

LGBTQ Youth
YMSM and YWSW
Who Engage in Survival Sex

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Highlights

In 2011, researchers from the Urban Institute launched a three-year study of lesbian, gay, bisexual, transgender, and queer or questioning (LGBTQ) youth; young men who have sex with men (YMSM); and young women who have sex with women (YWSW) engaged in survival sex in New York City. Working in partnership with the New York City-based organization Streetwise and Safe, researchers trained youth leaders to conduct in-depth interviews with 283 youth who engaged in survival sex in New York City and self-identified as LGBTQ, YMSM, or YWSW.

In February 2015 we released the first report, which focuses on the experiences and needs of youth engaging in survival sex; in September 2015 we released the second report, which describes youths' interactions with the criminal justice and child welfare systems. In this third report of the series, we focus on youths' sexual, physical, and mental health problems; substance use behaviors; and treatment and service provider experiences.

Access to Safety features data collected from youth respondents about their exposure to sexually transmitted diseases (STDs) and other health issues, extent of substance abuse, and treatment and service provider experiences. We identified key findings using a multimethod analytic approach, as highlighted below and described further throughout this report.

Youth interviews resulted in the following key findings:

- Most youth reported using barrier and nonbarrier protection, most frequently condoms, against sexually transmitted infections (STIs) and pregnancy. Those youth who did not use protection cited financial and personal reasons, including getting paid more to not use a condom, not feeling the need to use protection with their partner or friend, trusting regular clients, and being forced to not use a condom.
- Medical providers are often the first professionals young people see when they have a medical issue or a question pertaining to sex or relationships, and they usually can assure patient-doctor confidentiality. Given these facts, medical providers are in a unique position to develop a trusted relationship with youth that allows them to feel comfortable discussing their engagement in survival sex. Health care providers can then provide youth with referrals and connect them to other agencies that might help with nonmedical needs, in addition to advocating on youths' behalf to receive certain services.

- Ninety-three percent of the youth interviewed visited one or more service providers in New York City. Of the 260 youth who visited a service organization or program, 99 percent accepted help from that provider, and 94 percent said they would seek such assistance again.
- Although most of the youth had positive things to say about the youth programs and services offered to them, some recounted negative experiences, especially feeling discriminated against based on their sexual orientation and/or gender identity and expression, particularly in urgent care and emergency room settings
- Over a third (36 percent) of the 260 youth who sought services stated their needs were fully met, but nearly two-thirds (64 percent) had unmet needs. The most common services youth wished had been offered by the provider they visited were vocational/education assistance (15 percent), permanent housing assistance (13 percent), and short-term crisis or emergency shelter (7 percent).
- Service providers often work together to meet client needs by forming formal and informal partnerships. Formal partnerships may take the form of a structured, regular activity involving more than one organization, such as a weekly workshop or clinic that one service provider holds at another service provider's organization. They may also involve formal program referrals or formal agreements between organizations. Informal partnerships, which are also important for service providers, are less regular or mechanized activities between different organizations.
- There is a lack of services once a youth reaches age 18 or 21. New York City particularly lacks funded beds for youth between the ages 21 and 24, in addition to medical and mental health care, job skills training, and educational opportunities.

Terminology and Definitional Considerations

Before we discuss the findings from this study, it is important to address and define the terms we use throughout this report. Some of the terms we chose reflect the word choices of the young people we interviewed. The words describe their behaviors and experiences as opposed to labeling them based on these behaviors and experiences.

Cisgender: Individuals whose experiences of their gender match the sex they were assigned at birth.

Gender expression: The aspects of behavior and outward presentation that may (intentionally or unintentionally) communicate gender to others in a given culture or society. These aspects include clothing, body language, speech, hairstyles, socialization, interests, and presence in gendered spaces (e.g., restrooms, places of worship). A person's gender expression may vary from the gender norms traditionally associated with the person's sex assigned at birth. Gender expression is separate from gender identity and sexual orientation (Perry and Green 2014).

Gender nonconforming: People who have or are perceived to have gender characteristics or behaviors that do not conform to traditional or societal expectations. Gender-nonconforming people may or may not identify as transgender. Although gender-nonconforming people are often assumed to be lesbian, gay, or bisexual, sexual orientation cannot be determined by a person's appearance or degree of gender conformity (Perry and Green 2014).

Sexual orientation: Whom a person is physically and emotionally attracted to. Sexual orientation is distinct from gender identity; transgender people may identify as heterosexual, bisexual, gay, lesbian, or any other sexual orientation.

Transgender: People whose gender identity (internal sense of being female, male, or another gender) is incongruent with their sex assigned at birth (physical body). Transgender is also used as an umbrella term to refer to communities of people that include all individuals whose gender identity or gender expression do not match society's expectations of how they should behave in relation to their gender (e.g., transsexual, transgender, genderqueer, gender nonconforming, and other people whose gender expressions vary from traditional gender norms) (Perry and Green 2014).

Young men who have sex with men (YMSM): Young men who may identify as heterosexual but have sex with members of the same sex, often in exchange for money and/or material goods.

Young women who have sex with women (YWSW): Young women who may identify as heterosexual but have sex with members of the same sex, often in exchange for money and/or material goods.

Exploiter: An individual who uses tactics involving force, fraud, and coercion to control a young person's involvement in the commercial sex market.

Peer facilitator: A peer, who may or may not be engaged in survival sex, who provides nonexploitative support to someone engaging in survival sex, so the person engaging in survival sex does not have limited mobility; decides what they do and what they trade sex for; and is not subject to force, fraud, or coercion.

Youth engaged in survival sex: The phrases "youth engaged in survival sex" and "youth who exchange sex for money and/or material goods (e.g., shelter, food, and drugs)" are used here to reflect young people's experiences of involvement in the commercial sex market in their own terms. These terms describe a behavior as opposed to labeling the youth themselves.

Gay family: An alternative familial network of LGBTQ people that may act as an alternative to the family of origin from which many LGBTQ people, particularly youth, have been excluded. The term may also be used to refer to drag houses in the ball scene.

Ball scene/house culture: A community consisting primarily of black and Latino and Latina LGBTQ people organized around anchoring family-like structures, called houses, and competitive balls. Led by house mothers and fathers, houses function as families whose main purpose is to organize the balls and to provide support for their children to compete in balls and survive in society as marginalized members of their communities of origin. Houses offer their children multiple forms of social support, a network of friends, and a social setting that allows free gender and sexual expression. Ultimately, houses within the ballroom community constitute figurative, and sometimes literal, homes for the diverse range of members involved in them (Arnold and Bailey 2009).

Barrier and nonbarrier protection: Any contraceptive or other protective device or method used to prevent unwanted pregnancy or the transmission of human immunodeficiency virus (HIV) or other STDs. Protective devices and methods include male condoms, female condoms, lubricant, preexposure prophylaxis, postexposure prophylaxis, HIV antiretroviral therapy, spermicide, hormonal methods, emergency contraception, diaphragm, cervical cap, or sponge.

Literature Review

LGBTQ youth, overall, are at a disproportionately greater risk for negative health outcomes compared with heterosexual and cisgender youth. Many of the differences between LGBTQ and non-LGBTQ youths' exposure to violence, abuse, sexual victimization, mental health risks, and sexual health risks are fundamentally tied to the difficulties LGBTQ youth face in their adolescent development. Additionally, stressful life events that undermine youths' stability, such as homelessness, only serve to further weaken the healthy development of youth and expose them to physical and mental health risks, such as victimization and the need to trade sex for survival (Rosario, Schrimshaw, and Hunter 2012). Youth who simultaneously identify as LGBTQ and are homeless face disproportionately more negative health outcomes than youth who are not homeless and not LGBTQ (Cochran et al. 2002). These youth have greater needs for social service environments that address their uniquely vulnerable status (Acevedo-Polakovich et al. 2013).

Mental Health

LGBTQ youth are at a higher risk of experiencing physical abuse, sexual abuse, and other forms of violence and victimization than are heterosexual and cisgender youth (CDC 2011; Cochran et al. 2002; D'Augelli, Pilkington, and Hershberger 2002; Friedman et al. 2002; Garofalo et al. 1998). As a result, LGBTQ youth experience more negative mental health outcomes than heterosexual and cisgender youth.

LGBTQ youth who experience discrimination, including verbal abuse, from their peers often exhibit symptoms of depression, and they have high risks of self-harming behavior and suicidal thoughts, ultimately contributing to severe emotional distress (Almeida et al. 2009; D'Augelli, Pilkington, and Hershberger 2002). Sexual abuse also has a negative impact on LGBTQ youths' mental health; LGBTQ youth who have experienced sexual abuse are more likely to experience such mental health issues as depression, borderline personality disorder, and posttraumatic stress disorder (PTSD). These mental health issues contribute to their riskier sexual behavior and more frequent suicidal behavior (Friedman et al. 2002).

As a result of stressors such as verbal, physical, and sexual abuse and harassment; discrimination; and family rejection, LGBTQ youth overall have poorer mental health than cisgender and heterosexual youth. LGBTQ youth have higher levels of depression and other mental health issues (Cochran et al. 2002; Friedman et al. 2002; Gangamma et al. 2008; Garofalo et al. 1998; Lock and Steiner 1999). These

young people are also disproportionately more likely to contemplate and complete suicide and self-harm than non-LGBTQ youth (Almeida et al. 2009; CDC 2011; D’Augelli, Pilkington, and Hershberger 2002; Friedman et al. 2002; Gangamma et al. 2008; Garofalo et al. 1998; Reisner et al. 2015). One study on the mental health of transgender youth found they were up to three times more likely to suffer from depression, anxiety, suicidal thoughts, and self-harm than cisgender youth (Reisner et al. 2015).

Studies focused on runaway and homeless lesbian, gay, and bisexual (LGB) youth found they had experienced inpatient treatment for mental health more frequently than their homeless heterosexual counterparts and were at greater overall risk for mental problems such as anxiety and depression (Gangamma et al. 2008; Rosario, Schrimshaw, and Hunter 2012). Other studies on homeless LGB youth confirmed similar results, finding that homelessness and its associated consequences—such as lack of social support and positive social relationships—along with the stigma, discrimination, and self-blame associated with homelessness, were instrumental to more negative mental health outcomes (Kidd 2007; Rosario, Schrimshaw, and Hunter 2012; Whitbeck et al. 2004). Among the runaway and homeless youth population, Whitbeck and colleagues (2004) found 57 percent of LGB youth reporting at least one suicide attempt, compared to one-third of heterosexual youth.

Physical, Sexual, and Reproductive Health

LGBTQ youth are also at greater risk of poor sexual health, including STIs and HIV, and they perform more risky sexual behaviors than heterosexual and cisgender youth (CDC 2011; Friedman et al. 2002; Garofalo et al. 1998; Lock and Steiner 1999). Homeless youth in general also have greater exposure to sexual risks, including having more than one sexual partner while not using condoms, contracting STIs, and engaging in survival sex (Halcon and Lifson 2004). In another study of youth who trade sex for survival, some youth reported forgoing condoms when having sex with clients if the client did not want to use a condom and was willing to pay more (Curtis et al. 2008). In the same study, 20 percent had an STI at one point in their lives. Many of these youth sought regular medical treatment and assistance: over 75 percent of youth had visited a doctor for a general checkup, including a gynecological exam for cisgender young women; 34 percent had been tested for STIs; and 21 percent had been tested for HIV (Curtis et al. 2008).

Substance Use

Several studies have found that LGBTQ youth have more substance abuse issues than heterosexual and cisgender youth (Cochran et al. 2002; D’Augelli, Pilkington, and Hershberger 2002; Friedman et al. 2002; Gangamma et al. 2008; Garofalo et al. 1998). In one study, LGBTQ youth had significantly different rates of drug use from heterosexual youth for cocaine or crack and speed or crystal methamphetamines (meth), and they used more types of drugs (Cochran et al. 2002). LGB youth also reported earlier initiation of drug use and more frequent use of cocaine and other illegal drugs (Garofalo et al. 1998). Homelessness among LGB youth was associated with greater substance abuse (Rosario, Schrimshaw, and Hunter 2012). Among one group of homeless LGBTQ youth who traded sex for survival, over half reported using marijuana regularly, and approximately a quarter reported using cocaine and alcohol regularly (Curtis et al. 2008). Studies show LGBTQ youth are more likely to report past month marijuana use than heterosexual youth, and weekly marijuana use among young urban men who have sex with men has been reported as high as 23 percent (Thiede et al. 2003). Due to the discrimination LGBTQ youth experience within schools, communities, and families, many turn to drugs or alcohol to help cope with these challenges (Cochran et al. 2002).

LGBTQ Service Usage

Because of the disproportionate risk for violence, abuse, victimization, and health issues that LGBTQ youth face compared with their heterosexual and cisgender counterparts, and the even more heightened risk when these LGBTQ youth are homeless, it is important to understand the landscape of service provision and usage for these youth. LGBTQ youth, particularly those who are homeless, visit service organizations for a wide range of services and resources: shelter and housing-related services, including short-term crisis or emergency shelter, transitional housing, and supportive housing; and a mixture of medical, psychiatric, legal, employment, education, social, and cultural services and programming (Choi et al. 2015). Runaway and homeless youth drop-in centers may also offer meals, showers, counseling, and friendship- and relationship-building opportunities. In one study of youth who trade sex for survival, 68 percent had visited a youth service agency for a range of basic needs such as medical care, nutrition, storage, counseling, and hygiene in addition to social needs (Curtis et al. 2008).

Challenges exist for youth and service providers alike. Some studies have shown LGBTQ youth have lower rates of social service usage, despite their greater need (Acevedo-Polakovich et al. 2013; Maccio and Doueck 2002). When they do seek out services, LGBTQ youth can be met with many

barriers, including discrimination and harassment for sexual or gender nonconformity by staff, denial of services, and solitary isolation (Travers and Schneider 1996). One study of social service providers identified several barriers for LGBTQ youth seeking to access services, including a lack of resources for LGBTQ-specific services, a lack of training and education for staff proficiency in LGBTQ needs, and youth's own tentativeness in seeking help or lack of knowledge that specific resources are available (Acevedo-Polakovich et al. 2013). Another study of service providers that address the needs of LGBTQ runaway and homeless youth identified a lack of funding, community support, access to peers in the field, training, and information as their top five barriers to improving services for this population. Providers also stated that their LGBTQ clients, particularly transgender individuals, faced disproportionate rates of poor health outcomes, including mental and physical health issues (Choi et al. 2015).

Current Study Goals and Methodology

With funding from the Office of Juvenile Justice and Delinquency Prevention and the Urban Institute, Urban Institute researchers set out to accomplish three goals with this report: (1) to describe and quantify the sexual and physical health outcomes among LGBTQ youth, YMSM, and YWSW engaged in survival sex in New York City; (2) to assess how many are using and abusing alcohol and drugs; and (3) to detail youths' access to and interactions with treatment and service providers. This study was based on the premise that in-depth peer-to-peer interviews were needed to fully explore and understand these experiences for LGBTQ youth, YMSM, and YWSW who exchange sex for money and/or material goods. We used a multimethod, quantitative and qualitative approach to address these study goals.

The data collected in this report came from (1) in-depth interviews with approximately 300 youth recruited using a respondent-driven sampling strategy (these data were later qualitatively analyzed and quantified) and (2) in-depth interviews with various stakeholders in the fields of criminal and juvenile justice, child welfare, and service provision to runaway and homeless youth and LGBTQ youth. For more information regarding how the Urban Institute, in partnership with New York City-based Streetwise and Safe, conducted the youth interviews, please refer to the first report of this series: *Surviving the Streets of New York: Experiences of LGBTQ Youth, YMSM, and YWSW Engaged in Survival Sex* (Dank, Yahner, et al. 2015).

LGBTQ Youth Health Issues, Substance Use, and Treatment Service Experiences

This report is the third and final report in a series to present findings from our study on the experiences of LGBTQ youth, YMSM, and YWSW engaged in survival sex in New York City. It focuses on the health outcomes, substance use and abuse, and treatment service experiences of these young people. The first report, *Surviving the Streets of New York* (Dank, Yahner, et al. 2015), describes how and why youth first engaged in survival sex, the characteristics of their peer networks, and their self-reported risks and benefits of trading sex for survival. The second report, *Locked In* (Dank, Yu, et al. 2015), discusses youths' interactions with the criminal justice and child welfare systems. This final report looks in more depth at these youths' health-related issues, service needs, and experiences with service providers.

Youth Demographics

Surviving the Streets of New York provides in-depth findings on the characteristics of the young people we interviewed for this study. Below we recap information on respondents' gender, race, and sexual orientation. Given the importance of gender, sexual orientation, and race to youths' self-identity and life experiences, throughout the report we sought to identify significant ($\alpha < .05$) differences in key findings by youths' gender, sexual orientation, and race. Overall, there were no differences by sexual orientation or YMSM or YWSW status and only two differences by gender and race.

Gender

Most youth in our sample identified as male (47 percent) or female (36 percent). More than 1 in 10 identified as a transgender woman (11 percent), transgender man (3 percent), transgender without specifying an additional gender identity (2 percent), or another gender identity (3 percent), including androgynous, femme, gender nonconforming, and genderless. Individuals also reported being queer and questioning (0.4 percent).

Race

Virtually all the youth in our study were people of color; 37 percent identified as African American or black, 22 percent as Latino or Latina, and 30 percent as more than one race or ethnicity. Other respondents identified as white (5 percent), Native American (1 percent), or another race (4 percent).

Sexual Orientation

Over a third of the youth identified as bisexual, almost a quarter identified as gay, and nearly one-sixth identified as lesbian. Thirteen percent characterized themselves as heterosexual, 3 percent described themselves as queer and questioning, and 9 percent identified another sexual orientation (including open, pansexual, no preference, and no label).

Sexual, Physical, and Mental Health Problems

In this section, we describe the youth respondents' sexual and physical health outcomes, including their use of protection against pregnancy and the spread of STIs. We also discuss chronic health issues they have faced, including diagnosed and undiagnosed mental health issues.

Use of Barrier and Nonbarrier Protections against Sexually Transmitted Infections and Pregnancy

All but two (99 percent) youth reported using barrier and nonbarrier protections to prevent pregnancy and STIs. For some youth this practice occurred only some of the time: approximately two-thirds (63 percent) said they *always* used protection, one-fifth (20 percent) said they did so *most of the time*, and one-tenth (11 percent) said they used protection *sometimes* (see figure 1).

The youth who reported using protection all of the time stated there were no exceptions to this rule, even when it came to their partners or if there was an offer of more money.

Every time. There is no working with me without a condom. I don't care how much money you try to pay me, I don't care if you put in an extra \$100, \$200, \$300 on top of it, no. (Respondent 5174, 21 years old, Latino, heterosexual, male)

Youth were primarily concerned with contracting diseases or becoming pregnant; as the following young man stated, the sex he was engaging in with strangers was purely transactional, not for pleasure.

Interviewee: Condoms are my most effective use because I have to be honest, I'm not doing this for pleasure. I'm doing this for money.

Interviewer: And how often do you use condoms?

Interviewee: All the time. Like, I don't know where these people go, where they are coming from, like if they just fucked their wife and they want to come on a stroll, I don't know what they are doing. (Respondent 199, 21 years old, black, gay, male)

As one 19-year-old bisexual black woman claimed, "There is no love without the glove" (Respondent 706).

Various reasons were given by the respondents who only used barrier and nonbarrier protection some or most of the time to explain why they did not always use protection, including getting paid more to not use a condom, not feeling the need to use protection with their partner or "friends with benefits," trusting regular clients, and being coerced or physically forced to have condomless sex. Many youth who were offered more money for condomless sex were forced to weigh the risk of contracting an infection or becoming pregnant against the necessity of the additional money, sometimes as little as \$25, which would meet basic needs such as food in their stomach or a hotel bed for the night. But as the following young transgender woman explains, some youth tried to employ additional harm-reduction practices when not using protection to reduce the likelihood of contracting an STI.

Interviewee: Lately I would say, 75 percent of the time [I use protection].

Interviewer: Do you not use protection sometimes because you can get more money?

Interviewee: Yes. I'm not going to lie about pay. Sometimes I don't and I be so scared. What am I doing? Oh my God . . . okay, but so I'll do things like use lubrication so there will be lesser ripping or like make them pull out, but you know even with pre cum I know that the risk or whatever but I'll still do things within that to lower my risk. I'll still do some harm reduction things but I know that it's still a big risk so, yeah. (Respondent 374, 21 years old, black, fluid, transgender female)

Another young man described how he would use his best judgment to determine if it was safe to have unprotected sex with a client for more money; he had found out recently that he was HIV positive.

So I have some dudes that they want to have unprotected sex, and I'll deal with that and I try with my best judgment . . . if I feel like you have something, I tell them. A condom is for your protection and for my protection, you don't know what I have, I don't know what you have, you don't know what you have, and I don't know what I have. But sometimes I still got to do it, I need the money, and some dudes throw in extra money for it, so I go with it, and just about a month literally, I think a month ago I found out that I was HIV positive, yeah so. (Respondent 262, 19 years old, multiracial, bisexual, male)

Some youth also felt it was only necessary to use a condom with clients, but having unprotected sex with a partner or friend made it more personal and enjoyable, and less like a transaction.

I'm very like double standard like when it comes to like Johns and everything. I'm all up for protection. I always use protection whether it's oral or something. But for some reason when it's like just somebody that I like and it's just like mutual sex, I can't use a condom. I am afraid because I'm so used to having sex all time with condoms and I just want to live a little. But I usually tell her I don't ever use condoms when I'm having sex mutual but then again I don't really have sex mutual that much, because I'm always having sex. (Respondent 729, 20 years old, Latino, gay, male)

It is important to note that a small number of youth reported they were sometimes forced to not use a condom while trading sex. The exploiter of the following young woman kept a box of condoms in the dresser next to the bed, but there were times when a condom was not used.

Interviewer: Did he [your exploiter] give you condoms to use or birth control?

Interviewee: He would have them in his drawer, in the room, like top drawer on the left in the back of his boxes, it was all the condoms, everything he needed . . . he tells them where the condoms at and that's when they go and put it on and that when they tap my leg.

Interviewer: Did you always use a condom?

Interviewee: I'm not going to lie, it was a couple of times that I did not and I wound up going to the doctor later on, when I got out of the situation, and I found out that I had certain stuff and I was really upset because it wasn't like I was being irresponsible . . . it was just, I was being forced. (Respondent 575, 20 years old, black, lesbian, female)

Some young people who reported that in the past they used protection some of the time stated that after having a health scare, such as contracting an STI or experiencing an unplanned pregnancy, they started using barrier and nonbarrier protection 100 percent of the time when they engaged in sex.

One time I got impregnated and [contracted] gonorrhea. And I wasn't sure those were from my partner or from one of the guys that I had slept with. So that scared me not knowing where it could have come from. So after that, I said I don't want to get pregnant or any kind of diseases, and like that woke me up even more, like okay, this is real. You know like now that I actually experienced it myself. This is not a game, so I need to use protection. (Respondent 236, 20 years old, Latina, bi-curious, female)

The most common form of barrier and nonbarrier protection youth reported using was a condom (95 percent), followed by dental dams (11 percent), birth control (10 percent), and female condoms (10 percent). Small percentages of youth also reported using finger cots (3 percent), lubrication (3 percent), and doctor visits (1 percent) as protection.¹

Although most youth reported using condoms as their main form of protection against sexually transmitted infections and diseases and pregnancy, some youth stated that because their main concern

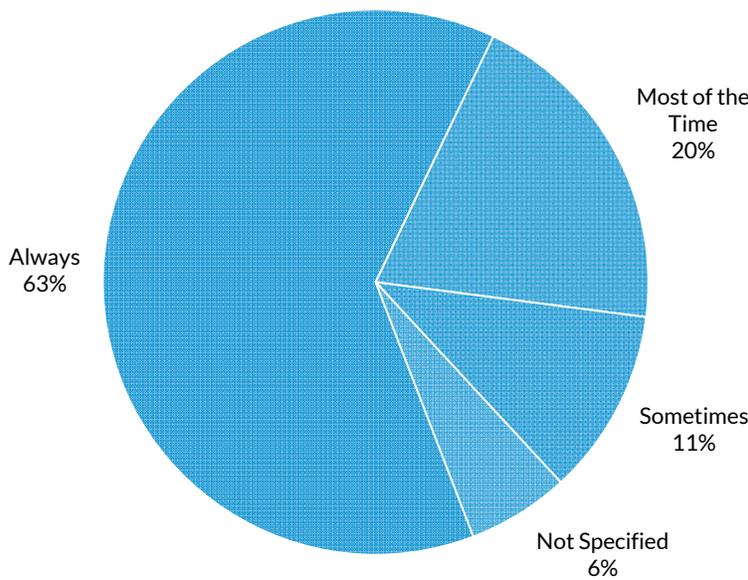
¹ In addition, one youth said they used the "pull out" method for protection.

was not getting pregnant, access to birth control was crucial. Others used any and all forms of barrier and nonbarrier protection available on the market.

I have been on birth control from like six months ago. I went to this free like Planned Parenthood Center and I got a Depo shot and they told me that will last for like six months, so maybe in January I have to go back again. And that's just for me not to get pregnant because what I'm I going to do at 20 years old with a kid? I can't even maintain myself, but like STD wise I always use a condom. (Respondent 606, 20 years old, Latina, bisexual, female)

I've used all; I've used dental dams, female condoms, male condoms, finger condoms. Worst case scenario, even if it's a female she wants to go down, the worst case scenario, use a toy and a condom on the toy. I've never had a pregnancy scare or anything. (Respondent 523, 20 years old, multiracial, lesbian, female)

FIGURE 1
How Frequently Youths Used Protection against STDs and Pregnancy



Note: n = 280 youth (99 percent of the sample).

For the 265 youth who reported using condoms, when asked who supplied them, over half (57 percent) cited a service provider, one-third (34 percent) reported purchasing condoms themselves, and 21 percent received them from a health clinic. Another 12 percent used condoms provided by their customers, and 4 percent received them from friends or family. Virtually none of the youth said they received condoms from an exploiter (2 percent) or peer market facilitator (1 percent). In fact, one young woman, as stated above, reported that her exploiter restricted her access to and use of condoms.

The youth who frequented service providers knew, and were comforted by the fact, that they had access to free condoms at most of the youth programs throughout New York City. As one young man explained, “From every single program I usually go to, like no matter what type of program I go to, I see condoms in a bucket. I go right for the bucket” (Respondent 5016, 20 years old, black, gay, male). Another young woman appreciated how she could “go to drop-in centers and get free condoms without having to tell anybody why” (Respondent 146, 18 years old, European, bisexual, female).

Although youth knew they could access free condoms at the various programs across the city, many still insisted on purchasing their own because they believed condoms purchased in a store have not been tampered with. Some young people would purchase a whole box at a pharmacy, and others would purchase a condom for a dollar at their local bodega. As this young man explained, he didn’t take any chances when it came to protection.

Interviewee: I’ll bring the condoms. I’ll bring the paper stating that I’m clean. I’ll bring the lube. I’ll bring things like that. I bring it for my own convenience. Cause you’re not gonna slip up with me.

Interviewer: And where do you usually purchase condoms? Do you get them for free somewhere?

Interviewee: I purchase them. I buy them in the store. (Respondent 1, 19 years old, Latino, gay, male)

Youth would also visit local health clinics to pick up free condoms along with other things, as this young person described.

I don’t really try to have a person buy them, because they can even poke holes in them, or do something sick and twisted. The doctors . . . I’m glad that they give us free condoms and stuff like that. The adolescent health clinic at Mt. Sinai gives us everything we need. (Respondent 127, 18 years old, black, gay, female)

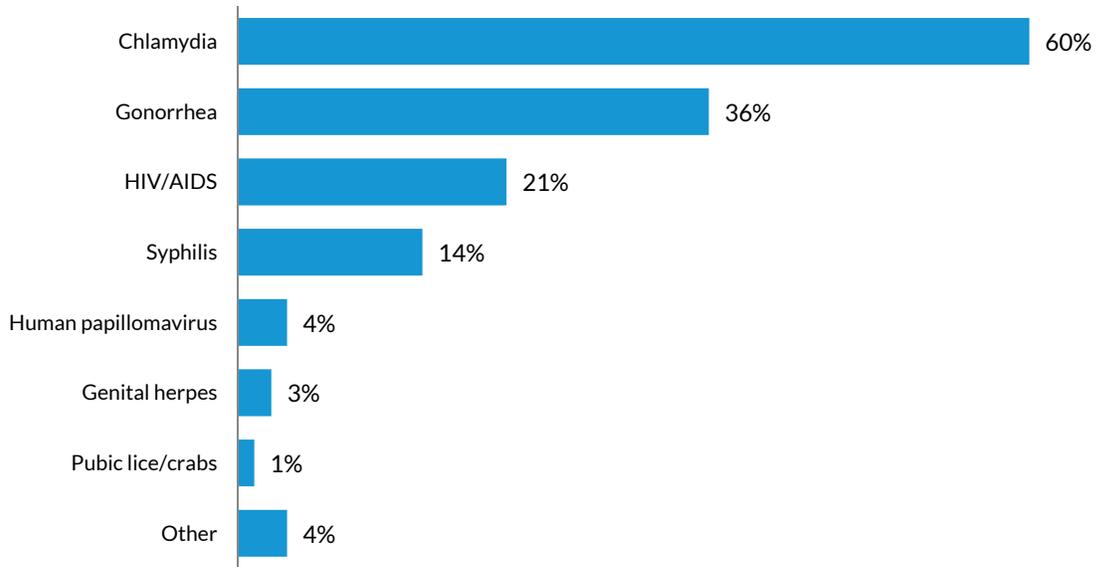
Not only was access to free contraception important for many youth, but also not having to answer questions as to why they wanted or needed condoms and other forms of protection provided a safe environment for youth, one in which they did not feel judged for their sexual behavior or choices, even when agency was constrained or nonexistent.

Sexually Transmitted Infections

Nearly 3 in 10 (29 percent) youth in the sample reported having a previous or current STI. Among these 80 youth, the most common types of infections included chlamydia (60 percent), gonorrhea (36 percent), HIV or acquired immune deficiency syndrome (AIDS) (21 percent), and syphilis (14 percent); see figure 2. Fewer shares reported having human papillomavirus (4 percent), genital herpes (3

percent), pubic lice or crabs (1 percent), or some other type of infection (e.g., genital warts, cold sores, mononucleosis). None of the youth reported having had bacterial vaginosis, hepatitis B or C, lymphogranuloma venereum, scabies, trichomoniasis, or yeast infections.

FIGURE 2
Types of STIs Reported by Youth



Notes: n = 80 youth who reported having an STD. “Other” includes genital warts, cold sores, and mononucleosis.

Contracting an STI like chlamydia and gonorrhea served as a seminal moment for many of the youth. After they were diagnosed, some young people made the conscious decision to always use protection; however, other respondents stated that the option of making more money to have condomless sex was too great given their often desperate circumstances. As one young woman explained, “I had chlamydia and I got so scared from that, I was like I can't do it no more, that was like the first month, but then I, like I need my money and so after I got treated for that and I'm back to doing it again” (Respondent 1012, 18 years old, Jamaican, lesbian, female). Another young person described a situation in which he contracted chlamydia from a client and felt obligated to tell him because the client was married with children.

I had chlamydia from an older guy. But I was like 16, 17, and it was in the summer time. I didn't even know he was that old. Like, we went to the motel and everything, had sex, he bought me food, put me on the train. I didn't want to get him locked up because you know I have feelings like and mind you, he had a wife, kids my age and everything like that. When I found out I had chlamydia, I ran him out because I had a disease from [him], like if I didn't, I wouldn't have run him

out, but I had a disease like what else can I do? So like I drove to his building or whatever [and I] saw him running out then. I didn't want to give him trouble, you know he got kids to support, but this is life. (Respondent 5028, 19 years old, multiracial, bisexual, transgender male)

Youth who did not always use barrier and nonbarrier protection reported feeling stress and anxiety about their futures. In fact, over 20 percent of respondents reported they were HIV positive. Some youth stated they did not always use condoms when trading sex and that they had contracted HIV from a client. A handful of youth stated they tested HIV positive after being raped by a client, or in the case of the following young man, a friend.

Interviewee: I never knew what STI I had because it was treated once I got it and it went away; it was a couple of years ago. But as of right now, just recently, I'm at the beginning of HIV positive. And to this day I don't know how I contracted it. It hurts though because . . . I used a condom all the time and I don't do drugs . . . I don't know.

Interviewer: Is there something you just found out recently?

Interviewee: In July I tested negative. [But] I was raped a couple of weeks back because I was drunk at this guy's house who supposed to be my friend and he raped me. I don't hate him or despise him because he did what he did. (Respondent 251, 21 years old, Latino, gay, male)

Another young man learned he was HIV positive after being forced to work for an exploiter for a couple of years.

Interviewee: I have HIV.

Interviewer: Was that during the period when you were working for him [your exploiter]?

Interviewee: Yeah, that's when.

Interviewer: How long have you been getting treatment for?

Interviewee: About a while. Yeah, I didn't find out till a couple of months later [after leaving my exploiter]. And I was getting sick and so . . .

Interviewer: So you were getting sick and that's what prompted you to get tested?

Interviewee: Yeah, but it helped me.

Interviewer: How old were you, were you like 17?

Interviewee: Yeah, I'm 18 now. I was young, I was young when I was doing all of this. I was struggling. (Respondent 484, 18 years old, multiracial, heterosexual, male)

Youth diagnosed with HIV were often in shock after receiving the diagnosis, and some immediately sought treatment and a support system to help them cope with the news. Yet some youth struggled to secure consistent, free or affordable, and gender-affirming HIV prevention, care, and treatment services, or they reported that they prioritized other basic, commonly short-term necessities, such as food, clothing, and shelter, before seeking medical treatment and support.

Other Health Problems

Almost two in three (64 percent) youth reported suffering from other health problems beyond those transmitted sexually. The highest rates of self-reported health issues were among white youth (93 percent), Latinos and Latinas (70 percent), and multiracial youth (70 percent), compared to 54 and 50 percent of black/African American youth and those of other racial backgrounds, respectively; these differences were significant at $p = .010$.

For the 174 youth who reported nonsexually transmitted health problems, most issues were mental health disorders such as bipolar (37 percent), depression (21 percent), anxiety (8 percent), stress or PTSD (7 percent), and schizophrenia (5 percent). Physically, the primary health problem youth reported was asthma (44 percent of those with a health issue), and another 4 percent said they had diabetes. In addition, nearly half of the 174 youth who reported having a nonsexually transmitted health problem reported another type of mental or physical health problem, ranging from attention deficit disorder, anger, and dissociative personality to sickle cell anemia, epilepsy, heart murmurs, and kidney disease.

Over one-third of the respondents had been diagnosed with bipolar disorder as a child or a teenager. However, some of the young people felt they were misdiagnosed, and many of the symptoms and behaviors that suggested bipolar disorder, depression, and mania were actually typical reactions and emotions for a young person who has been through a number of traumatic experiences.

My doctor diagnosed me with bipolar, but I don't think I'm bipolar. I just think I had a hard life and that I'm a teenager. I been through the struggle, too—it's just like I have . . . I'm angry.
(Respondent 768, 20 years old, black, questioning, female)

Interviewee: Last year I went to do tests so I went to the hospital. I just said I was suicidal. I came out all happy so that they can let me out, so that's why bipolar came around, yeah. That's how they [diagnosed] me. [They were] like you were all sad yesterday and now you're happy and all, so.

Interviewer: Do you agree with that diagnosis?

Interviewee: Of course not. (Respondent 201, 18 years old, Puerto Rican, transgender male)

Other youth who felt they were properly diagnosed with bipolar disorder did not necessarily believe the medication prescribed to them worked, and they found other methods to help them manage the symptoms.

Interviewee: I have ADHD, bipolar and I have a heart murmur.

Interviewer: Do you take medication for all of that?

Interviewee: No, I don't take any medication for bipolar and ADHD because I'm into anger management for my bipolar and my ADHD . . . [there] is no stopping that. And I have a heart murmur. I was diagnosed [with bipolar] when I was about eight years old because I used to throw temper tantrums and they went on from there because my temper tantrums—I used to throw chairs, break windows, and I didn't know how to control my anger because I was adopted when I was younger. So it was like I had a lot of anger inside so that's the only way I could unleash it. I'll

go out and break down a door or say throw a computer screen out of the window, type like that. But I learned how to calm myself. (Respondent 379, 21 years old, multiracial, heterosexual, male)

Some respondents also reported that the medication for bipolar disorder made them feel lethargic and foggy-headed, and as the following young man explained, it was important to stay alert and clear-headed when trading sex.

Interviewee: I am supposedly bipolar and schizophrenic. But when I was younger, I used to say I heard voices. I didn't hear no goddamn voices. I was using it as an excuse when I got in to a fight, like, "Oh, I heard voices." They were like, "All right, you go to a hospital, come back in two days." So it was that kind of diagnosis, but bipolar, yes. I used to take pills for it, which was Abilify, and Seroquel. They used to give me those two for bipolar disorder, but I stopped taking them.

Interviewer: And when did you stop taking them?

Interviewee: Years ago. When I started prostituting, I stopped taking them. I was like what the fuck. [I was too] doped out. Can't do shit. (Respondent 446, 19 years old, multiracial, bisexual, male)

Only 7 percent of respondents reported being diagnosed with PTSD, but given the emotional and psychological distress some of the youth described during the interviews, PTSD is likely underdiagnosed among this population. The small percentage of youth who had been diagnosed with PTSD were often suffering from depression as well, which for some youth stemmed from prior trauma.

Interviewee: I have diabetes and I have posttraumatic stress disorder. Because something happened in my past when I was younger. And it kind of like, they had to put me on medicine because I kept having flashbacks of certain things. It kind of helped, you know, saw therapy.

Interviewer: So are you currently receiving help?

Interviewee: I need to see a psychiatrist, to do another evaluation and start on medicine. Because some days I get depressed and I get angry. (Respondent 1010, 19 years old, black, bisexual, female)

I do see a doctor and when they gave me pills to help me sleep because like sometimes I get nightmares and stuff, and then it's usually hard to sleep and whatnot. They've been trying to treat me because they said I use sex a lot to cope. (Respondent 236, 20 years old, Latina, bi-curious, female)

The two respondent quotations above and the one below show the imperative of recognizing that the PTSD from which many of these young people suffer stems from a variety of concurrent and even contemporaneous traumatic experiences. Rarely is it possible to pinpoint a single source. Thus, focusing exclusively on youths' experiences trading sex and/or commercial sexual exploitation will likely interfere with appropriate and adequate treatment for PTSD and similar issues.

Interviewee: I apparently have posttraumatic stress disorder.

Interviewer: Okay. Do you know where that stems from?

Interviewee: Childhood abuse. This is according to the therapist I'm seeing. I also have some depressive episodes, beyond that I have pretty much nothing else. (Respondent 1330, 20 years old, white, bisexual, male)

Although many of the youth listed a handful of mental health disorders with which they had been diagnosed, some youth described a much longer list, consisting of a range of Axis I and Axis II mental health disorders.

Interviewee: I'm a walking mess. I have asthma, I have mental problems, I have anger problems, I have depression problems, everything, like all that shit. But I'm so relaxed. People think I'm so like crazy, and I'm like, no, I'm normal, like whatever, I smoke my weed and I'm good.

Interviewer: Are you seeing treatment?

Interviewee: No. Hell no. Because I don't really buy into all that shit. Like people are controlling themselves, like a pill might aid you but it's not going to like, no I'm not buying it. Therapist, it's good to talk to people, but they are getting paid at the end of the day. (Respondent 269, 20 years old, Afro-Latino, male)

Interviewee: I used to have asthma, it's slowed down. Like when it comes down to it's just the bipolar disorder, anger, and depression, and then I have anxiety and panic attacks.

Interviewer: And are you on medications for it?

Interviewee: No, I haven't been on medication for eight years and it's bad. I've learned to like maintain it for a little bit, like I can maintain it. Like I get high so like you can maintain it and I can come back to normal, but . . .

Interviewer: Do you not have access to getting medication?

Interviewee: No.

Interviewer: But if you could, would you?

Interviewee: Yes, I used to have it, it just got cut off when I hit 18. And I've been trying to get it back so badly. I was on my mom's plan. (Respondent 524, 18 years old, multiracial, transgender female)

Many of the youth who had been prescribed medication by a doctor for their mental health disorders were not consistently taking it. Sometimes the youth did not like being dependent on medication, or they did not like how the medication made them feel. The lack of permanency in the lives of these young people renders adherence a difficult proposition. At any moment, youth might be thrown back into a crisis resulting in the interruption or discontinuance of monitoring and treatment, often as a result of traumatic events such as incarceration, sexual assault, or eviction. Even for those young people with US citizenship and who are otherwise eligible for Medicaid, the daily precarity of living on the edge of survival reduces the capacity of even high-functioning youth to satisfy benefits application, maintenance, and recertification requirements. As explained by the young multiracial transgender woman above, youth who reach the age of majority (like many transitional-age foster youth) may face a gap in health insurance coverage. There were also a small handful of youth who, as the following young woman described, believed something was wrong with them, but they were unable to get the help they needed despite multiple attempts.

Interviewee: I would like to get an evaluation because something, I want to say like something is wrong with me mentally, but I know something is wrong but because I can't—I don't have a good intention, I just . . . I don't know. Everything is a wait, everything is a wait.

Interviewer: Have you tried to go anywhere else?

Interviewee: I have been telling people. I have to tell them but they say that's by choice. I'd like to have a psychiatrist because I go through a lot and you know, I'm in the shelter. I'm 19, I have a 2-year-old to take care of myself, my mother is handicapped. She in and out of the hospital, and she has nowhere to go now. It just a lot of other stuff and then the shelter people their rules and these case managers, and then I'm trying to do my school, and then I'm trying to get my money on top of that.

Interviewer: It's a lot to shoulder, absolutely, but should you push a little harder about getting an evaluation?

Interviewee: They are not going to care until I snap and that's what I don't want to do.
(Respondent 190, 19 years old, Trinidadian, bisexual, female)

Medical Treatment Service Experiences

The young people interviewed for this study recounted experiences of service receipt, including their attempts to obtain medical treatment for mental and physical conditions, particularly the prevention, care, and treatment of STIs and HIV, as well as their visits to service providers.

Over 9 in 10 (91 percent) youth reported having received medical treatment from a doctor within the past six months, most commonly for an HIV or STI screening (60 percent). As shown in figure 3, almost all youth (97 percent) said they had seen a doctor within the past 12 months.

Having access to medical care through service providers, clinics, and mobile vans was cited as a major motivator for getting frequent HIV and STI screenings and other medical care. Some young people even stated they had developed a good rapport with their doctor and trusted the doctor enough to tell him or her about some of issues they were dealing with, including their engagement in survival sex. The following two young women described their relationship with their primary care physicians.

Interviewee: I go every month to the clinic.

Interviewer: To get the tests?

Interviewee: Yeah, some lady named X she knows me. My mum used to go to her. She's been working there for like 40 years now. She's been working there, and she's old but she is really nice and sometimes I go to her to talk when I have problems like with my boyfriend and stuff. And I have her number on my phone because she knows my mom like personally, and so sometimes I'll go there with little problems, like I feel sad about my mom, I'll call her. She listens. She's just there to listen, she doesn't judge me or nothing. That's why I need to talk to her. (Respondent 682, 18 years old, Haitian and Dominican, gay, female)

Interviewee: Before I turned 19. So that was like August. I had her [my doctor] give me STD screenings. I had her check out my tonsils because they always check on my tonsils because the mono makes them close, so she basically told me I'm healthy. She said that because I told my doctor everything. She said she wished I would stop escorting. I told her when I get a good job I will stop doing it, but I want you to know just because you are my doctor, just in case I start to

feel sick or anything, you already know my history, so you can help me then instead of asking me what's wrong or what have you been doing lately.

Interviewer: And how did she respond when you told her?

Interviewee: She was shocked. She was a hard taken for, because she was like she can't believe it, because she was my doctor since I was maybe like two, three months and so for her [to] see me grow up and then to do this . . . I guess it breaks her heart and in the same token, she is happy that I'm telling her and she is even more happy that I'm having protected sex. That make her really, really happy. (Respondent 472, 19 years old, black, gay, male)

The small percentage (9 percent) of youth who had not visited a doctor in the past year gave as reasons that they either did not have health insurance, were unaware of the free medical care offered by various clinics and service providers across the city, or were afraid of being tested and learning they had contracted HIV.

Interviewee: It's because I'm scared I'll find out that I have anything, really, but mainly HIV/AIDS. I'm really scared. I felt like if I ever find out that I have it, right in the clinic, I was going to kill myself. I was going to take the needle or whatever and I was going to jab it right in my throat.

Interviewer: So have you ever thought about, I guess, going to an agency where they support you while you're getting these services, or is it something that you just can't cope with at this time?

Interviewee: I've been to like different programs and stuff like that. They help. Even my gay mother has it (HIV), you know what I'm saying and stuff like that. She always tells me, she'll say, "Girl, no shade but girl, if you find out that you have it girl, it's no different from when you don't have it. Girl, is people out here that's been living with it for years and stuff like that." My mother had a nephew, he was the only gay person in the family which is a lie. But he had died of AIDS at the age of 21. My whole family would tell me that I'm just like him. I'm gonna end up like him. I don't want that to come true, no.

Interviewer: So you haven't seen a doctor since you've been in New York City, then?

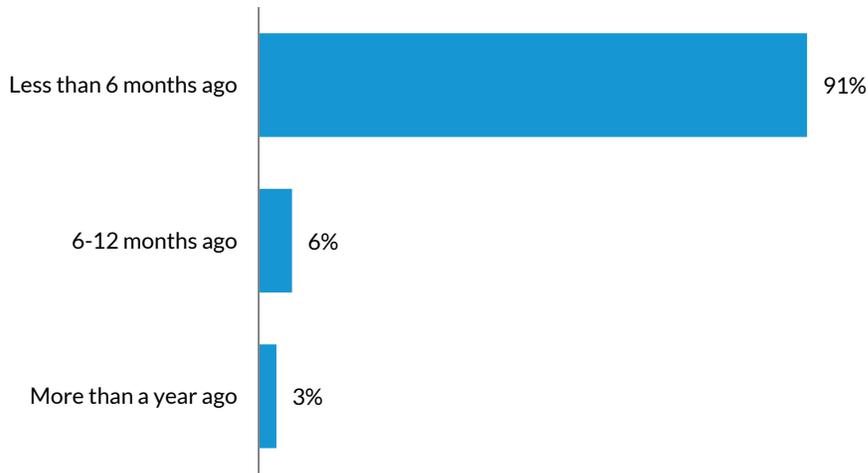
Interviewee: The other time I did checkup was, girl, I don't even remember my last time. Girl, I was lying when I said my last time getting checked up was June 1st. (Respondent 3, 19 years old, black, gay, transgender female)

Besides HIV and STI screenings, the second most common reason for youths' last doctor visit was for a physical evaluation (36 percent). Less commonly, youth last visited the doctor for a cold, flu, or cough (3 percent); chronic illness (3 percent); vaccine (2 percent); or hormone therapy (2 percent). Other reasons (9 percent) included injuries, anemia, birth control, abortion, and miscarriage. Youth who reported having an STD were also asked how they treated that infection; an overwhelming majority (96 percent) reported using medicine, and 4 percent did nothing.²

² This question was asked of 54 of the 80 youth who reported having an STI.

FIGURE 3

Timing of Youths' Last Check-In with a Doctor

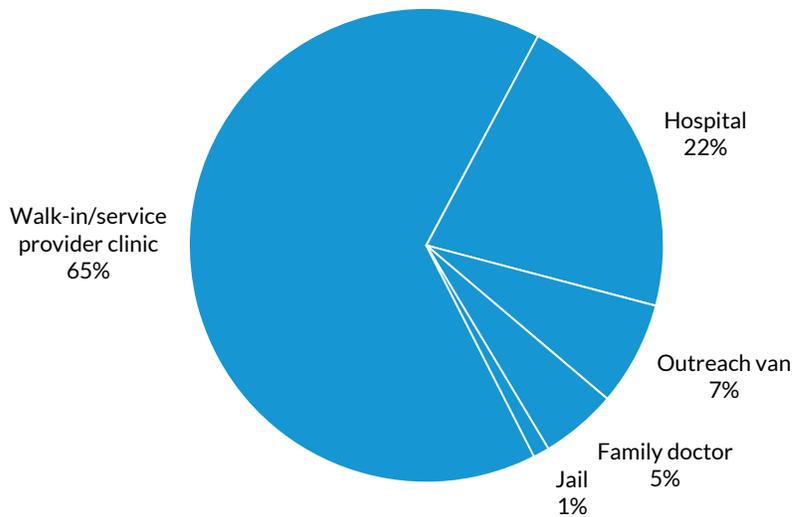


Note: *n* = 283 youth in the sample.

Youth in the sample were also asked where they had last obtained medical treatment; their responses are summarized in figure 4. As shown, almost two-thirds (65 percent) of the youth went to a walk-in or service provider clinic, and one-fifth (22 percent) visited a hospital (including the emergency room). Smaller percentages of youth received medical treatment from an outreach van (7 percent), family doctor (5 percent), or in jail (1 percent).

FIGURE 4

Location of Youths' Last Check-In with Doctor



Note: n = 283 youth in the sample.

Overall, two-thirds (65 percent) of the youth rated their last doctor experience as good, and another near third (29 percent) rated it as satisfactory. A small share (5 percent) of youth said their last doctor experience was poor; these youth had visited a walk-in clinic or hospital.

Young people described fairly positive interactions with medical staff, particularly with staff who came across as nonjudgmental and informative. Many respondents sought out clinics, mobile vans, and other medical services geared toward youth because they felt the staff would be more open to questions, know when to not ask questions, and explain things in ways young people could understand.

It's really pretty good because they don't ask many questions, why are you doing an HIV test and why you are getting tested. So that's been pretty good, so I'm just glad that they don't ask you so many questions because otherwise it usually gets pretty awkward. (Respondent 1330, 20 years old, white, bisexual, male)

Transgender youth, especially, looked for medical staff who had experience working with transgender individuals and were knowledgeable about hormone therapy and other gender-affirming medical treatment.

My experience at [name of provider] has been really good for the last month because I've been on hormones for about seven years, [since] I was 14. I wasn't supposed to, but started getting black market offline. So when I turned 18, I started getting medical hormones from the doctors in Nashville and it would be like \$2/300 a month. So I had no idea whenever I moved here that there were free hormones, that there was free this, free that, so I ended up coming to [name of

organization] and getting the free hormones and ever since then I'm like yes, this is a lot better. I'm okay. (Respondent 5175, 21 years old, white, heterosexual, transgender female)

Given that medical providers are often the first contact made by young people when they have a medical issue or a question pertaining to sex or relationships, and assuming there is adequate assurance and protection of patient-doctor confidentiality, many medical providers are in a unique position to develop a trusted relationship with the youth to the point that the young people feel comfortable discussing their engagement in survival sex. Doctors can then provide them with referrals and connect them to other agencies that might be able to assist them with some of their nonmedical needs, in addition to advocating on their behalf to receive certain services. Nevertheless, some young people chose not to disclose their engagement in survival sex with anyone, because as the following young woman describes, the possible stigma is just too much to endure.

Interviewee: I don't really like talking about my life. This [interview] is different; obviously I'm here to do this. With them [doctors], I don't really tell nobody about this.

Interviewer: And why don't you?

Interviewee: I mean pretty much, you know, I get embarrassed you know, because at the end of the day it bothers me when people talk about it because you know like I said a lot of people joke about it. So when I hear people talk about, oh, she's just some whore on the street just selling her body it bothers me because like sometimes people have to . . . they just don't know what to do like, and just the way it goes. I just feel people are going to judge me all the time for that. At the end of the day I don't care who the fuck knows, but it's just being concerned for myself.

Interviewer: Do you feel like at the clinic like they would treat you different if they knew or would you just feel different?

Interviewee: I would just feel different, not a lot of people know this about my life, unless you saw me out there, then that's how you would know, but other than that I really keep it to myself with a lot of people. (Respondent 5231, 19 years old, Latina and white, bisexual, female)

Substance Use Behaviors

Interviewed youth were asked a series of questions designed to capture their use and abuse of alcohol, drugs, and cigarettes. Nine in 10 youth in the sample reported current (87 percent) or past (4 percent) use of drugs, including alcohol and cigarettes. Of the 253 youth who reported current or past substance use, the most common substances used were alcohol (76 percent), tobacco (78 percent), and marijuana (79 percent). Substantially fewer substance-using youth reported use of cocaine or crack (14 percent),³

³ The rates of cocaine or crack use were two to three times higher among transgender female youth (35 percent) and other gendered youth (22 percent) compared to female (10 percent), male (11 percent), and transgender male (13 percent) youth; these differences were significant at $p = .017$.

ecstasy (10 percent), meth (2 percent), heroin (1 percent), LSD (1 percent), speed (0.4 percent), or other types of drugs (5 percent; including prescription pills, mushrooms, and molly).

The overall rates of substance use within the full sample of 283 youth are shown in figure 5. As shown, 9 percent of the youth reported no substance use, and approximately 7 in 10 reported use of alcohol, tobacco, and marijuana. Approximately 1 in 10 youth used cocaine, crack, or ecstasy.

Although the majority of the youth in our sample were homeless, and all were engaged in survival sex, most of the respondents were not addicted to hard substances, such as crack, cocaine, heroin, or meth. Youth cited a number of reasons for their substance use. Cigarettes, marijuana, and alcohol, the most commonly used substances, were primarily used to reduce stress and anxiety, and in some cases to help the youth sleep in what were often dangerous and uncomfortable conditions. Youth who abused harder, more addictive substances, such as crack or cocaine, as the following young man explained, did so to help them cope with having to trade sex with strangers night after night.

Interviewer: How about coke?

Interviewee: On certain occasions. Like when I'm going on dates, yeah.

Interviewer: When you go on dates you take coke?

Interviewee: Yeah, some of them.

Interviewer: Why do you take coke?

Interviewee: Because it numbs my body so I'm able to do it more often. I mean, I wouldn't do what someone else I know does, they smoke meth to keep them going.

Interviewer: So normally even when you are out on stroll, do you use coke before you go?

Interviewee: Yeah. (Respondent 366, 21 years old, Latino, gay, male)

A number of youth described either having had a bigger drug habit when they were younger or having had experimented with harder drugs, but in both cases they cut back or quit drugs altogether to save money and pull their lives together.

Interviewee: Yeah, I smoke cigarettes, I used to smoke weed. I don't smoke weed anymore. Not like that. Like today it was offered me. But I didn't smoke it.

Interviewer: So it's like sometimes you smoke it when it's around, but you're not like pursuing it? Any other drugs?

Interviewee: I tried some drugs, that's it.

Interviewer: But right now you're not using?

Interviewee: Only when I drink. Because I got introduced to that also by my aunt. I tried coke, and she used to do crack, so I tried it. Every time I drink, I want crack. I don't know why but I'm not hooked on it.

Interviewer: So how old were you when you were doing crack with her?

Interviewee: 17. But it's like only when I drink. It's like you give it an extra boost. But with crack, you take one, then you want another one, then you want another one. That's the way it like, it felt. (Respondent 1010, 19 years old, black, bisexual, female)

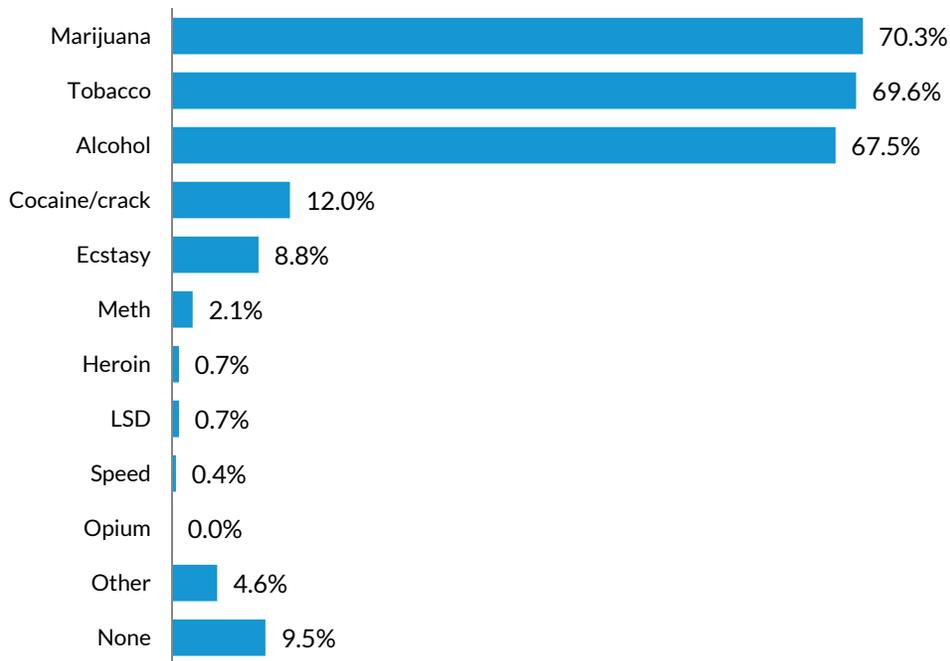
Interviewee: I used to smoke, I used to take e-pills, I used to drink but not no more.

Interviewer: Not any more, why is that?

Interviewee: I want to change in my life, that's why. (Respondent 603, 20 years old, black, lesbian, female)

FIGURE 5

Substance Use Reported by Youth



Notes: N = 283 youth in the sample. "Other" includes prescription pills, mushrooms, and molly.

The subset of youth who reported using alcohol, drugs, or cigarettes was asked about their frequency of use, a potential indicator of substance abuse. Most of those youth who used tobacco and marijuana did so frequently (e.g., several times a week, daily); specifically, 86 and 72 percent of tobacco and marijuana users, respectively, reported frequent use.⁴ A quarter of those who reported alcohol use said they did so frequently, but the majority (58 percent) reported occasional use (e.g., weekends, every few weeks), and 17 percent reported drinking rarely (e.g., few times a year). Of the 34 youth who reported cocaine or crack use, 18 percent said their use was frequent, 39 percent said it was occasional,

⁴ The remaining portions of this subset reported either occasional use of tobacco (10 percent) and marijuana (21 percent) or rare use of tobacco (4 percent) and marijuana (7 percent).

and 43 percent said it was rare. Most (53 percent) of the 25 users of ecstasy reported using the drug rarely; 12 percent reported frequent use and 35 percent occasional use.⁵

The young people reported mainly using marijuana and cigarettes daily, if not almost daily, to help them function or reduce stress.

Weed, I smoke weed every single day. Because I have to be high to make my money because I'm focused, you know. It makes me feel mellow and not stressed because when I'm stressed, I can't make my money. (Respondent 733, 21 years old, Latino, gay, male)

Other youth described using drugs and/or alcohol only when they have to trade sex. As the following young man explains, using alcohol or drugs is a way of numbing both the physical and emotional pain of having to engage in survival sex.

Well, I smoke a lot of cigarettes—I smoke at least a pack and a half a day. And when it comes to drinking, every time I stroll I make sure I'm at least buzzed or close to it. I try to make sure I got some kind of flow through my body. Because I want to numb the pain because you know strolling is not enjoyable to me. So I numb my emotional pain and physical pain before I go in. That way I'm just like a robot and I just do whatever they tell me to do. (Respondent 350, 19 years old, white, gay, male)

The age at which youth first began using substances ranged from as young as 4 years old for tobacco to 24 years old for alcohol; however, the median age for alcohol, tobacco, and marijuana was 15 years old. The median age was older for first use of cocaine or crack (17 years) and ecstasy (16.5 years).

The young people discussed various different ways in which they were introduced to drugs, including cigarettes and alcohol. For many respondents, family members played a big role in their first experience experimenting with drugs.

I smoked my first cigarette at 11, but I've been drinking because my grandmother was an alcoholic too, and she was like kind of crazy, like she passed away of liver disease anyway, but she would drink all the time and she drunk that red wine, it was really cheap. She would drink like two or three glasses a day. She said it made her heart feel better so she would kind of just hand me the cup and I was turning like eight so it was from like when I was like eight I was able to drink whenever, and my dad was an alcoholic too, so none of them even realized how much alcohol always in the fridge that they weren't consuming. Also because of that like I think that's why I kind of like, I don't feel like an excitement about it as much. Some people like really feel an excitement about and then they end up depending on it. I'm really cautious of that. (Respondent 274, 18 years old, Latina, bisexual, female)

Youth also described being forced by a family member to try cigarettes or alcohol for the first time as a way of teaching them a lesson not to use or abuse drugs, including cigarettes and alcohol.

⁵ No information on the frequency of substance use was available for other, lesser-used substances.

Interviewee: I can tell you the first cigarette I have ever had was at the age of 4.

Interviewer: Did someone give it . . . told you to smoke it or something?

Interviewee: Yeah, my uncle.

Interviewer: He told you to smoke it?

Interviewee: Yes, because . . . I was a little kid and my cousin, he started to roll up pretend cigarettes, because we were making fun of the adults. They were all outside smoking the cigarettes, so we thought it was funny. And my uncle comes inside the house and he says, he goes, "Boy, what's stuck in your head? Is that a cigarette?" I was like, "No, it's a piece of paper." He goes, "You like smoking? Come outside with me right now." He hands me a pack of cigarettes [and said], "Smoke the whole pack in front of me right now."

Interviewer: Did you smoke all of that?

Interviewee: I had to. He said, "If you don't smoke that pack I'm going to beat your ass."

Interviewer: So he thought that making you smoke it was going to make you not want to smoke it?

Interviewee: Yeah. Yeah, I have had worse before. I have cigarette shoved down my throat.

(Respondent 154, 19 years old, Latino, bisexual, male)

One young man described how he first experimented with crack at the age of 12 because his father was an addict and he had seen people in the movies using it, so he followed their technique.

12 [years old]. I was raised without my father. He was a drug addict, he was addicted to crack, and like one time like I just, I went sneaking around and I kind of, and then I found cocaine so . . .

You know I've always watched movies and like you know how to do it and stuff, so I just tried it.

(Respondent 225, 18 years old, multiracial, bisexual, male)

Another young woman associated her drug use with the time she was raped starting at the age of 9. It was her way of coping with the trauma.

Interviewee: I started smoking weed when I was 11.

Interviewer: But you say you stopped a while ago?

Interviewee: No, I just stopped recently this year because, the reason why I started smoking weed . . . when I was 9 I got raped and it was for 11 years because I just stopped and it was because I was holding on to that so long, and so I guess I was using that as a coping method and then in getting older you start realizing stuff about this thing. And weed wasn't the way for me. I just used it every time I got mad or I'm going through stuff that or if I want to go fuck a bitch. I get fucked up and just, you know, and that wasn't the way, you know. (Respondent 273, 20 years old, other, lesbian, female)

The 178 youth who reported substance use spent a minimum of \$0 and maximum of \$1,400 per week, with an average of \$96. The specific monetary breakdowns were \$17/week on average for the 76 alcohol users (range, \$0 to \$450 weekly), \$30/week for the 89 tobacco users (range, \$0 to \$350 weekly), and \$84/week for the 107 marijuana users (range, \$0 to \$700 weekly). The 7 crack and cocaine users reported spending \$0 to \$60 weekly (\$24/week on average); the 5 ecstasy users reported spending \$0 to \$100 weekly (\$23/week on average); and the 2 meth users reported spending \$0 to \$240 weekly (\$120/week on average).

Some of the young people cited cost as one of the main reasons for quitting cigarettes, alcohol, and/or other drugs. When they realized how much money they were spending on substance use on a weekly basis, they made the conscious decision to use the money they were making to help get their lives on track.

[For weed] Lately, nothing at all, I get it delivered for free, it's awesome. Yes, but I used to spend about a \$100 a week maybe per week altogether. [For cigarettes] Unless I figure this out it's like almost a pack a day so that's like let's just say 15 times 7 that's, damn \$105. That's why I quit. I was like I can't hustle enough to pay for this. (Respondent 1029, 21 years old, multiracial, lesbian, transgender male)

Other youth only realized how much they were spending per week once they started recounting to the interviewer how they were spending their money.

I go through a pack of cigarettes a day, so that's like \$12.50, and then weed is like \$20 . . . oops, that's some money, how come I don't realize it, hold on I'm squandering a lot of money. (Respondent 679, 20 years old, multiracial, lesbian, female)

Respondents also justified their expenditures on drugs because using helped them to cope with having to trade sex, but as the following young man explains, the drugs were also seen as a crutch that allowed them to continue to trade sex by numbing their pain.

I spend a lot of money, mostly on drug, and on cigarettes because I feel like the weed makes me not even think about what I'm doing in exchange for the money, but in the same token, is a crutch, but is a good crutch because I don't want to feel the pain, I feel like, oh this is my self-worth. This is what is bothering me so, I'll smoke a bunch. And it becomes very expensive, but at the same time I get the returns on it very quickly. (Respondent 472, 19 years old, black, gay, male)

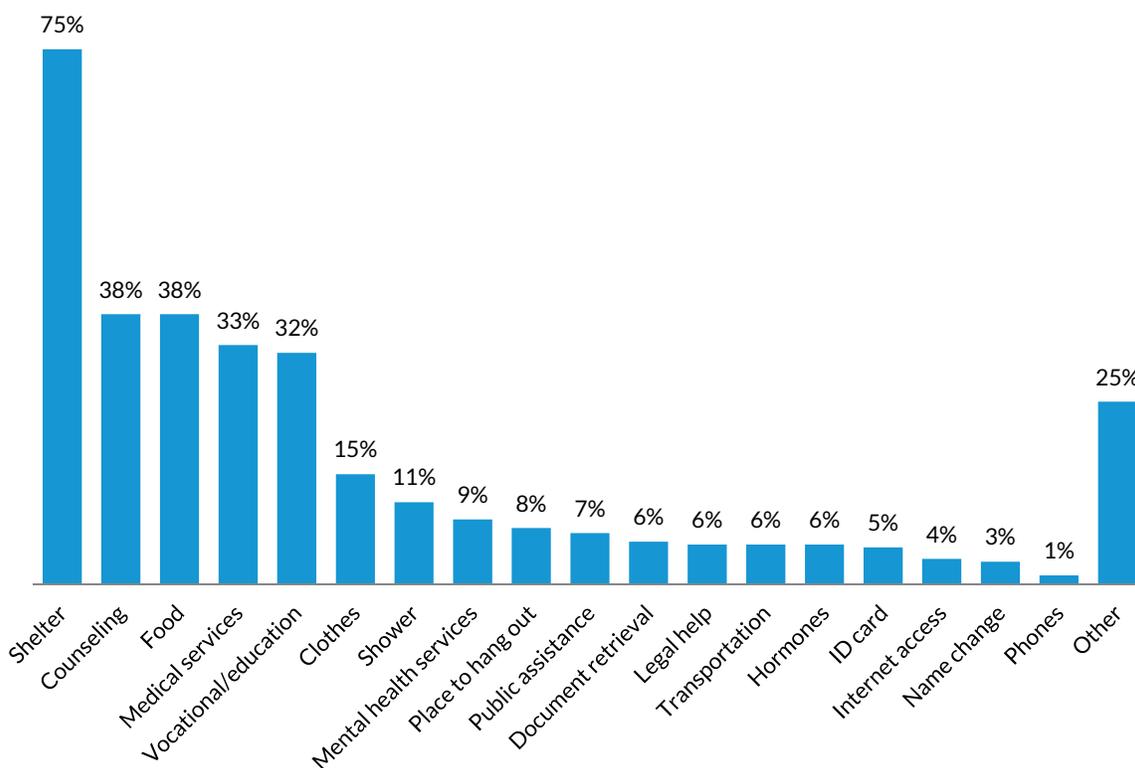
Although drug use and abuse is often prevalent among LGBTQ youth, YMSM, and YWSW who engage in survival sex, the main drugs of choice (cigarettes, alcohol, and marijuana) challenge the misconception that these young people are commonly addicted to "hard" drugs, such as crack, heroin, and meth. Although the young people stated that they often used cigarettes, alcohol, or marijuana to help cope with the stress of being homeless and having to engage in survival sex, many respondents were making a concerted effort to reduce their intake or quit the substances altogether.

Service Provider Experiences

Ninety-three percent of the interviewed youth visited one or more service providers in New York City. Of the 260 youth who visited a service organization or program, 99 percent accepted help from that provider, and 94 percent said they would seek such assistance again. Youth described the types of

services offered by providers (see figure 6). Three-quarters of the providers offered shelter, and approximately a third each offered counseling (38 percent), food (38 percent), medical services (33 percent), and vocational training and/or education (32 percent). Fifteen percent of the providers offered clothing to youth, and 11 percent gave them a chance to shower. In addition, a limited number of providers offered mental health services (9 percent), public assistance (7 percent), legal help (6 percent), and Internet access (4 percent). Further, one-quarter of the youth reported receipt of other services, including case management, housing assistance, laundry facilities, sex education, STD and HIV testing, needle exchange programs, and yoga.

FIGURE 6
Services Offered by Organizations and Programs Youth Visited



Notes: n = 260 youth who visited a service provider or service providers. “Other” includes case management, housing assistance, laundry facilities, sex education, STD and HIV testing, needle exchange programs, and yoga.

When asked about the services they received from programs in New York City, young people often mentioned numerous type of assistance and expressed gratitude for the help they received.

There is food. They have modes of transportation. If you are homeless, like shelters and some places help you to be able to get benefits or whatever. They help you find jobs—like [service provider] is actually helping me out a lot. They want to hire me to be like a peer counselor or whatever. I just have to get them some paperwork that's out in Jersey that I kind of have like don't have access to right now, but they really weigh in on me. They actually call me to just check on me and see like how I'm doing, make sure I'm doing all right in school and things like that. They give me movie tickets, they feed us. They actually help me out a lot like and, yeah, [service provider] the best I have been to all my life. (Respondent 434, 19 years old, black, bisexual, male)

These organizations offer so much. I mean, they offer housing, they offer shelter, they offer taking a shower, free clothing, free shoes. If you need to come in and get a free jacket, you know, you make an appointment. If you want to use the Internet, there are different hours to go on the Internet. If you're hungry and you're LGBT or gender nonconforming, you can come and eat some food and they give you the nice plates, the nice spoons, the nice bowls and something to drink. Actually some of them offer immigration status, if you don't have your green card you could try to apply for it and do something about it to get it. (Respondent 5127, 19 years old, black, transgender female)

Youth also credited the service providers for giving them the support system they desperately needed to turn their lives around and maintain a healthy lifestyle.

Interviewee: I love them, actually. Like I've been healthy since I've been here, doing like what I needed to do with such as documents and looking for work instead of like doing sex work.

Interviewer: And they've been helping you with that?

Interviewee: Not with like the job searching. I've been like sort of doing that on my own, but as far as like documents go, such as like ID and social security card and birth certificate, [name of organization] like gave me the resources. They've paid for it and like gave me the resources for like transgender people. (Respondent 759, 21 years old, Dominican and black, transgender female)

Some respondents who were born and raised outside New York City stated they specifically came to New York after hearing about the programs and services geared toward LGBTQ youth. The following young person came to New York City to seek help from an LGBTQ-specific organization so that they could be in an environment where they could be free to express themselves.

Interviewer: Oh, you came here six months ago?

Interviewee: Yes, because I read about the [name of organization].

Interviewer: So you came out here because of [name of organization]?

Interviewee: Mmmhmm, because down South they don't have nothing like [name of organization], you get to express yourself. Down South I'm a freak to most people. I'm an alien, everybody looking at me, you see my teeth have been cracked, got hit by a car, everything. I read about [name of organization] and it was a place that you can express yourself. They help you work your way up to the top, [help] you get that mindset, because anything is possible. So that's why I just go to [name of organization] because it's a place that you can go, get started with a transition, do whatever, and just be you. (Respondent 5260, 20 years old, black, transgender female)

Respondents also described not only the services they received through the various programs, but also the community they were able to be a part of and the friends they were able to make, which included many people who have been through similar struggles and experiences.

Interviewer: So what kind of services have you been offered from these places?

Interviewee: Housing, social psychology, food of course, and just the community, and the safe community itself. And getting to know friends and people that you can, like mirror, where you can reflect well from that. You've been there, you know what I'm saying? I mean the circle . . . one will start crying and other start crying. Someone has been there, you know? (Respondent 196, 20 years old, multiracial, open, male)

Although most youth had positive things to say about the youth programs and services offered to them, some recounted negative experiences, especially feeling discriminated against based on their sexual orientation and/or gender identity and expression.

Interviewee: I didn't like it. I've been there and I left because I didn't feel safe or comfortable in there. Because of the way everybody acts towards gay people.

Interviewer: Yeah. And what services, did they offer you at the other places?

Interviewee: Actually [name of provider] is good, you could be yourself, so that's why I like [name of provider]. I can be myself and I don't have to worry about nobody [being] judgmental. (Respondent 406, 20 years old, black, bisexual, male)

So they offered me a couple of service but I didn't want to take it, because in the [name of provider], it's like mostly straight people. And they don't like seeing bisexual. They don't like that at all. (Respondent 463, 18 years old, black, bisexual, male)

One young transgender woman described a situation in which she was waiting for approval from the federal Job Corp agency but encountered issues when her documents listed her as male. She had requested to be housed on the girls' floor, a practice that is illegal under federal law.

Interviewee: My goals right now, is to get started on my hormones. And make sure I have housing for the next year or so, which Job Corps take care of that very well. It's two years housing, and plus education. So you . . . I'm set with that one.

Interviewer: Does that look like it's gonna happen for you . . . to get into Job Corps?

Interviewee: I went to the interview. And the first thing yesterday they actually called me and they were having a problem because all my information still says I'm a male, but you know, I prefer to be placed on the girls' floor, or whatever girl dormitory. And she was like, well because they have minors, I couldn't that I be out in the room with them, etcetera, etcetera. The case worker is like, well because they're minors what if one of them was to come in the room while she was changing, and you know, what makes you think I'm going to be in the room, they have bathrooms. . . . And I would prefer to be in the bathroom than in the room where people can come in and out anyway. So that was, right now, I'm just waiting. I told them though that if they couldn't accommodate me being on the girls' floor, the boys' floor would be fine because housing [generally] over not being in the girls' dormitory is way better than being homeless and fighting to be in the girls' dormitory. (Respondent 221, 19 years old, black, heterosexual, transgender female)

Respondents also voiced frustration when it came to finding adequate shelter, specifically the lack of beds available to young people, which often resulted in a very long waiting list. For some youth, such as the following young man, not having access to a cell phone to be notified or inquire about an available bed made the situation even more frustrating.

You have to call every day to get on a waiting list and they make that deliberation on Wednesday, and at that time I didn't have a cell phone. My service got cut off, I just got it back turned on like a week before last check, and so I didn't have a phone to constantly kind of call. You know this is a shelter, why do I have to constantly call? There's not payphones around like that anymore, what am I going to do? So I just said scratch that and moved in with a friend. (Respondent 351, 20 years old, black, fluid, male)

Breaches in confidentiality and overall distrust of certain service providers were cited as reasons some youth chose to avoid certain providers or stop seeking help altogether. As the following young woman described, although her private information was shared by her therapist with another staff member, and then leaked to the rest of the shelter, she had little choice but to continue receiving services from the organization because the alternative was living on the streets.

Interviewee: Because when I was younger I was getting molested by my grandmother's boyfriend and I got raped by him . . . I felt uncomfortable because everybody in [name of shelter] found out when I went and I talked to only one person and it was confidential and they ended up telling another person and everybody heard it all around.

Interviewer: So you don't trust them?

Interviewee: No.

Interviewer: Who did you tell?

Interviewee: I told my therapist. She went and told my case manager and my case manager had a person in the room and he heard it and he started telling everybody.

Interviewer: So you don't want help from them anymore.

Interviewee: No.

Interviewer: But you're staying with them right now?

Interviewee: Yeah, because I have nowhere else to go, I don't have family . . . I'm in just like an emergency shelter for only 30 days and then after that I go into the streets again. (Respondent 5139, 20 years old, Latina, bisexual, female)

Although only 7 percent of youth stated they had never sought assistance from a service provider, almost all these youth said they did not seek help because they did not believe the programs could help them or had heard negative things about the organizations, specifically those that offered emergency shelter beds.

I heard a lot of rumors about the shelter system and I have got my close groups of friends I just feel safe, sleeping around them. (Respondent 166, 19 years old, white, gay, male)

Interviewee: So you've never been to like an agency that helps with your housing situation or anything like that?

Interviewee: No, I mean sometimes I don't like to talk to people, because sometimes people don't help you. They just want to know about your life, sometimes they just don't want to help you. So I just try on my own. (Respondent 5305, 20 years old, black, lesbian, female)

Over a third (36 percent) of the 260 youth who sought services stated their needs were fully met, but nearly two-thirds (64 percent) had unmet needs. The most common services youth wished had been offered by the provider they visited were vocational/education assistance (15 percent), longer-term housing assistance (13 percent), and shelter (7 percent). Smaller shares of youth wished for counseling (4 percent), financial assistance (4 percent), and medical services (3 percent). One percent each listed counseling, clothes, mental health services, public assistance, legal help, food, and a place to hang out. Additionally, 14 percent of youth described other services not easily categorized into those enumerated above, such as 24-hour availability, safer sex education, transit fare, self-defense workshops, and art therapy. The recommendations section of this report describes in more detail what additional services and assistance young people wished they had access to and areas for improvement within existing programs.

Of the 135 youth who were asked, 21 (16 percent) said they also refused services from certain providers. These youth who refused services cited reasons that included wanting to feel independent (28 percent), experiencing rudeness or harassment by staff (28 percent), experiencing homophobia or transphobia (22 percent), and not feeling safe (17 percent). One youth each also mentioned being barred or waitlisted, subjected to religious education, and sexually assaulted and harassed by staff.

Many of the youth who reported refusing services in order to feel independent felt they had achieved a level of stability in their lives and did not want to take away the opportunity for other young people who were in more precarious situations to access services.

I have a philosophy and it's basically don't take from the world what you don't really need, you know, and there's someone who needs it more than myself right now and I don't believe I need it like that anymore. You know what I mean like I don't, I'm not in a circumstance where I actually really, really need it you know. I have a job, I have two jobs, I was working at two different retail places across the street, then I didn't like one of them so I just stayed with one. So it's like I have a job, I need to get back into school in the spring. If there comes a time when I actually need it I'll do it, but if I don't need it I'm not [going to]. (Respondent 351, 20 years old, black, fluid, male)

Other youth reported a belief that they could never gain the independence they needed to move on with their lives either because service providers had limited resources (particularly for housing services) and may push out youth because of discriminatory and abusive treatment, or, as in the case of this young woman, a personal belief that such programs foster dependency.

I want to try to be more independent. So I mean right now I won't accept services because I want to be independent. So I want to try to, you know, that's why they have to since I'm 18 it's time for me to learn not to have somebody hold my hand all the time, but some of the times it was cool.
(Respondent 639, 18 years old, multiracial, gay, female)

Even though some of the young people stated they wanted to feel independent, most of them felt that "at the end of the day if I need help, I'm going to seek it, like this is where people go wrong; you feel like you're invincible and you could do it on your own, but you can't" (Respondent 258, 18 years old, black, gay, female).

Service Provider Perspectives

Who Are the Service Providers That Serve LGBTQ Youth Trading Sex for Survival?

We also interviewed leaders and staff of 16 service provision organizations in the New York City area that served the same population of youth we interviewed who traded sex for survival. Overall, many of the findings regarding the youth were confirmed by the service providers: these youth face many distinct challenges owing to their sexuality, gender identity, race and ethnicity, and homeless status that leads to their overcriminalization and poor mental, physical, and sexual health outcomes.

Services and Activities

The 16 organizations that served LGBTQ youth who trade sex for survival provided a wide variety of services. Although not every organization performed every service type, most organizations performed multiple activities under at least one overall service activity type: client connection, basic needs, health, future, social, and legal services. Many activities also overlapped, such as legal services that were triggered by a client's trafficking victim status, or a social workshop that overlapped with mental health care. Organizations frequently performed so many activities that when asked, individual respondents representing each organization often did not mention the entire array of services their organization performed. In this section, we describe the main categories of services provided across most organizations.

CLIENT CONNECTION

Client connection activities involve coming into contact with LGBTQ youth to let them know services to meet their needs are available, determining what a client's specific service needs are, and then tracking the progress and outcomes of individuals who become clients across various programs and services.

BASIC NEEDS

Service providers who provide basic needs seek to address survival fundamentals, the lack of which are often the impetus for LGBTQ youth to start engaging in survival sex. These needs include clothing, food, and the ability to take a shower and maintain hygiene. They also include one of the most important

services as identified by both service providers and youth: housing, including short-term emergency housing and long-term housing.

HEALTH CARE

Organizations also provided health-related care, including checkups and general treatment for common ailments; testing, treatment, and education for STDs; and therapy and psychiatry for mental health care. Some organizations also provided or helped clients obtain gender transition-related health services, such as hormones. Health care education comes in the forms of classes, workshops, and even interactive activities. For example, one service provider has a “health- and wellness-related and HIV prevention” workshop in which the youth make videos and write blogs related to increasing the well-being and health of young men.

FUTURE-ORIENTED ACTIVITIES

Many providers had classes or helped clients obtain services that were related to their desire to change their long-term futures. Some organizations provided life skills classes that taught clients financial skills among other basic lessons. Others provided educational resources, such as GED preparation, and employment resources that would help clients obtain and maintain a job, such as an internship program. Some organizations also have family reunification programs or services.

SOCIAL ACTIVITIES

Social activities provided by the service providers included group-based workshops and forms of peer social support, as well as activities purely for social and recreational enjoyment. Many organizations held regular workshops that served educational, social, and mental health functions, such as self-esteem workshops or client support groups. Organizations also held social events, such as movie nights, that provided a space for clients to engage with their peers and develop social relationships.

LEGAL SERVICES

Many organizations also provided legal services, whether as their primary service function or as a component of their overall service work. Legal services included both criminal representation and civil remedies. These services can also include gender transition-related services, such as changing a name or gender marker and getting a new ID. Within legal services, organizations also provided immigration services such as visa procurement and asylum and assistance with cases involving noncitizen minors, which often overlapped with criminal legal services owing to the immigration status of some clients.

Legal services also included assisting clients in navigating the process of procuring benefits, such as health insurance and food stamps.

HUMAN TRAFFICKING–SPECIFIC SERVICES

Some of the services mentioned above, particularly legal services, were only triggered by the determination of a client’s sex or labor trafficking status. Some organizations access certain types of resources and funding, such as Safe Harbor resources, that are designated to provide services specifically for eligible individuals who have legal status as victims of human trafficking. The provision of certain types of legal services or immigration services, such as the procurement of a T-visa for noncitizens who are determined to be victims of trafficking, can also be based on trafficking eligibility.

Partnerships

A key characteristic among the service providers we interviewed was their formal and informal partnerships with one another and dependence on each other to provide supplemental services. Because of the large range of services these organizations provide LGBTQ youth, the unfeasibility of providing comprehensive services at every location means organizations often outsource certain services to other groups. Certain organizations may refer clients to other organizations for different types of services, or bring in services provided by another organization to their own organization. For example, one service provider mentioned maintaining a weekly legal clinic at two other service providers located in neighborhoods that were fairly far away from their main office. Another service provider specified that apart from providing psychiatric services, basic medical care, recreation, life skills, education, and casework, all other services were outsourced to other agencies.

What service providers saw as their clients’ needs was important to how these partnerships formed. As one service provider stated, “We try to meet our clients where they’re at, so we get referrals from other agencies and service providers and through word of mouth.” Another service provider echoed the same sentiment: “We try to get people connected with whatever they’re interested in.”

Partnerships take place both formally and informally. Formal partnerships may take the form of a structured, regular activity involving more than one organization, such as a weekly workshop or clinic that one service provider holds at another service provider’s organization. They may also involve program referrals or formal agreements between organizations. Informal partnerships, which are also important for service providers, are less regular or mechanized activities between different organizations. These types of partnerships may preclude formal partnerships and may involve

relationship-building activities such as “stay[ing] in the loop about other projects” or “develop[ing] working relationships.”

However, there are certain challenges to collaborating with other organizations. Some service providers perceived a degree of unwillingness to collaborate due to competition for similar funding sources. Other service providers recounted that certain agencies do not work together because of disagreements about how to serve specific populations. For instance, multiple service providers stated that another service provider did not work with transgender females, so it was challenging to refer those clients to that organization.

Who Are Service Providers’ Clients?

Numbers Served

Because of the difference in sizes of the various organizations, the number of clients each organization served spanned from a handful to thousands over one year.

Age

Not all service providers served the same age groups, and most did not serve a large age range. Service providers typically served a teenage or young adult population, from age 13 up to the mid-twenties. Agencies tended to focus on a particular age range, with some serving only clients over 16 or 18 and some serving those under 16. One service provider commented on the lack of services once a youth reaches age 18 or 21, particularly a lack of funded beds for youth between the ages 21 and 24.

Sexual Orientation and Gender Identity

Although most organizations do not provide services solely to LGBTQ youth, some service providers specialize in serving LGBTQ youth or had staff or programs that targeted that population. LGBTQ sensitivity took place both formally and informally. One service provider noted that “there is not a specific or formal program geared toward LGBTQ [clients], but informally, yes.” Another organization representative said their clientele was “pretty much LGBTQ youth.”

Several organizations mentioned a low number of transgender clients coming through their doors, and others mentioned that they targeted transgender clients or were “conscious of the particular needs of trans youth.” However, the competency of organizations at addressing the needs of transgender clients appeared to vary. One service provider identified “the existence of transphobia in the service provider community” as a broader challenge.

Many organizations did not explicitly ask for clients to identify their sexual orientation or gender identity. One provider approximated that although more than 50 percent of their clients identify as LGBTQ, many more clients have chosen not to identify their sexual orientation or gender identity, and receiving services is not contingent on identifying as LGBTQ.

Race and Citizenship

Although not all service providers specified the racial makeup of their client populations, several organizations pointed out that their client population primarily comprised people of color, with whites making up a much smaller proportion of their client base. A few agencies mentioned having significant non-English-speaking client populations composed of undocumented noncitizens. This situation sometimes challenged staff who may not have the language capacity to tease through complex cases involving immigration authorities, the criminal justice system, and the client’s own barriers to speaking English and receiving services, particularly gender transition–related ones.

Survival Sex Engagement

In contrast with the law enforcement perspectives on youth who trade sex for survival (Dank, Yu, et al. 2015), the service providers did not see their clients as criminals but rather as individuals who were struggling to meet their basic needs. Service providers understood the challenges their clients faced in securing housing, employment, social support, and other basic needs, and several of them spoke of navigating this reality while providing their clients with basic services. One respondent explained that this reality is “interesting for us as harm reductionists. [We] don’t want them to feel judged for engaging in sex work.” Another service provider mentioned that their harm reduction philosophy is explained during intake. Regardless of whether clients were engaged in survival sex on their own or had a third-party exploiter, service providers overwhelmingly viewed their inability to gain stability both during and after trading sex as related to their lack of economic foundation and basic necessities for survival.

Determining whether a client has engaged in trading sex is also challenging. Several service providers mentioned that such a determination is not a regular part of their intake. Instead, this information may emerge during counseling, during an explanation of services, or during intake in a more delicate way: “[Whether they trade sex] is asked about at intake during probing, but the question is dressed up. We try not to make them feel guilty.” Another provider mentioned hesitation in adding a specific question about trading sex during intake, noting that it seems “abrasive” and perhaps irrelevant to the legal services the client was there to seek:

Adding another question and then follow-up and doing a whole intake around the issue when that’s not why they’re coming to us seems abrasive to me. I’m not sure we’ll do it, but we’re definitely able to provide service to youth who are disclosing to us that they’re trading sex for money and have a legal issue or concerns around it. You know we can do safety planning and we can hook them up with other services, and if there is legal needs, like an arrest around that or if folks are telling us that they’re trying to get out of it, or if there is an immigration need, then we can offer support.

The degree to which clients are comfortable identifying as someone who trades sex or being frank about doing so varies from provider to provider. Some clients are comfortable acknowledging trading sex, but others often do not use the label owing to embarrassment or shame, or they do not even consider it trading sex. One service provider believed that whether a client was open about identifying as someone who trades sex depended on the service environment as well:

In [the] past two months, maybe only two [in my organization] have discussed sex trading. It is sometimes casted as “engaging in sex,” but they [the clients] do not think of it as sex trading. There are people who are engaging and soliciting within the building. Young people are generally uncomfortable discussing the topic because of shame tied to sex work. There is less shame in communities that serve the homeless.

What Are Clients’ Health Outcomes?

Mental Health

The service providers viewed mental health issues as the most common health issue among their client population and an area that was critical to address. As supported by research and the youth interviews described above, service providers cited common issues of depression, PTSD, borderline personality disorder, and bipolar disorder among their clients. Many service providers offered mental health services, including psychiatry and clinical services, therapy and counseling, and group workshops and peer support groups.

Overall, the providers interviewed had conflicting thoughts around the mental health statuses of their clients. Similar to many youth in this study, several service providers believed certain disorders, such as bipolar disorder, were overdiagnosed and that the diagnoses process should be more “flexible.” Others thought that some disorders, such as PTSD, were underdiagnosed. One service provider described the complex needs of clients who come in with existing mental health issues, but who may find it challenging to grasp new diagnoses or deal with past misdiagnoses, particularly when the diagnoses can come from multiple sources, including both clinical sources, such as a past doctor, or informal sources, such as a partner telling the individual that they are bipolar.

[I] see people getting diagnosed with things that don't make sense. [I] ask people what they understand about mental health diagnosis. If it looks like the diagnosis is doing them harm, then we address it [and] try to rediagnose.

Sexual Health

The service providers in this study largely consider their work from a harm reductionist standpoint, meaning their focus is on reducing their clients' risk and exposure to potential physical and mental harm. As a result, almost all providers offered clients free and easily accessible contraception. Providers reported serving as resources for clients who wished to learn more about safe sexual behavior, and a number of programs had peer-led groups that focused on teaching youth about and promoting safe sex.

Substance Abuse and Dependency

Although past research has found that LGBTQ youth have greater substance abuse and dependency issues than heterosexual and cisgender youth, the service providers in this study reported seeing little drug abuse among their client population: “We don't see many substance abuse issues.” One provider mentioned that although there may have been a focus on harder drugs in the past, their clients mainly consume marijuana, cigarettes, and alcohol and use MDMA and other hallucinogens. This observation was confirmed in the youth interviews, as the majority of youth respondents stated their main substances of choice were marijuana, alcohol, and cigarettes.

What Challenges Do Service Providers Face in Serving LGBTQ Youth Engaged in Survival Sex?

Service providers mentioned several challenges related to their ability to serve LGBTQ youth engaged in survival sex; these challenges are discussed individually below.

Lack of Capacity and Space

A primary challenge cited by service providers is their inability to provide certain services to all clients who want them due to a lack of capacity and space. Service providers cited long waitlists for programs and shelter beds and small staff-to-client ratios and mentioned their inability to provide often crucial housing and mental health services.

[Our organization] is not in the position to service clients who have serious mental health issues. They need special medicine or attention [for] schizophrenia, PTSD, bipolar disorder, suicidal ideation, etc. [We] would love to serve them, but safety of other clients is a concern (reasonably evaluating our capacity). A nurse from [the] psych ward at [name of hospital] is part of the intake process to determine mental health status. This service is not cheap, but necessary.

This service provider mentioned that a “lack of physical space is also an issue, as well as the increase in rent,” a problem echoed by other providers who felt they were beyond capacity in terms of providing shelter space for their clients.

[Our] biggest need is shelter. [We] don't have the resources to address it. [We're] way beyond capacity. [We] have a psychiatrist on staff one day per week at the drop-in center, but that's nowhere near enough. Everything is way beyond capacity.

Lack of Funding

Service providers' lack of capacity and space to serve their clients is tied to a lack of funding to keep their services operational. Service providers receive funding from varied sources, including the federal, state, and local governments through various departments of health; specialty funds tied to homelessness; and specialty funds tied to human trafficking victims, such as Safe Harbor. Private individual giving was also cited as a funding source.

However, service providers cited existing funding as inadequate because of the complex needs of their client base and the sheer size of their client population. One service provider who serves

individuals over the age of 21 felt there was “not as much money dedicated to older clients” despite the community’s recognition that a youth may not be fully independent at age 21. The degree to which mental health services can be provided to a client base in serious need of these services also presents a resource challenge. As one service provider specified, “It costs about \$100 for a one-on-one psych evaluation.” Another mentioned that Medicaid often did not cover services specific for their LGBTQ client population that had high rates of victimization and programming needs, resulting in the need for the organization to provide services on their own with limited resources.

There are also certain challenges in pursuing larger government funding opportunities because of the need to follow complex reporting requirements that may produce disproportionately bigger burdens on smaller service providers. One service provider stated that “CDC [Center for Disease Control] has demanding reporting requirements, while other funding sources . . . are easier.”

Lack of Training and Personnel

Service providers identified a lack of full-time professional staff, appropriate training for staff, and appropriate external referrals as additional challenges. Because of the particular needs of their client population, which was primarily LGBTQ and homeless youth in need of mental health services, it was difficult to make sure internal staff and external referral providers were adequately trained to address these needs: “[It is] hard to find service providers and psychiatrists conversant in mental health, LGBTQ, [and] homelessness.” Because of the large degree to which service providers outsource or partner with other organizations to meet their clients’ needs, achieving cross-organization competency can be difficult.

[There is] a serious lack of training from the service providers. So I had a service provider call me the other day who didn’t know what LGBT was. She’s like, there’s a young person here, and he has this problem, being gay. And I was like, it’s not, is it a problem? I think there is hostility among staff.

Service providers who have had training in issues related to this population reflected positively on their experience, indicating that the training was related to their constructive, supportive work with their LGBTQ clients: “I actually think, honestly, the staff here does a really good job of being sensitive to trans-women.”

Cultural Competency

Several service providers cited a lack of language and cultural competency for non-English speakers and/or noncitizens as a challenging barrier to serving these subpopulations. Although some service

providers had Spanish-speaking capacity, that capacity could be limited (such as no Spanish language outreach work), and many organizations simply had no capacity for languages other than English. One service provider, the sole Spanish speaker in their organization, stated that “[we] cannot accommodate all languages.” As a result, reaching non-English-speaking clients who are primarily noncitizens can be a challenge. One provider mentioned they could barely reach Spanish-speaking youth, but ultimately the youth find their way to the service provider through social ties.

For some providers, cases involving clients with varied immigration statuses have resulted in a clear need for services in more languages.

I think language access is something we’re really looking at as we’re taking on more immigration clients. We are, we’ve now budgeted for translators and are starting to translate some of our written materials. I think we’re starting to take whole cases from start to finish working with a translator.

The need to expand cultural and language capacity, however, is contingent on funding that many service providers cannot easily access.

[We] don’t do Spanish-speaking outreach. [We have] no language capacity beyond English and Spanish, so we don’t know how to serve French population (e.g., Afro Caribbean). If we did more outreach, we could possibly target them, but we’re already turning people away so we haven’t put resources into it.

Beyond simply language capacity was also the lack of cultural competency to work with non-American clients. One service provider identified the “cultural dynamics in the family” as the prime challenge for noncitizen clients: “Sometimes parents leave the country, [and] most of those youth don’t go home. [Their] religious barriers are very difficult to overcome.”

Although the youth in our study were almost entirely born (97 percent) and raised (99 percent) in the United States, conversations with service providers show that the noncitizen population in the homeless and LGBTQ spectrum may have particular needs that are more challenging to address. The small percentage of foreign-born youth in our study is a limitation of our methodology, in that it did not allow us to fully ascertain the experiences of many foreign-born, non-English-speaking youth. Future research is needed to reach these populations of LGBTQ youth engaged in survival sex.

Discussion and Summary

For LGBTQ youth, YMSM, and YWSW, safety can refer to a variety of concepts and definitions. Safety can mean access to free contraception so they can practice safe sex. For transgender youth, it can mean access to transspecific medical care, including free hormones and treatment from doctors trained in health issues specific to transgender individuals. For the vast majority of LGBTQ youth, safety means being able to be in a space and around people who accept them for who they are, let them be who they are, and encourage them that anything is possible. As this report illustrates, the 283 young people we interviewed shared an array of stories about what safety means to them and their ability to access it through provider networks. We found that the existing medical and mental health care and services to assist youth gain stability in their lives are comprehensive, but they are also inconsistent and severely underfunded.

Similar to findings from past research, our study found LGBTQ youth were at high risk of STIs and HIV (CDC 2011; Friedman et al. 2002; Garofalo et al. 1998; Halcon and Lifson 2004; Lock and Steiner 1999). Although almost all the youth reported using condoms among other sexual and reproductive health devices, almost one-third stated they only used such protection some or most of the time. Often youth did not use protection because the client was willing to pay more to have condomless sex, and the offer of more money, even as little as \$25, was enough for the young person to take the risk depending on the severity of their circumstances. In Curtis and colleagues (2008), 20 percent of young people engaged in survival sex had an STI at one point in their lives; in comparison, 29 percent of young people in our study reported having had an STI or STD. Although the majority of youth reported they had contracted a curable STI, such as chlamydia or gonorrhea, 21 percent stated they were HIV positive. This finding conforms to national surveillance studies. Nearly half the 20 million new STDs each year are among people between the ages of 15 and 24 (Satterwhite et al. 2013). Young gay and bisexual boys and men (ages 13 to 24) accounted for an estimated 19 percent (8,800) of all new HIV infections in the United States and 72 percent of new HIV infections among youth in 2010 (CDC 2012).

The infection rate among this population warrants immediate attention. However, traditional prevention programming on abstinence, delaying the initiation of sex, condom access and usage, and negotiating safer sex do not readily apply to these young people. Even though the youth interviewed for this study were living on the edge of survival, 99 percent of them reported using condoms among other sexual and reproductive health tools, out of which 63 percent reported “always” using condoms or other devices, 20 percent reported usage “most of the time,” and 11 percent used such tools “sometimes.” By way of comparison, in a 2013 survey in the United States, of the 34 percent of high school students

reporting sexual intercourse in the previous three months, 41 percent did not use a condom, and 87.1 percent of students had never been tested for HIV (CDC 2014).

Research has demonstrated that LGBTQ youth have higher levels of depression and other mental health issues (Cochran et al. 2002; Friedman et al. 2002; Gangamma et al. 2008; Garofalo et al. 1998; Lock and Steiner 1999). We also found that a large number (64 percent) of LGBTQ youth reported suffering from other health problems, beyond those transmitted sexually. Most of those health issues were mental health disorders, such as bipolar (37 percent), depression (21 percent), anxiety (8 percent), stress or PTSD (7 percent), and schizophrenia (5 percent). As only 7 percent of respondents reported having been diagnosed with PTSD, and given the frequent and long-term trauma many of the young people were exposed to, one can assume PTSD is often underdiagnosed or misdiagnosed as something else. Some young people reported being diagnosed in childhood with a mental health disorder, especially bipolar disorder, and others reported being diagnosed as a teen, particularly with depression, anxiety, and PTSD. Some respondents believed they had been misdiagnosed with a mental health disorder, when what they were really suffering from was pain and anger from a traumatic childhood. Other youth accepted their diagnosis, but the medication they were prescribed and expected to take to help control the symptoms left them lethargic and foggy-headed, which in turn left them even more vulnerable when trying to survive on the streets.

LGBTQ youth, YMSM, and YWSW are being tested for HIV and seeking medical care regularly: over 9 in 10 youth reported having been to a doctor in the past six months. The majority of youth visited a doctor to be tested for HIV or other STIs or for a physical examination. Young people were most likely to seek treatment at a service provider drop-in center, urgent care, or at a hospital, specifically the emergency room. Medical examinations are compulsory for some service providers as part of intake, which may explain why so many LGBTQ youth, YMSM, and YWSW seek treatment through service provider clinics. Overall, two-thirds (65 percent) of the youth rated their last doctor experience as good, and another near third (29 percent) rated it as satisfactory. A small share (5 percent) of youth said their last doctor experience was poor; these youth had visited an urgent care clinic or hospital. Transgender youth in particular sought medical care from clinics and providers that were known for providing gender-affirming treatment, including expertise in and free or affordable access to treatments such as hormone therapy. Some youth also stated they had developed a good rapport with their doctor that let them feel comfortable disclosing their engagement in survival sex. The key to developing this relationship was providing a safe, nonjudgmental space in which youth felt they could say or ask anything without being asked a lot of follow-up questions, having to endure a lecture, or triggering the involvement of third parties such as parents, guardians, or child protection services.

Although several studies have found that LGBTQ youth have more substance abuse issues than heterosexual and cisgender youth (Cochran et al. 2002; D’Augelli, Pilkington, and Hershberger 2002; Friedman et al. 2002; Gangamma et al. 2008; Garofalo et al. 1998), and homelessness among LGB youth was found to be associated with greater substance abuse (Rosario, Schrimshaw, and Hunter 2012), of the 87 percent of youth in our study who reported using drugs, including alcohol and cigarettes, the main substances of choice were marijuana (79 percent), alcohol (76 percent), and cigarettes (78 percent). Substantially fewer substance-using youth reported use of cocaine or crack (14 percent),⁶ ecstasy (10 percent), meth (2 percent), heroin (1 percent), LSD (1 percent), speed (0.4 percent), or other types of drugs (5 percent; including prescription pills, mushrooms and molly). Service providers also confirmed the low use of harder, more addictive drugs among LGBTQ youth, YMSM, and YWSW.

Many of the young people reported experimenting with and using drugs from a young age, and some stated they were introduced to substances by a family member. Yet, as they got older, youth claimed to use and abuse substances less because they preferred to spend their money on basic necessities, such as food, shelter, and hygienic products, as well as understanding that in order to find stability in their lives, sobriety was a necessity. Nevertheless, some youth did use drugs, such as marijuana, alcohol, and cocaine, to help them cope with having to trade sex. Several respondents explained that numbing the pain with these substances was the only way they could bring themselves to trade sex.

Nearly all (93 percent) the young people had visited one or more services providers in New York City. When asked what services they received from the providers, 75 percent reported receiving shelter, and approximately a third each received counseling (38 percent), food (38 percent), medical services (33 percent), and vocational training and education (32 percent). Overall, young people were grateful for and approved of the services offered. Many of them accessed services from several providers because most providers were unable to cover all the young people’s needs under one roof. Respondents were referred to various organizations through other service providers, but word of mouth through their social networks was also an important and influential way for youth to hear about services, both good and bad.

Over a third (36 percent) of the 260 youth who sought services stated their needs were fully met, but nearly two-thirds (64 percent) had unmet needs. The most common services youth wished had been offered by the provider they visited were vocational and education assistance (15 percent), longer-term

⁶ The rates of cocaine or crack use were two to three times higher among transgender female youth (35 percent) and other gendered youth (22 percent) compared to female (10 percent), male (11 percent), and transgender male (13 percent) youth; these differences were significant at $p = .017$.

housing assistance (13 percent), and shelter (7 percent). Both service providers and youth reported that the lack of funding for beds, job training and internships, and counseling was a major issue that caused a lot of disruption in services for the youth, creating further instability. Additionally, funding for services was primarily limited to youth ages 16 to 21, which often left 22- to 24-year-olds, who are still technically eligible for services through youth programs, without shelter beds, access to group sessions, job training, and medical care.

Policy and Practice Recommendations

With each report released for this study, we have attempted to highlight the most crucial and urgent policy and practice recommendations that would improve these young people's lives. The recommendations in the first report (Dank, Yahner, et al. 2015) focused on the safety net of comprehensive services and safe and supportive housing options, gender-affirming health care, and living wage employment opportunities that would help LGBTQ young people, the majority of whom are unstably housed, to meet their basic needs and achieve stability in their lives, while also providing them with a safe space to be themselves. The second report (Dank, Yu, et al. 2015) put forth recommendations that focused on statutory and regulatory changes that would repurpose the law enforcement-based response to youth engaged in survival sex and instead fully resource voluntary and low-threshold services that meet youths' basic needs without the necessity of system involvement. This final report focuses on policy and practice recommendations specific to improving the physical and mental health outcomes of LGBTQ youth, YMSM, and YSWW engaged in survival sex, in addition to recommendations suggested by the young people in this study, around ways to improve and expand much-needed services and programs to help them gain stability in their lives and provide them a way out of having to trade sex for survival.

Increase the Number of Medical Vans That Meet Youth Where They Are, and Establish More Youth-Focused Medical Care at Clinics and Emergency Rooms

Over 9 in 10 youth reported having gone to a doctor in the six months before the interview; they were particularly vigilant about being tested for HIV and STIs. Although the majority of youth sought medical care and testing at a walk-in or service provider clinic (65 percent), the youth who received medical treatment from a medical van (7 percent) were especially appreciative of the convenience of the medical vans because the medical staff tended to park the vans in areas where the young people were most likely to congregate. Some youth also felt the staff on the vans tended to be more knowledgeable and less judgmental, which made them more comfortable approaching them for assistance. This perceived comfort level also increased their likelihood of being tested and increased their access to

condoms and other contraception. However, only a few clinics in New York City provide mobile medical services, and those that do often do not have the funding to go out seven days a week.

Youth who sought medical care from a walk-in clinic or emergency room were more likely to have a negative experience (5 percent). The negative experiences often had to do with encountering cold and impersonal doctors and nurses and not feeling comfortable or safe in that setting. The youth also felt the doctors and nurses did not know how to talk to them, and as a result, they often left confused and unsure of what was wrong with them and whether any follow-up care was needed. Having medical care providers in walk-in clinics and emergency rooms trained in how to serve teenagers and young adults is crucial to establish trust and ensure young people will continue to seek medical care when needed. It will also allow youth to feel more comfortable discussing certain issues they are facing, including having to engage in survival sex, which could result in providing them with the necessary support and additional resources to help them leave an exploitative situation.

Raise Awareness of Preexposure Prophylaxis Medication and Make It More Widely Available and Accessible to Youth to Help Reduce the HIV Infection Rate

Although all but two (99 percent) youth reported using protection to prevent pregnancy and STDs, for some youth this practice was true only some of the time. Approximately two-thirds (63 percent) of respondents said they “always” used protection, one-fifth (20 percent) said they did so “most of the time,” and one-tenth (11 percent) said they used protection “sometimes.” Nearly 3 in 10 (29 percent) youth in the sample reported having a previous or current STI. Among these 80 youth, 21 percent stated they had contracted HIV. According to the Centers for Disease Control, more than 1.2 million individuals in the United States are living with HIV infection, almost 1 in 8 are unaware of their infection, and the population most vulnerable to HIV infection is gay, bisexual, and other men who have sex with men of all races and ethnicities.⁷ Given those statistics, the percentage of youth who were HIV positive in our study was exceptionally high.

The youth most vulnerable to contracting HIV were those who did not use protection when trading sex for money and/or material goods. Many of these young people were offered additional money, sometimes as little as \$25, to have sex without protection. This additional money meant food in their

⁷ <http://www.cdc.gov/hiv/statistics/overview/atagance.html>.

stomach and a roof over their head for a night. Until we as a society can meet these young peoples' basic needs so they are not incentivized to have unprotected sex, increasing awareness of and access to preexposure prophylaxis (commonly known as PrEP), which has been shown to reduce the risk of getting HIV from sex by more than 90 percent,⁸ is a crucial and necessary step to preventing HIV infection among this population. Additionally, medical staff in clinics and hospitals across the country should be trained on how to administer PrEP or, at a minimum, provide referrals to local providers who offer this medical service.

Establish and Fund More Holistic and LGBTQ-Sensitive Mental Health Counseling and Care for Youth and Staff

For the 64 percent of youth who reported nonsexually transmitted health problems, most issues comprised mental health disorders such as bipolar (37 percent), depression (21 percent), anxiety (8 percent), stress or PTSD (7 percent), and schizophrenia (5 percent). Both youth and service providers interviewed for this study mentioned the need for more holistic and flexible mental health counseling and care. Service providers often have the youth go through a psychosocial exam as part of their intake. Youth often move around from provider to provider, which results in their being seen, and ultimately diagnosed, by different psychologists and psychiatrists. This lack of continuity can lead to conflicting diagnoses, misdiagnoses, and overdiagnoses of Axis I and Axis II mental health disorders, especially bipolar disorder.

Some respondents reported that once they received a diagnosis, they were prescribed medication and expected to take it as prescribed without any follow-up. Youth sometimes felt the medication they were prescribed, whether for bipolar disorder or depression, left them foggy-headed and lethargic, when they needed to be alert and clear-headed for their own safety. As a possible alternative to medication, and in some cases as a supplement to the medication, youth reported wanting more holistic mental health care that involved meeting regularly with a therapist and finding different ways, including art and dance therapy, to deal with their depression, anxiety, and PTSD.

Counselors and therapists who work with runaway and homeless youth often suffer from burnout and vicarious trauma, which leads to high turnover rates. Youth mentioned it was difficult to establish a trusting, long-lasting relationship with their therapist and case worker because the staff was always

⁸ <http://www.cdc.gov/hiv/basics/prep.html>.

changing and they were forced to retell their story over and over again. Several measures could reduce the burnout rate among social workers and therapists. They should be provided with appropriate mental health care, including trainings on how to deal with vicarious trauma and burnout, group and individual therapy sessions, and team building retreats. In addition, they should receive financial compensation commensurate to the level and burden of their work.

Expand Training to Mental Health Care Professionals and Other Youth Provider Staff on Signs of PTSD and Complex Trauma and Increase Resources Available to Treat LGBTQ Youth, YMSM, and YWSW Suffering from PTSD

Trauma-informed care has been identified by many advocates and practitioners who work with runaway and homeless youth, trafficked youth, and child welfare-involved youth as a best practice, and many have called for more funding and resources to ensure this practice is used by all agencies and organizations working with these populations. Given that the majority of youth interviewed for this study recalled frequent, and in some cases repeated, traumatic experiences they had endured throughout their short lives, it is surprising that only 7 percent reported having been diagnosed with PTSD. Without the proper diagnoses by mental health professionals, youth will not have access to the treatment and care necessary to effectively address the trauma. Thus, training not only mental health professionals, but also staff at youth provider organizations, on how to spot signs of PTSD is crucial to not only provide affected youth with the necessary long-term care, but also help those youth who have been triggered and need emergency assistance.

Increase Language Capacity and Provide Cultural Competency Training to Staff Who Work with Foreign-Born, Non-English-Speaking LGBTQ Youth

Although we did not interview many foreign-born young people for this study and interviewed only a handful of youth who stated that English was their second language,⁹ many service providers we spoke to who served LGBTQ youth said foreign-born, non-English-speaking youth made up a significant portion of their clientele. They also reported that one of their biggest challenges in meeting the needs of these young people was that their staff did not have the necessary language capacity or cultural competency to effectively serve these young people. As a result, they had to rely on a patchwork of service providers that might not specialize in serving LGBTQ youth but had the language capacity and cultural competency to communicate with them. However, many providers stated they would have no choice but to turn many of these young people away. By increasing the number of staff who speak multiple languages, in addition to training existing staff on cultural competency, foreign-born, non-English-speaking young people will be more inclined to seek help and have access to a larger social safety net.

Establish a Centralized, Formal Youth Services Referral Database

Service providers who serve youth, especially runaway and homeless youth, often rely on word of mouth and existing relationships to meet young people's needs. This practice often involves seemingly endless calls and e-mails to find an available shelter bed, doctor, and/or legal support, which can take hours out of a staff member's already packed day and more times than not ends in frustration and disappointment. This chronic problem could be alleviated by establishing a citywide, and ultimately a nationwide, centralized and formal youth services referral database that would provide up-to-the-minute information on available shelter beds, doctors, legal staff, and so forth. Such an effort would require thoughtful planning, a sustainable funding source, and dedicated staff, but its accomplishment would greatly help streamline the referral process and more effectively and efficiently assist young people at critical times in their lives.

⁹ As stated above, this low number of non-English-speaking respondents might stem from the limitations of the methodology we employed as it is possible foreign-born, non-English-speaking youth were not part of the social networks of the youth we interviewed for the study.

Listen to the Voices of Youth Regarding Their Recommendations for Services and Access to Programs and Safety

The policy and practice recommendations mentioned above reflect what the Urban Institute research team considers the most urgent and necessary changes based on the study findings. But we also asked our study participants what services they wish they were offered or had more access to. Below are some of the recommendations suggested by the youth, in their own voices.

Increased Comprehensive Short-Term and Long-Term Shelter Options, Including Options for Youth under the Age of 16 and More Beds Designated for LGBTQ Youth

Places for youth like 12, 13 where they can stay. (Respondent 5092, 19 years old, multiracial, bisexual, male)

Like the housing, it's crazy. I feel like, to just be there and then just leave and to have to wait two weeks to come back. [They] just need to get more on point with the house options. I think they should have some type of housing for kids that don't have a job at the time, because the only housing is for kids that is with the SSR, or with job which I feel is not right. (Respondent 456, 19 years old, black, heterosexual, male)

More serious intensive housing, because they say, "Oh, I'll put you on this list," but like the list is a 1,000 years long, a little more seriousness with the housing systems, that's all. (Respondent 334, 20 years old, multiracial, gay, male)

Better house improvement for lesbians and gays because they don't really offer that and I don't kind of, you know, like feel uncomfortable around certain people and they don't offer the way you can get away or be around people that's just like you. (Respondent 681, 19 years old, black, lesbian, female)

Expansion and Funding of All Services and Shelter Beds to Youth up to 24 Years Old

I wish they offered more groups for people that were like over the age of 21, because like once you get to that age you have to go on your own and just find your way so I wish they had more programs for people like older than 21. (Respondent 471, 20 years old, black and Latino, gay, male)

The thing about it is like with certain services like they have to cut you off at 21. You can't be in there if you are over 21. Like I'm 21 so I really can't be in there anymore. So when you are 21 you can't go there and vogue and vogue it out and Kiki, you can't do that. Because of the funding and some of the sponsors, when you are 21-24 they don't really, they don't feel like you are a

youth, they feel like you are a grown-up. (Respondent 272, 21 years old, black, bisexual, transgender female)

Trainings and Classes on Financial Literacy and Budgeting

I wish they would offer like whatever like money management like how to budget [our] money. (Respondent 1095, 21 years old, Dominican and Puerto Rican, gay, male)

I guess better street survival skills, which probably would be hard to offer, knowing the society, but just better street survival and better economic skills, money management, balancing check books. Stuff that would help to I guess fit in the norm of the society because you know, I can't do this forever. (Respondent 5188, 20 years old, Latina, queer, female)

Intensive Job Training and Resume Building and Internships Aimed toward Skill Building for LGBTQ Youth

I wish that they would take away these long group meetings and group talks and actually start putting in the work towards filling up job applications, building resumes, applying for school and I understand that's on our part we have to be consistent. But even in trying like I've made appointments on my case manage like over three times and they all . . . didn't happen. (Respondent 5045, 20 years old, black, open, male)

I wish that they offered some kind of job bank where they knew of few places that were hiring LGBTQ youth in specific. (Respondent 729, 20 years old, Latino, gay, male)

Internships for trans men or lesbian people because everything out there is gay guys, trans females. There's not a lot of donations for trans men, especially bigger people, and it's extremely frustrating. (Respondent 1029, 21 years old, multiracial, lesbian, transgender male)

Mentorship Programs That Help LGBTQ Youth Navigate City Agencies and Service Providers to Determine What Will Work Best for Them in Gaining Stability in Their Lives and Meeting Their Goals

I'm taking help from anywhere that I can at this present time because it's like this is a real difficult moment for me, and the only knowledge that I would have of any other places or anything like that would be based on my own research or whatever. I would kind of like want somebody who been there before and done that to better explain things in depth for me, to see which program to weed out and which one to keep instead of visiting all 13 of them and then find out only two of them are [useful]. (Respondent 1346, 20 years old, black and Latino, bisexual, male)

Group Sessions That Provide Youth the Opportunity to Discuss Anything and Everything, Including Trading Sex for Survival

I wish they had more like . . . there's a lot of gay girls in there, I wish they had like some type of thing for like gay or queer people. There are a lot of gay people there, just something like some program, something where we could come, we could talk, we could sit, we could discuss anything. They have it but it's more broad. I want something more specific to us and then they talk about how prostitution and money and all that is bad and it makes it seem so bad but they don't understand, it is like saying people who got money, who work. We don't work, we are in a shelter for a reason and this is what we're doing because we have to do it, it's not like you all are going to give us money. So I feel like that's BS to tell us that. I always tell people, whatever way you make your money, just do you, just be safe, and I mean safe as in don't risk your life, other than that I don't care. Yeah, they always talk bad about it and I understand, but then again I feel like you all go home, you have money, you all have got cars, you have to go home and sleep in a bed and do this and pay for this and that. They always trying to talk about prevention of prostituting and that it's not good [to prostitute], and if you know a person that is doing, you could come as confidential and tell us, we will give them tips. (Respondent 523, 20 years old, multiracial, lesbian, female)

Increased Funding for All Low-Threshold Programs and Services to Assist Runaway and Homeless Youth

I mean I wish these help programs were a little bit more, I just wish there were more of them, you know what I'm saying. But they've been really helpful. They've helped me get everything I really need, so I'm pretty satisfied with where it is at. You know I wish they had like funding to do what they want to do. (Respondent 1330, 20 years old, white, bisexual, male)

I wish they offered more services for runaway homeless teens because I see that a lot of budgets getting cut. It's a lot of things that they are trying to cut away. We are runaway homeless teens. Would you rather have a place [for us] to stay or [have us] sleep on the trains where we get locked up since we didn't get a place to stay? When I was like really homeless, I couldn't go back to no shelters. I was sleeping on the trains, I was getting locked up on purpose if I hadn't something to eat and go somewhere to sleep. And I got tired of it. (Respondent 379, 21 years old, multiracial, heterosexual, male)

Concluding Thoughts

As our first report stated, our interviews with young people engaged in survival sex highlight the reality that there is no universal or typical narrative among youth who exchange sex for money and/or material goods. The interviews also point to the importance of providing individualized services and support. Nonjudgmental, voluntary, and low-threshold services that meet the basic needs of youth without criminal justice system involvement are among the primary recommendations of past national and local studies (Institute of Medicine and National Research Council 2013; NYCAHSIYO 2012; Walls and Bell 2011; YWEP 2009, 2012). Our study's findings echo these recommendations and further support the creation and expansion of services for LGBTQ youth. Although some states and municipalities specifically reference "gender-specific," "separate," or "gender-responsive" services in their laws to protect youth who have been exploited for sex and labor purposes (also known as Safe Harbor laws), no program has defined gender-supportive or culturally competent care in the context of LGBTQ youth. Our study illustrates the importance of strengthening and expanding such services so they are not only gender responsive but also culturally competent, age appropriate, and supportive of LGBTQ youth.

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