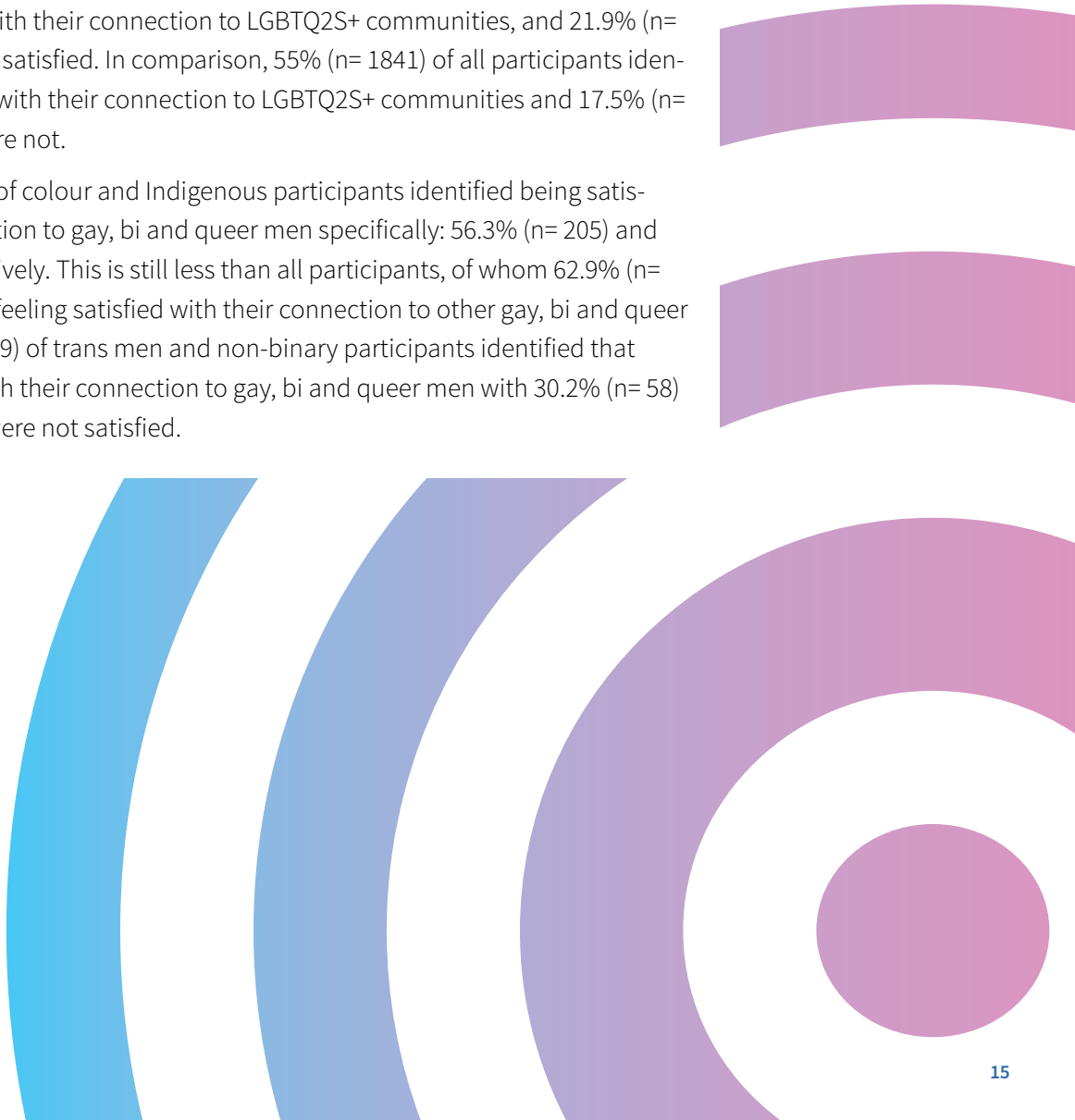
In contrast to the trans men and non-binary respondents, 64% (n= 224) of POC and 63.4% (n= 1984) of all participants reported not having spoken to a mental health resource in the past year, as opposed to only 33.2% (n= 63) of trans men and non-binary participants. Of note, a higher percentage of Indigenous participants accessed a mental health support in the past year in comparison with the overall sample: 27.3% (n= 36) had seen a registered counsellor, 21.4% (n= 28) had spoken with an Elder, and 12.9% (n=17) had spoken with a Knowledge Keeper. Even though a higher percentage of Indigenous participants had spoken to a mental health support, there was still a large percentage, 42.4% (n= 56) who had not. While not every participant may need or should access these supports, higher uptake of these services may be indicative of higher mental health disparities amongst these participant groups.

Across all participant groups, a majority of respondents were able to identify four or more people that they could go to for help or if something went wrong (see Table 4). There was a slight difference across participant groups for respondents who could identify more than ten people they could go to for support: 20% of Indigenous (n= 26),

19.8% of people of colour (n= 70) and 20.5% of trans men and non-binary people (n= 38) compared with 26.8% (n= 872) of all participants. While only 3.5% of all respondents reported that they have no one to count on if something went wrong, there was variation between population groups, with 4.5% of POC (n=16), 3.2% of trans/non-binary (n=6), and 7.9% of Indigenous (n=10) participants indicating that they had no one. This distribution across groups shifted when looking at participants that reported that they had one person they could go to with 3.4% of POC (n=12), 7.9% of trans/non-binary, and 3.9% of Indigenous (n=5) participants reporting this compared with 4% of all participants (n=129).

Participants were asked about feelings of satisfaction with their connection to LGBTQ2S+ communities, and then more specifically their feelings of satisfaction with their connection to other gay, bi and queer men. Trans men and non-binary participants had the highest percentage of respondents who said that they felt satisfied with their connection to LGBTQ2S+ communities at 59.2% (n= 113). Only 47.2% (n= 170) of people of colour identified feeling satisfied, with another 21.4% (n= 77) saying that they did not feel satisfied. For Indigenous respondents, only 41.4% (n= 53) identified feeling satisfied with their connection to LGBTQ2S+ communities, and 21.9% (n= 28) said they were not satisfied. In comparison, 55% (n= 1841) of all participants identified feeling satisfied with their connection to LGBTQ2S+ communities and 17.5% (n= 585) reported they were not.

Of note, more people of colour and Indigenous participants identified being satisfied with their connection to gay, bi and queer men specifically: 56.3% (n= 205) and 51.6% (n= 65), respectively. This is still less than all participants, of whom 62.9% (n= 2093/3328) identified feeling satisfied with their connection to other gay, bi and queer men. Only 46.4% (n= 89) of trans men and non-binary participants identified that they were satisfied with their connection to gay, bi and queer men with 30.2% (n= 58) identifying that they were not satisfied.



Recommendations

The findings from *Sex Now 2018* are in line with previous research that documents mental health disparities among queer and trans young people in comparison with their heterosexual and cisgender peers (Veale et al., 2017). While the majority of *Sex Now* participants still scored low for both depressive and anxiety symptoms, a significant number of young GBT2Q men and non-binary people scored high on both scales. This was especially true for trans men, non-binary and Indigenous participants. Despite the high percentage of young GBT2Q men and non-binary people who experience anxiety and depression symptoms, very few in this study identified speaking with a mental health practitioner. More mental health services and resources that are specifically designed for and engage young people are desperately needed to address these health disparities. Beyond just developing resources and services, however, new programming needs to centre the unique experiences and perspectives of queer and trans people more broadly. Furthermore, policymakers and front-line practitioners need to consider 'upstream' interventions as well, to address the structural, root causes of these disparities. That is to say, treating the hurt (anxiety, depression and other mental health disparities) without addressing the root cause (racism, transphobia, and other forms of marginalization) will inevitably have limited impact. We recommend that service providers use an intersectional, life-course informed approach to develop or update resources. These resources should explicitly address not only the disparities in mental health outcomes but also the unique strengths that queer and trans young people and particularly young Indigenous Two-Spirit and other people of colour, bring to their everyday lives. We recommend that there also be programs developed specifically, and explicitly, for Two-Spirit, queer and trans Indigenous young people and young people of colour to explore the experiences that are unique to their communities.

While the idea of developing and investing in a dramatic expansion of mental health resources for queer and trans young people might seem daunting, it is essential. By developing community-based mental health services and interventions that help develop social support networks we will be better able to respond to the specific issues, needs, and experiences of young queer and trans communities (Snapps et al., 2015). Investing in this community-based approach also has the potential to create benefits beyond the immediate reduction of depressive and anxiety symptoms. As we have seen in our findings from *Sex Now 2018,* young GBT2Q men and non-binary

respondents who also identify as Indigenous or as people of colour are less likely to report feeling connected to broader LGBTQ2S+ communities. By developing community-based programs to address the mental health disparities experienced by queer and trans Indigenous Two-Spirit and people of colour we may see stronger relationships develop which serve to insulate from negative health outcomes. This will only be the case if these programs are built using anti-racist, decolonizing, and anti-transphobic approaches that build on the strengths and cultural knowledge of the communities that they serve. Furthermore, it stands that broader LGBTQ2S+ communities and individuals need to commit to anti-racist and decolonizing practices within their own community spaces to support GBT2Q men and non-binary people who are Indigenous or people of colour.

In terms of future avenues of research, we suggest that future lines of inquiry employ a socio-ecological and intersectional lens to better understand social contexts, social connections, and community and give a fuller picture of the needs and mental health of queer and trans communities. While previous research attributes disparities in mental health outcomes to minority stress, this framework may not illuminate the ways that communities may also have unique strategies for supporting their health and wellbeing. Our current study of *Sex Now* data suggests that understanding young GBT2Q men and non-binary people's mental health will require a more complex and specific understanding of experiences of both marginalization and resilience. For example, based on a minority stress framework (Meyer & Frost, 2013), we would expect to see a higher need for mental health support and higher indication of depression and/or anxiety amongst participants of colour because of the compounding effects of experiencing both racism and homophobia; however, the findings from this study did not support this. In contrast, responses from participants of colour were not significantly different from the average in either anxiety or depression scales. Further exploration into what unique protective factors may be present for specific communities is needed and has the potential to give insight into unique sites of intervention specifically for queer and trans people of colour.

We also recommend that future research include an exploration of the mental health experiences of Black, Indigenous and People of Colour (BIPOC) communities specifically, allowing for a more nuanced discussion of different outcomes between racialized communities that may have different experiences. These communities cannot be seen as homogenous and experience many differences in drivers of mental health outcomes and protective factors, social connections, and experiences of racism. For example, our current analysis grouped all people of colour together; however, for example, experiences within Black communities and Asian communities are different and attention to these differences in future research is needed. We did look specifically at the Indigenous participants, but future research needs to specifically engage Two-Spirit concepts and Indigenous or Two-Eyed seeing approaches. The findings

of the current study indicate that both POC and Indigenous respondents felt less satisfied with their connection to LGBTQ2S+ community. Further exploration into this disparity may offer opportunities to consider how LGBTQ2S+ communities can shift to encourage and support connection and engagement with young BIPOC people (CBRC, 2020).

Future community mental health programs need to hold space for complexity in service provision, considering the diverse experiences across and within queer and trans communities and BIPOC queer and trans and Indigenous Two-Spirit communities specifically. Both within and external to the LGBTQ2S+ community, BIPOC queer and trans and Indigenous Two-Spirit people have diverse experiences with racism as well as diverse experiences connecting to supports and connecting to their communities that warrant specific attention and consideration in both future research and future mental health program design and delivery. Effective and relevant mental health programming needs to take into account these complex differences in order to develop and deliver services that feel accessible, respectful, relevant, and safe.

Conclusion

This report provides a starting place from which to support the development, targeting, evaluation, and scale-up of community mental health projects, such as *Do You Mind?*. Mental health resources should explicitly address not only the disparities in mental health outcomes, but also the unique strengths that young queer and trans people and particularly young people of colour, bring to their everyday lives.

The findings from the *Sex Now* survey suggest that depression and anxiety are important and distinct mental health concerns for young GBT2Q men and non-binary people, with anxiety being more common amongst the populations surveyed. These findings align with previous research that suggests that queer and trans young people experience higher rates of depression and anxiety (D'Augelli et al., 2006; Ferlatte et al., 2020; Greytak et al., 2016; Kosciw et al., 2016). While some parts of these communities appear to be more connected to mental health services, major gaps remain in accessible, relevant mental health services for young queer and trans communities. We suggest that community-based programming can begin to fill these gaps by offering services that are developed with the specific and diverse needs of young queer and trans populations in mind. As Mayo (2017) argues, thinking and researching with young people about how to challenge forms of exclusion needs to become a priority. Further research and program evaluation involving young queer and trans people may provide opportunities for better understanding how these communities of young people utilize their community connections to support their mental wellness and how they might connect with and feel included in the communities that are important to them through programs like *Do You Mind?*.

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