San Mateo County Pride Center

Final MHSA Innovation Evaluation Report

RDA CONSULTING

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

SAN MATEO COUNTY PRIDE CENTER

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This report was developed by Resource Development Associates under contract with San Mateo County Behavioral Health and Recovery Services.

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Acknowledgments

The San Mateo County Pride Center—partner organizations StarVista, Peninsula Family Service, and Outlet—have demonstrated unparalleled dedication and engagement to serving the LGBTQ+ community in San Mateo County. Over the five years of the MHSA Innovation project, the Pride Center has shown up with a consistent commitment to gathering data and learning about what the Pride Center has done well and what it could improve. Pride Center staff provided data, time, and interpretation to strengthen the evaluation.

Participants and clients of the Pride Center have been incredibly generous in opening up about personal experiences with mental health services before and after the Pride Center, sharing perspectives about Pride Center programs and services, and offering insights to continually improve the way the Pride Center and San Mateo County serve, include, and lift up the LGBTQ+ community.

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Introduction

Project Description

The San Mateo County Pride Center is an Innovation (INN) program under the Mental Health Services Act (MHSA) that is funded by the San Mateo County Behavioral Health Recovery Services (BHRS) department. The San Mateo County Pride Center (Pride Center or the Center) is a formal collaboration of three partner organizations: StarVista, Peninsula Family Service (PFS), and Adolescent Counseling Services (ACS).

- **MHSA INN Project Category:** Introduces a new mental health practice or approach.
- **MHSA Primary Purpose:** 1) Promote interagency *collaboration* related to mental health services, supports, or outcomes and 2) Increase *access* to mental health services to underserved groups.
- **Project Innovation**: While it is not new to have an LGBTQ center providing social services, there is no model of a coordinated approach across mental health, social and psycho-educational services for this marginalized community.

Pride Center Learning Goals

Learning Goal 1 (Collaboration): Does a coordinated approach improve service delivery for LGBTQ+ individuals at high risk for or with moderate to severe mental health challenges?

Learning Goal 2 (Access): Does The Pride Center improve access to behavioral health services for LGBTQ+ individuals at high risk for or with moderate or severe mental health challenges?

As a coordinated service hub that meets the multiple needs of high-risk LGBTQ+ individuals, the Pride Center offers services in three components:

1. *Social and Community Activities*: The Pride Center aims to outreach, engage, reduce isolation, educate, and provide support to high-risk LGBTQ+ individuals through peer-based models of wellness and recovery that include educational and stigma reduction activities.
2. *Clinical Services*: The Pride Center provides mental health services focusing on individuals at high risk of or with moderate to severe mental health challenges.
3. *Resource Services and Training*: The Pride Center serves as a hub for local, county, and national LGBTQ+ resources. Pride Center staff host year-round trainings and educational events for youth, public and private sector agencies, community service providers, and other community members. Common topics include understanding sexual orientation and gender identity, surveying common LGBTQ+ issues and mental health challenges, and learning how to provide culturally affirmative services to LGBTQ+ clients.

Summary of Need

Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, and other (LGBTQ+) individuals commonly experience depression, anxiety, suicidal thoughts, substance use, homelessness, social isolation, bullying, harassment, and discrimination. LGBTQ+ individuals are at higher risk of mental health issues compared to non-LGBTQ+ individuals given that they face multiple levels of stress, including subtle or overt homophobia, biphobia, and transphobia.[1] Across the United States, a majority (70%) of LGBTQ+ students report having experienced harassment at school because of their sexual orientation and/or gender identity, and suicide is the second leading cause of death for LGBTQ+ youth ages 10-24.[2]

These nationwide trends are no less evident in San Mateo County. According to the San Mateo County LGBTQ Commission's 2018 countywide survey of 546 LGBTQ+ residents and employees, nearly half of adult respondents (44%) identified a time in the past 12 months when they felt like they needed to see a professional for concerns about their mental health, emotions, or substance use. At the same time, 62% of adult respondents felt that there were not enough local health professionals adequately trained to care for people who are LGBTQ+, and fewer than half (43%) felt their mental health care provider had the expertise to care for their needs. Among LGBTQ+ youth who responded to the survey, three-quarters (74%) reported that they had considered harming themselves in the past 12 months, and two-thirds (65%) did not know where to access LGBTQ+ friendly health care.[3]

In this context, BHRS developed the San Mateo County Pride Center as a coordinated behavioral health services center to address the need for culturally specific programs and mental health services for the LGBTQ+ community. The establishment of the Pride Center also fulfills the MHSA principle to promote interagency collaboration and increase access to mental health services for underserved groups.

Project Timeline and Implementation Update

This report covers the full period of Pride Center implementation from June 1, 2017 – June 30, 2021. The Mental Health Services Oversight and Accountability Commission (MHSOAC) approved the project on July 28, 2016. In fiscal year (FY) 2016-17, the Pride Center undertook foundational activities related to the planning and startup of the Pride Center (see Figure 1). The Pride Center secured a site in December 2016 and was in a period of "soft opening" from March through May 2017. The Pride Center opened to the public on June 1, 2017. In March 2019, the MHSOAC unanimously approved a two-year funding extension for the Pride Center as an MHSA Innovation Program, with the goal of strengthening internal and countywide collaboration efforts, measuring clients' clinical outcomes, and develop a set of best practices for others to replicate the Pride Center's service delivery model.

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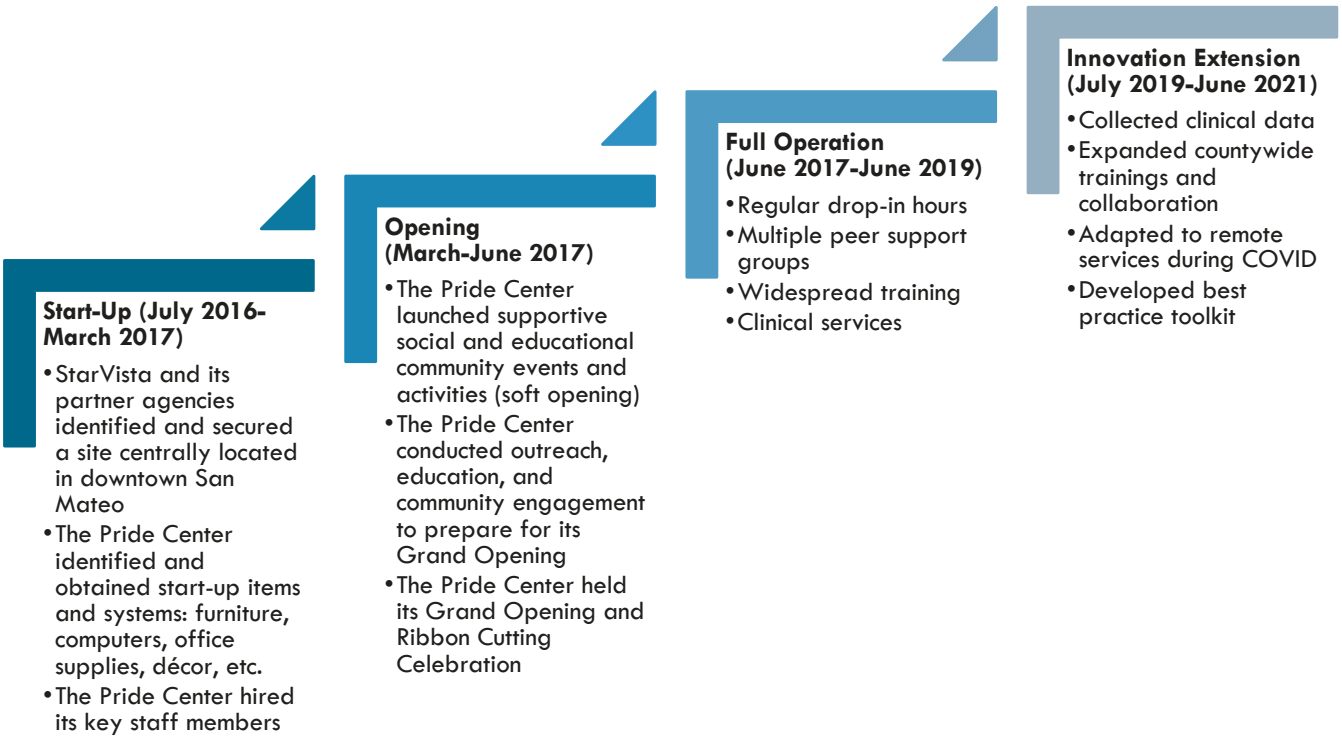
[1] King, M., Semlyen, J., Tai, S. S., Killaspy, H., Osborn, D., Popelyuk, D., & Nazareth, I. (2008). A systematic review of mental disorder, suicide, and deliberate self-harm in lesbian, gay and bisexual people. BMC Psychiatry, 8:70

[2] GLSEN, *2017 National School Climate Survey*; The Trevor Project, "Facts About Suicide." <<https://www.thetrevorproject.org/resources/preventing-suicide/facts-about-suicide/>>

[3] San Mateo County LGBTQ Commission, "Survey Results of San Mateo County LGBTQ+ Residents and Employees," 2018 ed.

Figure 1. Pride Center Implementation Timeline



Changes to Innovation Project

Initially, when BHRS released its request for proposals (RFP) for the administration of the Pride Center, BHRS was concerned that the applicants did not demonstrate the capacity to effectively serve the community of interest, thus BHRS did not award the grant at this point and instead re-released the RFP. The second time, five partner agencies applied as a collaborative: StarVista, a San Mateo County mental health nonprofit, as the lead agency, along with Daly City Partnership, Peninsula Family Service, Outlet–a Program of Adolescent Counseling Services, and Pyramid Alternatives.

There were some changes to the composition of partner agencies during the project. FY2016-17, Pyramid Alternatives merged with StarVista. In FY2019-20, the director of the Daly City Partnership transitioned out of their position, and without the presence of the Director, Daly City Partnership made the decision to withdraw from the collaborative model. Given that the Pride Center no longer had a partner agency located in North County, Pride Center staff examined the needs in North County and strategized to fill this gap by developing targeted outreach plans and strengthening existing connections and referral pathways to service providers and resources in that area (e.g., Daly City Youth Health Center).

Evaluation Overview

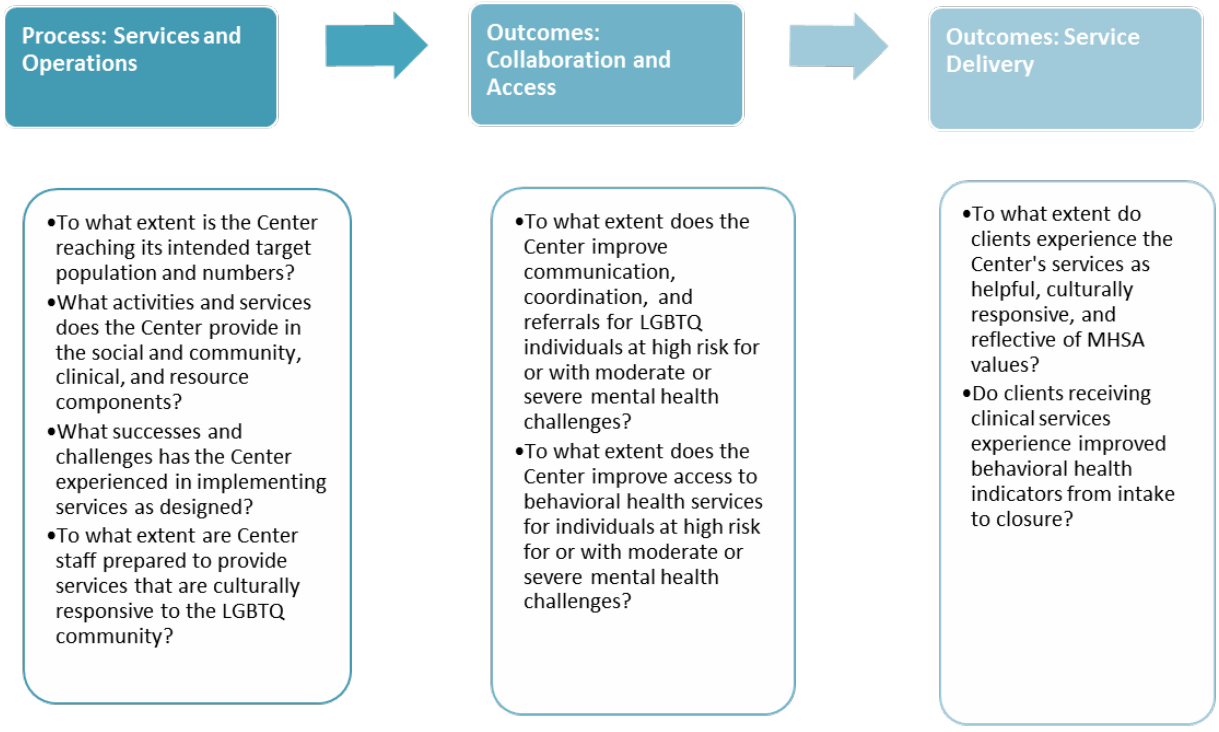
Learning Goals and Evaluation Questions

In accordance with the requirements for MHSA INN programs, BHRS selected two Learning Goals—Collaboration and Access—as priorities to guide the development of the Pride Center. BHRS sought to explore how this innovative model of coordinated service delivery and community engagement could enhance access to mental health services within underserved LGBTQ+ populations, particularly for individuals at high risk for, or with, acute mental health challenges. In turn, the program domains of Collaboration and Access are areas in which the Pride Center might serve as a model to expand of mental health services for LGBTQ+ individuals in other regions.

BHRS contracted Resource Development Associates (RDA) to conduct the evaluation of the Pride Center implementation and outcomes. RDA collaborated with BHRS and Pride Center leadership and staff to develop data collection tools measure program and service outcomes. To maximize RDA's role as a research partner and fulfill MHSA Innovation evaluation principles, the evaluation used a collaborative approach throughout, including Pride Center staff and partners in operationalizing the evaluation goals into measurable outcomes and interpreting and responding to evaluation findings.

BHRS sought to learn how the Pride Center enhanced access to culturally responsive services, increased collaboration among providers, and, as a result, improved service delivery for LGBTQ+ individuals at high risk for or with moderate to severe mental health challenges. To guide the evaluation, RDA and BHRS developed evaluation questions in three categories (see Figure 2).

Figure 2. Evaluation Domains and Questions



Evaluation Methods

The mixed methods evaluation incorporated both a process evaluation (what services were provided and how well) and an outcome evaluation (the extent to which the project contributed to positive changes). The evaluation team used the following quantitative and qualitative data sources to explore the evaluation measures listed in Table 1.

Quantitative Data

- Attendance and demographic reporting collected on an ongoing basis
- Participant Experience Survey administered annually
- Clinical Assessment collected at intake, six-month follow-ups, and exit
- Client Self-Assessment collected at intake, six-month follow-ups, and exit
- Staff Collaboration Instrument[4]

Qualitative Data

- Focus groups and interviews with Pride Center participants annually
- Focus groups with Pride Center staff, partners, and Community Advisory Board annually
- Interviews with Pride Center and partner agency leadership annually
- Interviews with external partner agencies in FY2020-21

Table 1. Evaluation Measures

Outreach and Implementation of Services
Number of individuals reached
Types of activities and services provided in the social and community, clinical, and resource components
Successes and challenges of implementing services as designed
Cultural responsiveness of services
Collaboration and Access to Services
Effectiveness of communication, coordination, and referrals for LGBTQ+ individuals with moderate to severe mental health challenges
Improved access to behavioral health services for individuals with moderate to severe health challenges
Service Delivery Outcomes
Client service experience (e.g., experience with services, facility, and service providers)
Improved health outcomes among clients

Data Analysis

To analyze the quantitative data from demographic data and clinical data, RDA examined frequencies and ranges. To analyze qualitative data, RDA transcribed focus group and interview participants' responses to appropriately capture the responses and reactions of participants. RDA thematically analyzed responses from participants to identify commonalities and differences in participant experiences within and across demographic characteristics and identity groups. It should be noted that the number of baseline and follow-up clinical assessments represented a small proportion of clinical clients and therefore should not be generalized to all clients.

[4] After reviewing results and consulting with BHRS staff, the evaluation team determined that the data provided by the survey was not as relevant to the evaluation as initially intended and discontinued its use in FY19-20.

Population Served

This section presents the number of participants served by the Pride Center in two ways:

- **Non-clinical reach**: The Pride Center reported demographic information for participants in trainings, social events, drop-in hours, and peer support groups. These numbers are duplicated.
- **Clinical participants**: The Pride Center collected individual-level data for each participant in therapy and/or case management. The number of clinical clients is unduplicated.

Table 2 below shows the Pride Center's **reach** over the course of implementation. FY2016-17 was a startup year; the numbers represent the Pride Center's inaugural "30 Days of Gay" in June 2017. FY2019-20 services were partially online and FY2020-21 services were fully online and there were some challenges documenting the total numbers served. Therefore, the Pride Center estimates they served more people than were counted. In all, the Pride Center reached at least 2,000-3,000 people per year through trainings, social events, drop-in hours, and peer support groups.

BY THE NUMBERS: FY2020-21

2,000+

Participants served through clinical, social, training, and drop-in services

169

Unique individuals received clinical services

2,700

Hours of clinical services delivered

359

Community members served across 10 different peer support groups

300+

LGBTQ+ older adults contacted on a regular basis via emails, calls, and support groups

Table 2 also shows the unduplicated **clinical participants** in each fiscal year beginning in FY2017-18. Because some clients received services for multiple years, the numbers are duplicated across fiscal years. The Pride Center increased its clinical capacity over the years, from 93 clients in the first year of clinical services to 169 clients in the most recent year—which included the transition to telehealth services. The total unduplicated number of clinical clients served across all fiscal years was 395.

Table 2. Count of Participants by Fiscal Year

	FY2016-17 (startup)	FY2017-18	FY2018-19	FY2019-20	FY2020-21
Duplicated Count of Non-Clinical Participants	1,197	3,056	3,000*	3,395	2,312
Unduplicated Count of Clinical Participants	N/A	93	153	132	169

* Approximate count

Participant Demographics

Below are key highlights and trends from the demographic information from non-clinical participants and clinical clients.[5,6,7] Full demographic data tables are included in the Appendix.

Table 3. Demographic Highlights and Trends

	Non-Clinical Participants	Clinical Participants
Age	• Between 30-40% of participants each year were youth and transition age youth • Between 50-60% were adults ages 26-59 • Between 8-10% were adults age 60 and older	• Compared to non-clinical participants, clinical clients were younger—49% were youth or transition age youth • Fewer older adults were served in clinical services (5%)
	County Comparison: • *The Pride Center saw a lower percentage of older adults than represented in the county (17% of the county is age 65 and older)*	
Race	• Over 50% of participants each year identified as either multiracial or people of color—about 60% of participants in FY2017-18 and 2018-19, and a lower proportion (51%) in FY2019-20 • Between 50-60% of participants each year identified as White, with this proportion increasing over time (46-51% identified as White only)[8] • Hispanic/Latinx was the next highest racial group served (21-23% each year), followed by Asian or Asian American (17-20%)	• Compared to non-clinical participants, the proportion of clinical clients who identified as White only was lower (40%) • The proportion Latinx clients in most years was higher (29-34%) and declined somewhat in FY20-21 (24%) • The proportion of Asian or Asian American clients was lower (11%)
	County Comparison: • *The Pride Center saw a higher percentage of non-clinical participants who were White and a similar percentage of clinical participants who were White compared to the county overall (39% of the county identified as only White)* • *The Pride Center saw a lower percentage of Asian participants (31% of the county, vs. around 18% of Pride Center participants and only 11% of clinical clients)* • *One-quarter (24%) of county residents are Hispanic or Latino/a/x, which is nearly consistent with Latinx representation at the Pride Center (21%). An even higher proportion of clinical clients identified as Latinx (26%)* • *While only around 6% of Pride Center participants identified as Black, this is higher than the percentage of Black residents in the county (3%)* • *Native Hawaiian, Pacific Islander, Native American, and Alaska Native participants were represented at rates comparable to the population of San Mateo County (2% and 1% of county residents, respectively)*[9]	

[5] Demographic data for non-clinical participants was available from FY2016-17 through FY2019-20. Data from FY2020-21 was not available because of data limitations resulting from the COVID-19 pandemic. In the analysis of trends over time, data from FY2016-17 are not included because the Pride Center had only been open for one month at that point. It is also important to note that the latter part of FY2019-20 was during the COVID-19 shelter-in-place, therefore it is likely that not all participants are represented.
[6] Demographic data for clinical clients was available beginning in FY2017-18 (when clinical services began) and continuing through FY2021-21.
[7] The Pride Center made several modifications to the demographic form in 2019 to expand response options available. Therefore, some data is not comparable across years.
[8] Because participants could select more than one race, over half of participants identified as White and over half identified as another race.
[9] "U.S. Census Bureau Quick Facts: San Mateo County, California," *U.S. Census Bureau website*. <<https://www.census.gov/quickfacts/sanmateocountycalifornia>>

	Non-Clinical Participants	Clinical Participants
Sex	• A majority of participants each year identified their sex at birth as female (55-61%)	• A majority of clinical clients identified their sex at birth as female (56%) and 44% responded that they were assigned male at birth
Gender Identity	• A majority of participants identified as cisgender (between 62-69%) and about 36% identified as transgender/gender expansive • Cisgender women made up about 40% of participants each year • Cisgender men and transgender or genderqueer/gender nonconforming participants were the next highest groups, each making up somewhat even proportions of participants (between 20-30%)	• Compared to non-clinical participants, there was a higher percentage of transgender clinical clients • 43% of participants identified as cisgender; 49% identified as transgender, genderqueer, or gender non-conforming • There was a slight increase during FY2020-21 in clients who identified as either nonbinary or questioning or unsure about their gender identity
Sexual Orientation	• LGBQ+ individuals made up over 70% of participants; the percent identifying as heterosexual was between 20-30% each year • Around 30% of participants each year identified as gay or lesbian • The percent identifying as bisexual more than doubled from FY2017-18 (9%) to FY2018-19 (21%) • Around 20% of participants each year identified as queer or pansexual, with this percentage increasing over time	• Compared to non-clinical participants, there was a higher percentage of LGBQ+ clinical clients (86%) and a lower percentage of heterosexual clients (14%) • A higher percentage of clinical clients identified as queer or pansexual (29%) • There was a slight increase in FY2020-21 in clients who reported that they were questioning or unsure of their sexual orientation
	County Comparison: • *The County of San Mateo LGBTQ Commission's 2017-18 LGBTQ Wellness Survey estimated that 4% of the San Mateo County population, or 30,000 people, were LGBTQ+.*[10]	
Disability	• Between 58-67% of participants reported that they did not have a disability • For those identifying with a disability, chronic health conditions, mental health conditions, and other disabilities or conditions were the most commonly reported	• Compared to non-clinical participants, a lower percentage of clinical clients reported not having a disability (45%) • Mental health and chronic health conditions were most common; 13% reported a combination of disabilities
Income	• The proportion of participants at the lowest end of the income range (under $50,000/year) doubled from FY2017-18 (32%) to FY2018-19 (64%), and then declined in FY2019-20 (49%)	• Clinical clients had even lower incomes than non-clinical participants, with 79% reporting incomes under $50,000/year
	County Comparison: • *Among participants ages 18 or older, over half are considered Extremely Low Income (less than $38,400) or Very Low Income (less than $63,950) for San Mateo County, based on 2021 US Department of Housing and Urban Development (HUD) individual income levels*[11]	

[10] SMC LGBTQ Wellness Survey. https://lgbtq.smcgov.org/smc-lgbtq-wellness-survey
[11] 2021 San Mateo County Income Limits as determined by HUD. Retrieved from https://housing.smcgov.org/sites/housing.smcgov.org/files/2021%20Income%20Limits%20revised%20042721.pdf

Project Outcomes

This section discusses the outcomes of the Pride Center INN project in terms of its two learning goals and clinical outcomes. A summary of key findings is below followed by a discussion of each outcome area.

Highlights: Coordinated Service Delivery Model

Internal Collaboration: The Pride Center's passionate staff have fostered collaboration with each other to serve clients and facilitate linkages to services within and outside of the Pride Center.

Community Reach: The Pride Center's model of collaboration with partner agencies has expanded the Pride Center's reach both geographically and demographically.

External Provider Network: External collaboration efforts positioned the Pride Center as a leader in advancing LGBTQ+ inclusion and visibility in San Mateo County and has become well integrated in the county's external network of providers.

Organizational Model: Several factors emerged as core needs for an effective collaborative service delivery model: clarity of roles and responsibilities; involvement from leadership of all partner agencies; formal venues for cross-training and communication with partner agencies; a robust staffing structure for program planning, management, and administration; strategies to support staff wellness; and proactive fundraising and sustainability.

Highlights: Access to Mental Health Services

Mental Health Outcomes: The Pride Center has substantially increased access to mental health services for LGBTQ+ individuals, and this access appears to have led to improvements in mental health wellbeing and clinical outcomes.

Protective Factors: The evaluation consistently found that having access to a safe space to build cultural identity and community for LGBTQ+ individuals is an important protective factor against negative mental health outcomes.

Clinical Service Capacity: The Pride Center has used various strategies to increase clinical capacity to serve the LGBTQ+ community. The Pride Center qualified for Medi-Cal reimbursement, serves as a training placement for clinical interns, and engages in training and partnerships with external organizations. The Pride Center has prioritized clinical services for members of underserved and marginalized communities and is working to engage more racially/ethnically diverse clients, older adults, individuals who speak languages other than English, and those outside central San Mateo.

Access and Engagement: The key facilitators of continued engagement with the Pride Center were feeling a sense of community, feeling welcome and safe, feeling connected to staff, and enjoying the services and programs. Community members were less inclined to engage when they did not feel their identities were represented among Pride Center staff or in Pride Center programming and when the timing of events did not work with their schedules. Shifting to fully virtual programming during COVID-19 allowed the Pride Center to maintain a touchpoint for the LGBTQ+ community regardless of their geographic proximity to the Pride Center, although some participants, including older adults, tended not to engage in virtual programming. Access to in-person services has been influenced by the geographic spread of the county, limited public transportation, and accessibility barriers within the Pride Center space.

Highlights: Clinical Outcomes

Overall Mental Health: Clinical participants reported improved mental health since they started receiving services. The proportion of clinical clients who rated their mental health and their ability to cope with stress as "good" or "excellent" doubled from baseline to follow-up. Clients shared that receiving care from LGBTQ+ clinicians reduced anxiety and depression by increasing their sense of belonging and acceptance.

Targeted Mental Health Needs: Clinical participants saw improvement in areas of their mental health targeted by the Pride Center. While it is not possible to attribute improvements solely to clinical services, assessment results suggest that clinical clients—including those with lower and higher needs at baseline—showed improvement in key needs at follow-up, including anxiety, depression, adjustment to trauma, and family relationships.

Client Strengths: Across both adults and youth, the biggest change at the domain level was an improvement in the Strengths Domain. Youth saw the greatest improvements in this domain, with the greatest gains in interpersonal skills, cultural identity, resourcefulness, natural supports, and optimism. The biggest improvements in adults' strengths were in talents/interests, optimism, spiritual/religious, community connection, and resiliency.

Impact of Social-Political Environment: Some findings from clinical data suggest impacts of trauma and COVID-19. One-third of adults and nearly one-third of youth were in the actionable range for "cultural stress," which includes circumstances in which the individual's cultural identity is met with hostility. From initial to follow-up assessment, job history and vocational strengths saw the greatest *decline* of any area (needs or strengths), which may be an indication of the economic effects of COVID-19.

Coordinated Service Delivery Model

Learning Goal 1: Does a coordinated approach improve service delivery for LGBTQ+ individuals at high risk for or with moderate to severe mental health challenges?

Benefits of Collaboration at Multiple Levels

"Staff have dynamic collaborations working with case management, mental health; [in a] one-stop-shop, we can do warm handoffs, introduce [clients] to someone on staff, bring them in gently to a new environment."

–Pride Center staff

Pride Center's passionate staff have fostered collaboration with each other to serve clients and facilitate linkages to services within and outside of the Pride Center. Staff have developed positive working relationships within the Pride Center, supported by regular team meetings and clear communication. The clinical team and Case Manager have worked together to establish care plans for clients. The longer staff work at the Pride Center, the more familiar they become with the local network of services, and the more effective they can be in connecting participants with supportive services. Respondents to the Participant Experience Survey consistently found it easier to connect to services *within* the Center than *outside* the Center. With the transition to virtual programming during COVID-19, it has not been as easy for participants in one type of service to find out about the other types of services the Pride Center offers; this is easier when participants are in the physical space and can see flyers and hear about other services.

"The partners [are each involved] in specializations… one organization could never have done it [alone]."

– Community Advisory Board member

Collaboration among Pride Center partner agencies has expanded the Pride Center's reach both geographically and demographically. When the Pride Center was formed, the partner organizations, which had existed long prior in San Mateo County, offered the fledgling Pride Center a stamp of approval as a trustworthy institution. Bringing together multiple organizations to operate the Pride Center has helped ensure that programming and services accommodate a wide range of participants. Pride Center partner agencies agreed that being part of a collaborative model has not only contributed to the Pride Center's success; it has also enhanced their individual organizations' services. As the lead agency, StarVista reported that they have been better able to reach youth, older adults, and the northern part of the county because of their partnerships with PFS and ACS. In turn, PFS reported that being a partner agency has expanded the population they serve and increased their agency's cultural sensitivity to the LGBTQ+ community.

"The Center has gotten LGBTQ out of the closet [in San Mateo County]."

–Partner Agency

The Pride Center has positioned itself as a leader in advancing LGBTQ+ inclusion and visibility in San Mateo County and has become well integrated in the county's network of providers. The Pride Center's outreach efforts and organizational partnerships have helped the Pride Center build a large, countywide network. Behavioral health providers, health care providers, legal service providers, and more have relied on the Pride Center for guidance on LGBTQ+ inclusion, community building, and mental health care. Pride Center staff have trained hundreds of county staff members on sexual orientation, gender identity and expression (SOGIE) and LGBTQ+ inclusion. On a regular

basis, the Pride Center has been brought in for consultation with behavioral health service providers, BHRS, and other County departments on organizational policies and practices related to LGBTQ+ responsive service delivery. The Pride Center consistently receives and makes referrals to other providers, and in FY2020-21 the Pride Center developed a roadmap of services to help transgender and non-binary community members identify and navigate gender-affirming resources. All partners agreed that the Pride Center has increased LGBTQ+ visibility in San Mateo County, ultimately creating a more welcoming and inclusive environment for LGBTQ+ individuals to live and participate in the larger community. As evidence of the changing atmosphere of inclusion, in FY2019-20 and FY2020-21, each of the cities in San Mateo County observed Pride Month and raised the Pride flag.

Components of Collaborative Organizational Model

Through the INN project, the Pride Center, partner agencies, and BHRS gained firsthand experience in implementing a collaborative, multi-service center from the ground up. There were numerous lessons learned along the way. These centered on the importance of having:

- Clear expectations for the roles and responsibilities of partner agencies;
- Support and involvement from leadership across partner agencies;
- LGBTQ+ competency and racial/ethnic diversity among staff at all levels;
- Venues for cross-training and communication channels between partners;
- Time and space for strategic planning and program planning;
- A staffing structure that supports reasonable workloads and minimizes burnout;
- Staff to support program management and administrative duties; and
- Designated roles and responsibilities for fundraising and sustainability planning.

The accompanying LGBTQ+ Pride Center Best Practice Toolkit **reflects key considerations and resources for building an effective collaborative service delivery model to serve the LGBTQ+ community**.

Access to Mental Health Services

Learning Goal 2: Does the Pride Center improve access to behavioral health services for LGBTQ+ individuals at high risk for or with moderate or severe mental health challenges?

Impacts of LGBTQ+ Centered Clinical Model

With a clinical model of therapy *by and for* LGBTQ+ individuals, the Pride Center has improved access to mental health services for LGBTQ+ individuals who would be less likely to seek or remain in care with non-LGBTQ+ providers. Having a LGBTQ+ therapist has supported many participants' mental health treatment, as participants feel more understood and supported compared to previous experience with non-LGBTQ+ therapists. Many clients noted that they struggled to find adequate mental health care locally beforehand and faced issues when their providers were not trained to work with LGBTQ+ clients. According to participants, LGBTQ+ therapists are more likely to understand their lived experiences; this means that participants are not spending valuable treatment hours explaining terminology, identities, or types of relationships that non-LGBTQ+ therapists may not understand. Not having to worry about whether their therapist will understand them relieves anxiety that many LGBTQ+ individuals experienced when receiving services from non-LGBTQ+ providers. As a result, participants have been able to begin treatment with a fundamental sense of trust that they may not have been able to establish with their previous mental health care providers. This trust sets a foundation for a strong patient/provider relationship, which ultimately supports a productive treatment process.

> *"When I went to cisgender, heteronormative therapists, I got a blank look. They didn't get it. The [therapists] here understand it on the inside."*
>
> *– Adult participant*

The Pride Center has filled a particular gap in access to mental health services and supports for participants who identify as transgender or nonbinary. The Pride Center's clinical services, peer support groups, and other programs have been responsive to participants across the LGBTQ+ spectrum, particularly those who are marginalized within health care and public systems, such as transgender and nonbinary individuals. Transgender and nonbinary individuals made up a higher proportion of the Pride Center's clinical clients compared to all Pride Center clients. Pride Center staff regularly support transgender or nonbinary participants through the Pride Center's Name Change Clinic, a process than can be difficult and frustrating when undertaken alone. The Pride Center's Resource Library also includes chest binders that are made available free of charge to participants. In addition to these regular programs and resources, the Pride Center has also sponsored events such as the annual Transgender Day of Remembrance and a photo project and social media campaign.

> *"I don't feel like I need to hide things from [the therapists]. It was a major step in my life…I've had transphobic therapists in the past."*
>
> *– Youth participant*

Staff members' warmth and client-centered approach encouraged participants to engage in and remain connected with Pride Center services. The Pride Center's hardworking and passionate staff have bolstered the LGBTQ+ community in the county. Many participants and outside partners with the Pride Center named specific people as the epicenters of initiatives, services, or the overall welcoming nature of the Center itself. Before the COVID-19 shelter-in-place, participants of all ages credited the Pride

Center staff—clinicians, program staff, and administrative staff alike—for fostering the Pride Center as a welcoming environment.

Cultural Identity as a Protective Factor

Providing a physical location and inclusive space for LGBTQ+ individuals has improved mental health and wellbeing by reducing social isolation, ameliorating stigma, and creating a sense of community. The Pride Center demonstrated how having a safe space to build cultural identity and community is a significant protective factor for LGBTQ+ residents. Many participants feel that the Pride Center is a therapeutic experience, including many community members who do not use the Pride Center for formal clinical services. Prior to the opening of the Center, many participants had to travel to San Francisco, the East Bay, or San Jose to find an LBGTQ+ friendly community space. Other participants cited that the Pride Center was valuable simply as a space where they could go to find a peaceful, quiet environment. During COVID-19, the Pride Center successfully shifted to fully virtual programming, maintaining a touchpoint for LGBTQ+ community members during this difficult time.

> *"What I really like about the Pride Center is that it's a safe space, and it's not triggering."*
>
> *– Youth participant*

Social events and peer support groups have offered opportunities to build community within and across identity groups. The Pride Center supported up to 10 peer support groups at any given time. These peer-led groups offered a space of belonging and social support. The Pride Center also held a multitude of events like the county's first queer youth prom, an adult prom, movie nights, book clubs, and co-sponsored events with outside partners for cultural heritage months. While many peer groups were centered around specific identities or age groups (e.g., Latinx, transgender, Filipinx, youth, older adults), social events offered an opportunity for people across the LGBTQ+ spectrum to share space. Participants of all ages cited the Pride Center's intergenerational events as some of their favorite programs. In this way, the Pride Center's collaborative service model has helped to create an environment where participants who might never otherwise interact could find commonality. Unfortunately, many of these events have not been able to happen during COVID-19, so virtual activities have tended to focus on specific identities.

Clinical Service Capacity and Reach

Through direct services, coordination with outside providers, and training and consultation, the Pride Center has expanded clinical capacity throughout the county to serve LGBTQ+ clients with all levels of mental health need. The Pride Center alone cannot—and was not intended to—meet the mental health treatment needs of all LGBTQ+ individuals in the county. In the four years that clinical services were offered, the Pride Center served nearly 400 clients, increasing the number of clinical clients served each year and consistently maintaining a full caseload with a waitlist. The Pride Center has largely served clients with low to moderate mental health needs. The Pride Center can bill Medi-Cal for services to clients with serious mental illness (SMI) and receives Medi-Cal referrals from the County, though the multi-step referral process has caused some delays in receiving referrals. The Pride Center has also played a role in preventing the escalation of SMI by providing therapy and case management to higher-need clients who may have avoided seeking services (e.g., psychiatric or medical services) because of negative past experiences with non-LGBTQ+ providers and fear of discrimination. It is also important to note that because there is no tool that specifically assesses LGBTQ+ clinical needs, it may be that the CANS/ANSA underestimate some clients' level of need—for example, LGBTQ+ clients may be severely impacted by cultural and family issues, but as those are only a few items on the assessment, clients may not appear to be high need.

The Pride Center has reached a diverse clientele through its staffing structure, payment options, and dedication to serving members of underserved and marginalized communities. The Pride Center has served clients of diverse ages, racial/ethnic groups, gender identities, sexual orientations, and incomes. To achieve its clinical reach, the Pride Center hired clinical providers who identified as LGBTQ+, secured contractors to serve as clinical supervisors, hired clinical trainees, offered services on a sliding scale to private pay clients, and qualified to receive Medi-Cal reimbursement for services. Below is a summary of the Pride Center's clinical capacity and reach by race/ethnicity, language, and age.

- *Race/ethnicity*: The Pride Center's clinical staff has generally been racially and ethnically diverse, though there were no Black/African American clinicians. Compared to non-clinical participants, the Pride Center served a higher percentage of Latinx clients and lower percentages of White clients and Asian or Asian American clients in clinical services.
- *Language*: At different points in time, the Pride Center had Spanish-speaking and Cantonese-speaking clinicians. The Pride Center recruited for, but was unable to fill, a bilingual Spanish language clinical position in FY2020-21, which may account for the slightly lower proportion of Latinx clients served that year.
- *Age*: The Pride Center faced administrative barriers in serving older adult clients as there was not a licensed clinical social worker (LCSW) on staff to bill Medicare. Additionally, as discussed below in the *Factors Influencing Access and Engagement*, the Pride Center generally struggled to engage older adults in clinical and non-clinical services.

Factors Influencing Access and Engagement

This section discusses factors that facilitated and hindered participant access (their ability to participate in services) and engagement (their desire to begin or continue participating) in the Pride Center.

Facilitators of Access. Having information about the Pride Center, whether through social media, email lists, word of mouth, or referrals is the first step to accessing services. The Pride Center employed a community engagement and outreach specialist, and the Center built a strong referral network with providers, schools, and employers. The Pride Center has offered services at no or low cost. All social and community activities are free; case management services are free; and clinical services are offered on a

sliding scale, though the Pride Center recognizes the sliding scale may still be a challenge for some clients. The Pride Center also offered services at different times of day, including daytime and evening programming. In the past two years, Coast Pride (another LGBTQ+ organization) started offering services in Half Moon Bay, which lessens barriers to access for individuals in that part of the county. To address technology barriers to address among older adults, the Pride Center started hosting an "App-y hour" tech workshop for older adults as a collaboration with PFS. Remote services offered an opportunity for clients to engage in services without a need for transportation. Online services have also facilitated access for individuals who have disabilities or chemical sensitivities. To maintain access, it is likely the Pride Center will offer a hybrid model even after in-person services resume.

Facilitators of Engagement. A sense of community, rapport with staff, enjoyment of services and programs, and feeling their identity is affirmed were primary facilitators of continued engagement. Among survey respondents who had engaged less frequently with the Pride Center, around three quarters reported that they planned to continue participating.

Top reasons for continuing to participate in the Pride Center:

- Feeling a sense of community at the Pride Center
- Feeling welcome and safe at the Pride Center
- Enjoying the services and programs
- Feeling connected to staff
- Feeling their identity is affirmed at the Pride Center

Source: Participant Experience Survey

Barriers to Access. Despite intensive outreach efforts on the part of the Pride Center, a number of participants expressed that they had only recently become aware of the Pride Center and perceived that many others in the community are not aware of the available services. The geographic spread of the county and limited public transportation were a challenge to ensuring access to in-person services. The Pride Center offered services at different times of day to accommodate different schedules, but it is difficult to meet everyone's needs. One of the main reasons survey respondents reported not participating in services was that the timing of events did not work with their schedules. Additionally, as in previous years, some participants mentioned the physical accessibility of the Pride Center, noting that some areas can only be accessed via stairs, and some furniture is difficult for older adults and people with disabilities to access comfortably. While services were virtual for much of FY2019-20 and all of FY2020-21, some participants, including older adults, struggled to engage in virtual programming. Language is also a barrier to access. In FY2020-21, the Pride Center was only able to offer services in English and Cantonese; there were Spanish speaking in the past, but not during the most recent fiscal year. There were no staff who spoke Mandarin or Tagalog, the other threshold languages in San Mateo County.

> *"Getting info in time out to community—that has been one of the biggest issues…struggling so hard to get info to community."*
>
> *–Partner Agency*

Barriers to Engagement. Survey, focus group, and interview participants highlighted several factors that influenced their engagement in the Pride Center.

BIPOC representation among staff and participants. The Pride Center has espoused a commitment to be an inclusive space for LGBTQ+ community members of color and has continued to offer dedicated programming for Black, Indigenous, and other people of color (BIPOC). Pride Center staff, partners, and participants alike acknowledged that in large part, being a welcoming and inclusive space necessitates having staff who represent the racial/ethnic and cultural backgrounds of prospective participants. Some focus group and survey respondents shared a perception that the clientele and staff of the Pride Center are mostly White. While participant demographic data show that approximately half of all Pride Center

participants are non-White, it may be that participation in certain programs is predominantly White. Staff shared that establishing and retaining a racially diverse staff has been a challenge, particularly Black/African American staff. Though the racial/ethnic makeup of Pride Center staff shifted across the years, in FY2020-21, six staff identified as White, two as multiracial, and one person each as Asian/Asian American, Black/African American, Latinx, and Pacific Islander.

"I would like to see more POC at events, but we need to have more POC on staff first."

–Partner Agency

Programming reflective of participants' identity. The Pride Center has continued to prioritize serving BIPOC residents, including holding events in partnership with the African American Community Initiative of San Mateo County. Staff and partners reported challenges specifically around engaging Black/African American individuals. Demographic data from participant sign-in indicate that, proportionally, the Pride Center is serving a higher percentage of Black/African American clients (around 6%) than the overall San Mateo County population (3%). That said, demographic forms do not contain information about participants' level and consistency of engagement. The abovementioned barriers speak to the context of intense and public racial oppression across the country, which disproportionately impacts queer people of color. Pride Center clinical data also appeared to reflect this reality: in the clinical assessment, the "cultural stress" item—which includes circumstances in which an individual's cultural identity is met with hostility—was scored as an area of high need and did not see improvements from baseline to follow-up.

"My experience has been a little rocky. The first year I tried coming, it was hard, because it was a predominantly white space and didn't feel okay, as a queer person of color in a white space… Throughout the years the Pride Center has been evolving, there's been other queer people of color here, and spaces for queer people of color. Not just queer people or people of color, but both—I don't have to choose."

-Adult participant

Engagement with older adults. In both social and clinical spaces, the Pride Center had difficulty attracting and maintaining engagement with older adults. In the clinical sphere, the Pride Center consistently attempted to reach the older adult population without much success. In the social sphere, the Pride Center struggled to maintain participation despite having a dedicated staff person from PFS for 12 hours per week. Older adults tend to be more socially isolated in general. When programming became virtual during COVID-19, it was even harder to engage older adults. The Pride Center hosted technology education courses for older adults and connected older adults to smart phones and tablets with one-year paid internet services; however, it remained consistently difficult to engage LGBTQ+ older adults. Older adult participants and some partner agency staff perceived that the Pride Center catered to a younger crowd, noting that the staff tend to be younger and the physical location was more appropriate for youth in terms of aesthetics and physical accessibility. As mentioned above, the Pride Center building is not fully physical accessible. Additionally, some older adults described that they were not comfortable going to a visibly LGBTQ center—coming from a different generation that endured intense discrimination for their sexuality, stigma remained a barrier.

Engagement during COVID-19

As described above, the Pride Center made a quick transition to virtual programming during COVID-19. The Pride Center has been able to maintain therapy services through telehealth platforms. Online peer support groups have become accessible for people outside of the central San Mateo area and outside of the county itself. Virtual Pride Week garnered views from thousands of people. Online services have facilitated access for individuals who have disabilities, chemical sensitivities or live outside the central San

Mateo area. Two-thirds of clinical clients in FY2020-21 were new, which highlights the level of mental health need during COVID-19. In FY2020-21 when programming was fully online, the Pride Center reported:

- Providing new programming for people of color such as a Queer, Trans, BIPOC group for folks 14-25 and events for Filipinx Pride Month
- Doubling the number of trainings including adding a Trans 101and Pronouns 101 training
- Contacting over 300 LGBTQ+ older adults on a regular basis, via emails, calls, and support groups
- Delivering over 2,700 hours of service with therapy and case management clients
- Serving 359 community members in peer support groups
- Training over 500 people

Of course, there have been challenges as well. Staff reported that it has been difficult to maintain engagement in peer support groups due to "Zoom fatigue." Online services have increased barriers for older adults, lower income individuals, individuals who are unstably housed, and those living in a hostile environment. In addition, not all clients have access to devices with video calls or a safe place to have private conversations. Further, virtual services make it more difficult for staff to maximize the "one-stop-shop" model; they cannot simply walk to the office next door and introduce a client to another staff person.

"Even though shelter in place is in order and COVID is scary, the Pride Center has helped make me feel like I'm still part of a community, and it means so much to me to not feel as if I've been forgotten."

–Participant

Respondents to the Participant Experience Survey were asked to report on their online engagement during the pandemic in FY2019-20 and FY2020-21. Most respondents reported being informed about and satisfied with the Pride Center's online services: in both years, 81% agreed or somewhat agreed that the Pride Center offered online options for the services that were most important to them. Of those who participated in online services in FY2019-20 and FY2020-21, most agreed or somewhat agreed that online services have been engaging (90% and 85%, respectively), gave them a sense of community (87% and 82%, respectively), and were easy to access (81% and 89%, respectively).

The Pride Center conducted a survey during the fall and winter of 2020 to better understand the impact of COVID-19 on the LGBTQ+ community in San Mateo County. The survey received 532 responses and the key findings are reflected in the Pride Center's **LGBTQ+ COVID-19 Impact Survey Report**.

Clinical Outcomes

This section presents data on the participants who received clinical services, which included therapy and case management, from FY2017-18 through FY2020-21. Findings include data from the following sources: 1) Client Self-Assessment, which asks clinical clients to rate how they felt about their mental health and their ability to cope with stress in the last 30 days; and 2) the Adult Needs and Strengths Assessment (ANSA) for adults and the Child and Adolescent Strengths and Needs (CANS) for youth.[12]

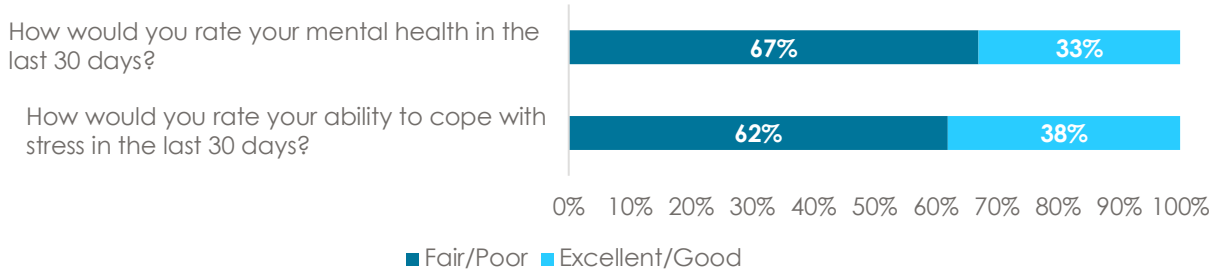
Client Self-Assessment

The Client Self-Assessment asks clinical clients to rate how they felt about their mental health and their ability to cope with stress in the last 30 days.

Baseline Data

Baseline data were available for **122 clients**. At initial assessment, two-thirds of the clients (67%) rated their mental health as poor or fair and rated their ability to cope with stress as poor or fair (see Figure 3). For both self-assessment questions, "fair" was the most common response at baseline. Only 3% of clients rated their mental health as "excellent" and 2% rated their ability to cope with stress as excellent at baseline. Suggesting impacts of COVID-19, self-assessment data during FY2020-21 showed a somewhat higher percentage of clients rating their mental health as fair or poor (72%).

Figure 3. Clients' Initial Screening Experiences (n=122)



Follow-up Data

Follow-up assessments (either a 6-month or discharge assessment) were available for **48 clients**. For individuals who had multiple follow-up assessments, the most recent assessment was used to determine change. The data below includes the 48 clients who had both an initial and a follow-up assessment. Figure 4 and Figure 5 indicate that at follow-up, a higher percentage of clinical clients reported positive mental health and ability to cope with stress. At baseline, 31% of clients rated their mental health as "excellent" or "good" in the past 30 days, which increased to 50% at follow up. Clients also reported an increased ability to cope with stress in the past 30 days (31% at baseline and 58% at follow up).

[12] There are several reasons why the number of clinical assessments recorded is lower than the number of clinical clients. Due to start-up needs, most clinical data collection began in FY2018-19. Some clients may have terminated services before a discharge assessment was completed. During COVID-19, there were data gaps as the Pride Center shifted to telehealth. In addition, there may have been gaps in onboarding and training for clinical staff around data collection. The Pride Center is taking steps to improve clinical data collection and documentation, including establishing training protocols, developing reports to identify gaps in assessment data, and incorporating data review in clinical supervision meetings.

Figure 4. Clients' Mental Health in Last 30 Days (n=48)

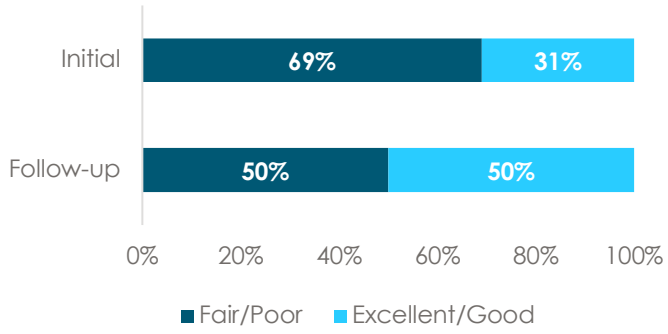
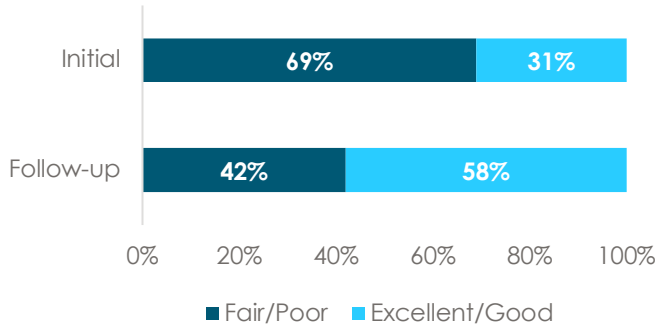


Figure 5. Clients' Ability to Cope with Stress in Last 30 Days (n=48)



Client Strengths and Needs

This section summarizes the results of the assessments administered to clinical service participants—the Child and Adolescent Strengths and Needs (CANS) for youth and the Adult Needs and Strengths Assessment (ANSA) for adults.[13]

- **88** adults had an initial ANSA
  - **61** had an initial and follow-up
- **24** youth had an initial CANS
  - **11** had an initial and follow-up

The follow-up analysis includes only individuals who had both an initial and follow-up assessment (e.g., a 6-month, 12-month, or 18-month subsequent assessment or discharge assessment) between FY2017-18 and FY2020-21. For individuals who had multiple initial assessments, the earliest assessment was used to determine the baseline. For individuals who had multiple follow-up assessments, the most recent subsequent assessment was used to determine change. For the ANSA, the average time between assessments was 321 days (10.5 months), ranging from 14 to 993 days. For the CANS, the average time between assessments was 197 days (6.4 months), ranging from 119 to 378 days.

The ANSA/CANS "actionable range" is defined as a score of 2 or 3. To interpret change over time, a positive change is indicated by a decrease in score.

The analysis included the primary domains of the assessments: Functioning Domain, Strengths Domain, Cultural Factors, Behavioral/Emotional Needs, Risk Behaviors, and Caregiver Resources and Needs (CANS). The ANSA and CANS scoring rubric is as follows: 0 = no evidence; 1 = history, suspicion; 2 = action needed; and 3 = disabling, dangerous, immediate action. To explore clients' needs from multiple angles, the analysis examined average ANSA and CANS scores for each domain and for the individual items within each domain. In addition, the analysis examined the percent of clients who received ANSA scores in the actionable range.[14] Key takeaways from the analysis are presented below. For full assessment results, see the Appendix.

[13] The CANS/ANSA was not administered if: a) the client only attended a one-off Name and Gender Change Workshop or was a drop-in client seeking out resources; b) the client was only a participant in the Kennedy Middle school group; or c) the client was active for less than 1-2 months or had several no-shows that prevented staff from gathering enough data for a proper assessment.

[14] Because of the small number of follow-up CANS assessments, this analysis was only conducted for the ANSA.

Overall Level of Need

At both the initial and follow-up assessment, each needs domain had an average score of less than 1, which falls between "no evidence" and "history or suspicion" and is below the actionable range (see Table 4 and Table 5). See below for a note on interpreting the Strengths Domain.[15]

Table 4. Average ANSA Domain Scores and Change Over Time

Domain	Baseline Avg Score	Follow-up Avg Score	Avg Change
Functioning Domain	0.62	0.61	-0.01
Strengths Domain	1.71	1.59	-0.12
Cultural Factors	0.53	0.50	-0.03
Behavioral/Emotional Needs	0.70	0.68	-0.02
Risk Behaviors	0.20	0.20	0.00

Table 5. Average CANS Domain Scores and Change Over Time

Domain	Baseline Avg Score	Follow-up Avg Score	Avg Change
Functioning Domain	0.55	0.47	-0.08
Strengths Domain	1.61	1.30	-0.31
Cultural Factors	0.50	0.36	-0.14
Caregiver Resources and Needs	0.35	0.31	-0.04
Child Behavioral/Emotional Needs	0.46	0.45	-0.01
Risk Behaviors	0.11	0.15	0.04

Areas of Highest Need at Baseline

Although the average baseline score at the domain level was less than 1, several items within the domains had average scores between 1 and 2 ("action needed"), indicating that a higher proportion of clients had a score in the actionable range for these items. Table 6 and Table 7 below ranks the ANSA and CANS items that had the highest average score at intake across all domains and show the percent that received a score of 2 or 3 (the actionable range) for these items.

Table 6. Items with Highest Average Need at Baseline: ANSA (N=88)

ANSA Item	Average Baseline Score	Percent of Clients in Actionable Range
Anxiety	1.51	59%
Depression	1.47	57%
Family Relationships	1.38	50%
Adjustment to Trauma	1.26	48%
Social Functioning	1.07	33%
Cultural Stress	1.01	31%

[15] The Strengths Domain uses the following rubric: 0 = centerpiece strength, 1 = useful strength, 2 = identified strength, and 3 = no evidence. Unlike the needs domains, a score of 2 may not indicate that action is needed.

Table 7. Items with Highest Average Need at Baseline: CANS (N=24)

CANS Item	Average Baseline Score	Percent of Clients in Actionable Range
Anxiety	1.35	43%
Depression	1.17	39%
Cultural Stress	1.04	30%
Social Functioning	1.00	33%
Sleep	1.00	30%

The data above demonstrate that mental health issues, particularly anxiety, depression, and trauma, were prevalent among Pride Center's clinical clients. Anxiety and depression were indicated as the highest areas of need for both adults and youth. Family and social relationships also rose to a high level of need. Youth also had higher needs with respect to sleep at baseline compared to adults. It is also notable that cultural stress was indicated as an area of need for both adults and youth.[16]

Changes in Needs Over Time

While it is not possible to attribute improvements solely to clinical services, results suggest that clinical clients showed improvement in key needs, including anxiety, depression, adjustment to trauma, and family relationships.

Average Domain and Item Scores

Between the initial and follow-up assessment, the average scores for each domain showed slight positive changes (Table 4 and Table 5 above). While changes in average domain scores were small, several items within the domains saw improvements. Items that saw an improvement of 0.20 points or more are shown in Table 8 and Table 9. For adults, the highlighted rows show that three of the items with the highest need at baseline (anxiety, adjustment to trauma, and family relationships) were among those with the most improvement. High-need items at baseline that did not show improvement at follow-up were social functioning and cultural stress; however, there was improvement in the cultural identity item.[17]

Table 8. Items with Highest Changes in Average ANSA Scores (N=61)

ANSA Item	Baseline Avg Score	Follow-up Avg Score	Avg Change
School*	0.61	0.23	-0.38
Cultural Identity	1.00	0.67	-0.33
Anxiety	1.57	1.32	-0.26
Family Relationships	1.41	1.19	-0.22
Adjustment to Trauma	1.30	1.08	-0.21
Sexual Development	0.60	0.40	-0.20

**Note that this item was completed for only 33 of the clients, as it was not applicable to all adult clients.*

[16] Cultural Stress refers to "circumstances in which the individual's cultural identity is met with hostility or other problems within his/her environment due to differences in attitudes, behavior, or beliefs of others (this includes cultural differences that are causing stress between the individual and his/her family). Racism, homophobia, gender bias and other forms of discrimination would be rated here.) See: http://www.acbhcs.org/providers/CANS/docs/ANSA/ANSA_25_Manual.pdf

[17] Cultural Identity refers to "an individual's feelings about her/his cultural identity, including race, religion, sexual orientation, gender identity, and ethnicity.

For youth, the highlighted rows show that two of the items with the highest need (anxiety and social functioning) were among those with the most improvement.

Table 9. Items with Highest Changes in Average CANS Scores (N=11)

CANS Item	Baseline Avg Score	Follow-up Avg Score	Avg Change
Social Resources	0.70	0.27	-0.43
Anxiety	1.50	1.09	-0.41
Social Functioning	1.00	0.73	-0.27
Recreational	0.45	0.20	-0.25
Language	0.30	0.09	-0.21
Residential Stability	0.30	0.09	-0.21
Psychosis (Thought Disorder)	0.20	0.00	-0.20

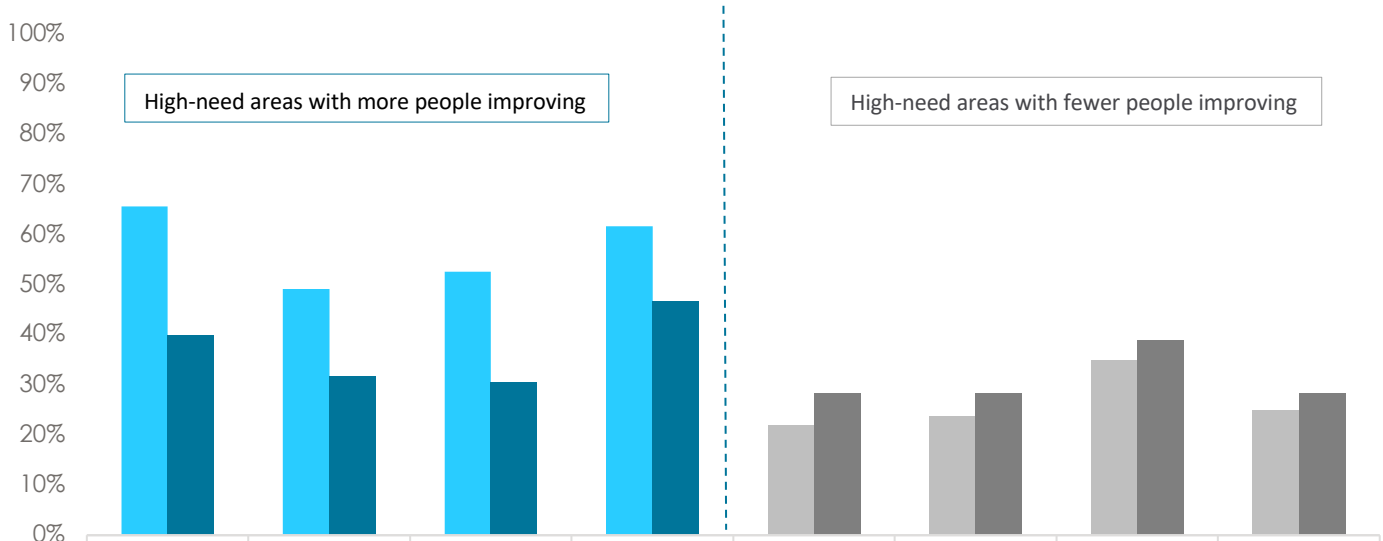
Percent of Clients in Actionable Range

As mentioned above, an additional analysis was conducted with ANSA and CANS data. Figure 6 and 7 below depict the items for which at least twenty percent of adults and youth received a score in the actionable range. For each item, the first column represents the percent of clients with an actionable score at baseline, and the second column represents the percent of clients with an actionable score at follow-up.

As shown on the left-hand side of the chart, there were substantial decreases (i.e., improvements) in the percentage of clients with an actionable score for key items such as anxiety, adjustment to trauma, family relationships, depression, sleep, and social functioning. This suggests that some clients with higher need achieved greater stability during the time that they received clinical services.

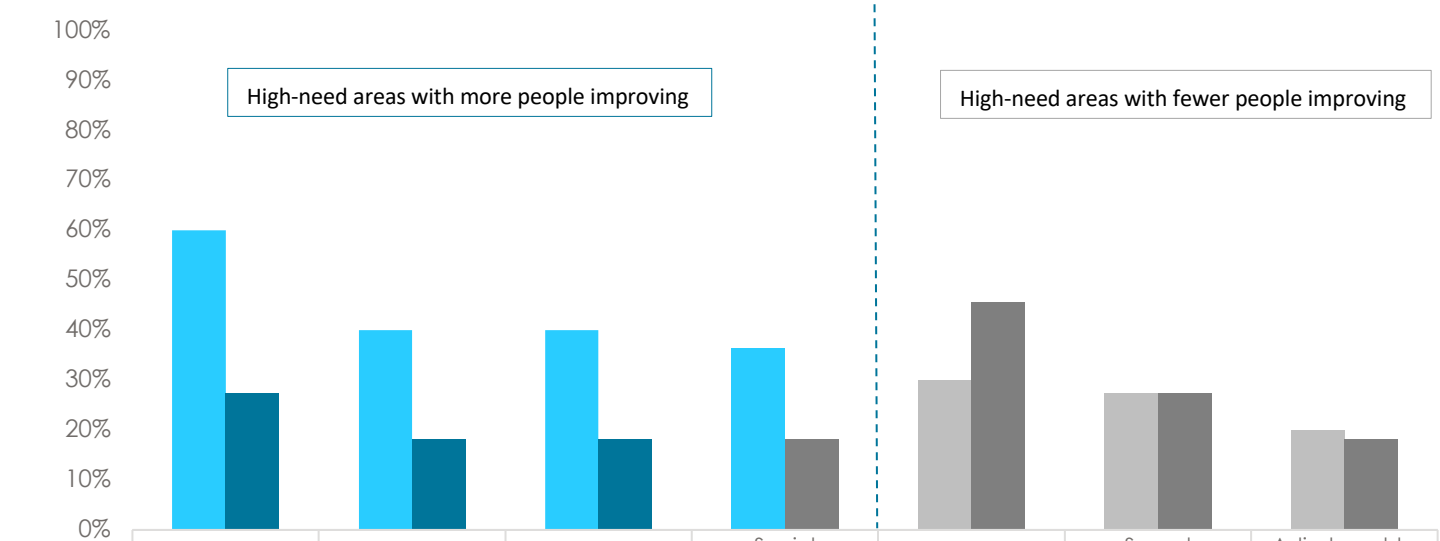
As shown in the right-hand side of each chart, some items with a substantial percentage of clients in the actionable range did not show any change, or showed negative change, from the initial to follow-up assessment. For adults, this included interpersonal problems, living situation, social functioning, and cultural stress. For youth, this included cultural stress, sexual development, adjustment to trauma, and family functioning.

Figure 6. Percent of Adult Clients with Score in Actionable Range



	Anxiety	Adjustment to Trauma	Family Relationships	Depression	Interpersonal Problems	Living Situation	Social Functioning	Cultural Stress
Baseline	66%	49%	53%	62%	22%	24%	35%	25%
Follow-up	40%	32%	31%	47%	28%	28%	39%	28%

Figure 7. Percent of Youth Clients with Score in Actionable Range



	Anxiety	Sleep	Depression	Social Functioning	Cultural Stress	Sexual Development	Adjustment to Trauma
Baseline	60%	40%	40%	36%	30%	27%	20%
Follow-up	27%	18%	18%	18%	45%	27%	18%

Strengths

For adults and youth, the strengths with the most positive average scores at baseline were as follows:

Adults

- Volunteering
- Spiritual/Religious
- Community Connection
- Educational Setting
- Family Strengths
- Vocational

Youth

- Spiritual/Religious
- Community Life
- Vocational
- Cultural Identity
- Interpersonal
- Resourcefulness

At follow-up, the largest improvements in adults' strengths were seen in the talents/interests, optimism, spiritual/religious, community connection, and resiliency items. Notably, from initial to follow-up assessment, job history and vocational strengths saw the greatest *decline* of any item (needs or strengths), which may be an indication of the economic effects of COVID-19.

Across both adults and youth, the biggest change at the domain level was an improvement in the Strengths Domain for youth. The largest improvements in youths' strengths were seen in the interpersonal, cultural identity, resourcefulness, natural supports, and optimism items.

Next Steps

Sustainability

The Pride Center has had an invaluable impact on San Mateo County LGBTQ+ inclusion and visibility and the evaluation data presented in this report supports the importance of sustaining this innovative approach to addressing LGBTQ+ individuals' mental health needs. Stakeholders across various sectors unanimously supported the long-term sustainability of the Pride Center. BHRS is committed to supporting sustainability efforts ongoing, which includes providing continued MHSA funding for the Pride Center.

Sustainability has been a core function of the Pride Center since inception. The Pride Center includes a "Development" Program component, which consists of one part-time grant writer with the goal of diversifying funding sources for the Pride Center. The grant writer researches and applies to prospective philanthropic organizations' grant opportunities, works with corporate sponsors, and cultivates donors. Most recently, this position was transitioned under StarVista's Development team to help streamline communication and efforts; the grant writer works collaboratively with StarVista's Development team and the Pride Center Program Director. The Pride Center Program Director is actively involved in establishing long-term sustainability and working collaboratively with BHRS to address a $130,000 deficit anticipated in FY2022-23. Revenue opportunities that will be explored by the Pride Center include increasing fee-based trainings for organizations looking to improve LGBTQ+ inclusivity and client outcomes, room rental and community event donation requests, monthly donor campaigns, grant opportunities, and increasing clinical billing.

Stakeholders have been involved in the decision to sustain and fund the Pride Center with MHSA monies starting in April 2019. A Pride Center update on progress toward the INN learning goals and client outcomes was presented to the MHSA Steering Committee, the Mental Health Substance Abuse Recovery Commission (MHSARC), and stakeholders. A proposal to support the Pride Center was first presented in October 2019 following input sessions conducted July-August 2019 with the MHSARC Older Adult, Adult, and Youth Committees, as well as the Contractor's Association, the Office of Consumer and Family Affairs Lived Experience Workgroup, and the Peer Recovery Collaborative. The proposal at the time included a one-time contribution of $700,000 to the Pride Center to begin FY2021-22. This was as an interim solution, given inability to increase the MHSA ongoing budget at the time, and with the intention to incorporate the Pride Center ongoing sustainability as part of the FY2020-23 MHSA Three-Year Plan Community Program Planning process. An estimated 40 members of the public attended the presentation on October 2019 and had the opportunity to ask questions and provide public comment. Additionally, The MHSARC held a public hearing and voted to close a 30-day public comment on February 2020 and subsequently voted to recommended approval of the interim solution to use one-time unspent funds for the Pride Center. Our local Board of Supervisors approved this plan on April 7, 2020.

With the COVID-19 pandemic, significant revenue decreases were initially projected for MHSA statewide. Given this uncertainty, the Pride Center was not included in the approved FY2020-23 MHSA Three-Year Plan ongoing budget but remained in the one-time unspent fund commitment. Actual revenue received in FY2020-21 and future projections for MHSA increased significantly, which allowed stakeholders to propose updates to the MHSA budget and this included moving the $700,000 funding for the Pride Center to the MHSA ongoing budget as of FY2021-22.

Stakeholder input continued through June 30, 2021 and engaged the MHSA Steering Committee; the Coastside, East Palo Alto, and North County Collaboratives; the Contractor's Association; the MHSARC Youth, Adult and Older Adult Committees; the Diversity and Equity Council; and the Lived Experience

Workgroup. On July 7, 2021, the MHSARC reviewed the public comments received and held a public hearing and vote to submit the plan to the Board of Supervisors for approval.

Future Considerations

As the Pride Center partnership continues with MHSA and external funding, the following key considerations emerged from the five-year evaluation.

Operations and Governance

1. Continue to restructure staff positions so that responsibilities and workloads are manageable and consider ways to increase staff compensation and incentives. These actions will help promote long-term staff retention and may also help the Pride Center recruit more BIPOC staff.
2. Align the clinical need in the community with the number of clinical hours available from Pride Center clinical staff. Consider hiring full-time clinicians and examine pay rates for clinical supervisors, clinicians, and pay differentials for bilingual and licensed staff.
3. Continue to document organizational policies and procedures and ensure staff onboarding and exit procedures are in place.
4. Solidify practices to collect and record clinical assessment data for all clients and regularly analyze and review clinical outcomes by age, race/ethnicity, and language.
5. Leverage the CAB to support strategic planning and fundraising. This may include recruiting new community members to serve on the CAB and identifying resources to deliver coaching to the CAB on board operations.
6. Continue to strengthen development efforts with the goal of diversifying funding sources for the Pride Center and establishing long-term sustainability and growth.
7. Secure funding to hire Program Manager(s) to develop and oversee a high-level vision for the Pride Center's programming, including aligning the volume of programming to staff capacity; and Administrative Coordinator(s) to support general operations, the clinical team, and marketing and communications.

Programs and Services

1. Continue hiring and partnership strategies to reach racially/ethnically and culturally diverse clients, older adults, and clients who speak languages other than English.
2. Continue to build the network of LGBTQ+ responsive mental health providers to meet the needs of clients with serious mental illness (SMI).
3. Continue to explore how the Pride Center can support satellite locations and/or other LGBTQ+ organizations in North and South County, while considering the Pride Center's staff capacity.
4. Build the Pride Center's sliding scale therapy practice by attracting clients who can pay full fee to subsidize others.
5. Offer some services virtually even after in-person services resume to maintain expanded access.
6. In virtual programs, showcase the different types of services the Pride Center offers to increase awareness about the multi-service model.
7. Identify ways that some Pride Center resources can be directed toward Pride Center staff, as staff are also affected by ways the LGBTQ+ community is marginalized.

Summary and Conclusion

The Pride Center achieved its intended outcomes of operating as a collaborative model to increase access to services and contribute to positive clinical outcomes for LGBTQ+ individuals who have experienced or are at risk of mental health challenges.

Summary of Outcomes

Having a physical location for the Pride Center dramatically increased visibility for the LGBTQ+ community and created a safe space for LGBTQ+ community members. The impacts of the Pride Center were above and beyond the initial intention for the project, as the fact of having a space designed for and by the LGBTQ+ community proved exceptionally valuable in creating a sense of community, belonging, and safety for community members. In this way, the mere existence of the Pride Center served as a protective factor for the LGBTQ+ community.

"Just knowing [the Center] is here [is important]… Just having it here and being in the news, seeing the flags…It's that visibility, creating a norm."

– Adult participant

"I want you to know that it was one of the best trainings that I have attended, and it shifted in how I think about the work now."

–Training participant

Through education and training, the Pride Center built capacity of existing services to serve the LGBTQ+ community. The Pride Center was highly successful in this aspect of their services. They served as the leader in introducing the use of SOGIE questions in the county at large, provided many ad hoc trainings and workshops on gender and sexuality, collaborated with other partners on workshops, and provided consultation to other organizations. In this way, the Pride Center greatly expanded the capacity of behavioral health and other service providers to offer LGBTQ+ responsive services.

The clinical team supported the wellbeing of individuals experiencing mental health challenges. The Pride Center was largely successful in this aspect of their services and continues to grow its clinical capacity. Pride Center therapists and clinical trainees provided individual therapy to LGBTQ+ community members with mild-to-moderate and moderate-to-severe mental health challenges. On average, participants in clinical services experienced improvements in their overall mental health, including depression, anxiety, trauma, and family issues, during their time receiving clinical services. The Pride Center has also provided case management to help connect community members to needed services such as health care, housing, and employment. The impact of clinical services for the transgender community was particularly strong. The Pride Center is working to improve its reach with the older adult community, marginalized racially and ethnically diverse clients, clients who speak languages other than English, and clients outside the central part of the county.

"The clinical services here are great. [Gender] transitions are scary, so it's great to come here—where people remember your pronouns, your name. My home situation isn't validating, so having a place that is safe helps me continue to transition when otherwise I might not have and would still suffer from the mental health issues that I was going through."

–Adult participant

The Pride Center's social activities, resources, and peer support groups provided a space to build community and resilience. The Pride Center saw much success in this area and continues to expand programming to improve engagement with BIPOC communities and older adults. The Pride Center engaged hundreds of LGBTQ+ community members and family members in events including movie nights, book clubs, 10 peer support groups, a youth prom, and the community's first ever adult prom. The Pride Center's Name Change Clinic was one of the first of its kind and impacted the lives of transgender and nonbinary clients in San Mateo County and beyond. The Pride Center continues to develop strategies to engage members of the community who do not see themselves reflected in the race/ethnicity of staff, who live outside the central San Mateo area and face transportation barriers, and who are over age 60 and may not feel comfortable visiting an openly LGBTQ+ space and may have challenges with transportation or technology access for virtual services.

"I found out about the Pride Center from my school therapist. I talked to her about my sexuality and how I feel about it, she recommended the peer groups for me. Since I've started coming, I feel happy and I'm accepting myself more."

–Youth Participant

Through intentional marketing and community engagement, the Pride Center increased awareness about the Pride Center's services among community members and community partners. The Pride Center invested highly in this effort and the Pride Center became increasingly well known. At the same time, there is more work to be done to ensure the Pride Center's array of service offerings widely known in the LGBTQ+ community.

Key Components of Collaborative Service Delivery Model

The following factors emerged as essential to an effective collaborative service delivery model. These factors inform the accompanying **toolkit**.

- **Clear roles and responsibilities** of partner agencies, who should be selected based on geographic reach, racial/ethnic and linguistic diversity, and be LGBTQ+ centered and/or have a high level of LGBTQ+ competency.
- **Involvement from leadership** of all partner agencies to support continued engagement in the partnership.
- **Formal venues for cross-training and communication** with partner agencies to ensure clear lines of communication and a high level of competency in LGBTQ+ topics.
- **Aligned staffing structure and program portfolio** such that the number and types of programs is scaled based on the capacity of the staff.
- **Robust staffing for program planning, management, and administration**, including staff to manage an overall programmatic plan, policies and procedures, staff onboarding, billing for clinical services, and data collection.
- **Strategies to support staff wellness** and prevent burnout, including realistic staff position descriptions, compensation, and wellness incentives.
- **Proactive fundraising and sustainability planning** to ensure long-term success.

Resources Developed

The Pride Center **best practice toolkit** is designed to disseminate lessons learned from Pride Center implementation and helpful resources to other counties wishing to implement a collaborative multi-service center for the LGBTQ+ community.

The **LGBTQ+ COVID Impact Report** of San Mateo County is the first known data on how the pandemic has impacted sexual and gender diverse people in the state of California.

The **Best Practices for Community Surveys** document contains recommendations for collecting data on sexual and gender identities.

Conclusion

The Pride Center fundamentally changed the network of services available to the LGBTQ+ community. In doing so, the Pride Center promoted LGBTQ+ visibility and belonging, and filled gaps in culturally responsive mental health treatment services for the LGBTQ+ community. Participants overwhelmingly stated that the Pride Center provided a novel space where they feel at home in their identity, and its physical space provided a sanctuary. In this way, the Pride Center demonstrates how having a safe space to build community can be a significant protective factor for LGBTQ+ residents.

"The impact of the Pride Center is felt across the entire health system."

–Partner Agency

With the conclusion of the INN project, the Pride Center will continue being funded by the County's MHSA strategy and will continue to seek public and private funding. As the Pride Center progresses and grows, leadership and staff remain committed to their efforts to be a safe and welcoming space for all members of the LGBTQ+ community, particularly BIPOC and low-income individuals. The Pride Center has been a monumental effort and success in San Mateo County and the hope is that it will lead to similar efforts in other counties.

"I remember living in the County without the Pride Center existing—it felt like I was alone, very alone…. Just knowing the Pride Center is here in my community makes me feel more comfortable. The fact that it's supported by the County, the Board of Supervisors, I feel more welcome in this county, more comfortable to be who I am. It's empowering." - Participant

LGBTQ+ Pride Center Best Practice Toolkit

The San Mateo County Pride Center was formed as an Innovation (INN) program under the California Mental Health Services Act (MHSA) funded by the San Mateo County Behavioral Health Recovery Services (BHRS) department. The San Mateo County Pride Center is a collaboration of three partner organizations. As a coordinated service approach that meets the multiple needs of LGBTQ+ individuals, the Pride Center offers services in three categories:

1. *Clinical Services*: The Pride Center provides mental health and case management services focusing on individuals at high risk of, or with moderate to severe, mental health challenges.
2. *Social and Community Services*: The Pride Center aims to outreach, engage, reduce isolation, educate, and provide support to high-risk LGBTQ+ individuals through peer-based models of wellness and recovery that include educational and stigma reduction activities.
3. *Training and Resources*: The Pride Center serves as a hub for local, county, and national LGBTQ+ resources. Pride Center staff host year-round trainings and educational events for youth, public and private sector agencies, community service providers, and other community members. Common topics include understanding sexual orientation and gender identity, surveying common LGBTQ+ issues and mental health challenges, and learning how to provide culturally affirmative services to LGBTQ+ clients.

The following considerations are based on lessons learned from the implementation of the San Mateo County Pride Center. These considerations are intended to support other cities, counties, and regions that wish to start a collaborative multi-service center for the LGBTQ+ community. Not all considerations will apply to everyone as not every program will be the same. However, we hope these tips and considerations will be supportive for others wishing to create collaborative programming for the LGBTQ+ community.

Please see the San Mateo County Pride Center Evaluation Report for a detailed description of the Pride Center services and what we learned through five years of evaluation of our progress and outcomes.

1. Organizational Model

Building an effective model includes many considerations, and there should be significant time spent planning before starting any program.

A. Concept Development

- ☐ **Involve the local community.** An LGBTQ+ Center should arise from the needs and desires of the community. There should be efforts to hear from diverse LGBTQ+ community members about what they would like to see in their community, and LGBTQ+ community members should be involved in developing the initial concept.
- ☐ **Garner support from stakeholders and decision-makers.** Key decision-making bodies, such as a Board of Supervisors, City Council, County Health departments or local LGBTQ commission are critical for building a foundation of support and buy-in for an LGBTQ+ Center. Build relationships, and keep in mind that it may take years to progress from a concept to reality.
- ☐ **Design the collaborative model.** A collaborative model is not simply a collection of organizations working together; the benefit of a collaborative model is that it is more than the sum of its parts. For the model to be successful, it is important to be intentional about how the partners will work together. It may be beneficial to contract with a consultant to design the model and work with the selected partners to learn how to operate as a partnership.

B. Selection of Partner Agencies

- ☐ **Choose partner agencies with diverse reach** in terms of the demographic groups (e.g., age, gender, race/ethnicity, language) and the geographic areas they serve.
- ☐ **Choose partner agencies with capacity to participate and contribute to the partnership.** This includes ensuring that executive leadership are fully invested and that the agency has the capacity and willingness to be part of a long-term partnership. Of course, sometimes circumstances change, so be prepared to adapt to changes to the composition of partners.
- ☐ **To the extent possible, choose partner agencies that have a foundational knowledge of and cultural humility regarding LGBTQ+ issues and language**, such as an understanding of the differences between gender identity and sexual orientation, the importance of pronouns, and a willingness to learn and take feedback.
- ☐ **Partner agencies should also have foundational knowledge of and cultural humility around race/ethnicity, disability, income, and other diverse qualities**.

C. Organizational Planning

- ☐ **Begin with a strategic planning phase before launching programming**. To establish a shared vision, cohesive strategies, and achievable programming with the resources available, it is essential to start with a planning process led by a qualified facilitator who is experienced in guiding a strategic plan.

- The strategic planning process should include a community needs assessment to gather input on the types of programs and services the Center could provide.

☐ **Formalize partner roles and responsibilities through Memoranda of Understanding.** There are many options for the types of responsibilities and level of involvement of each partner in the collaborative model. Without clear roles and duties, the partnership can run into trouble if one partner feels they are taking on more than their reasonable share and other partner agencies are not clear about their expected involvement. Creating a Memorandum of Understanding (MOU) with each partner agency should be a prerequisite to starting the partnership.

- Roles and responsibilities should make it clear which agency has the authority to make final decisions regarding the partnership.
- MOUs should include a grievance and conflict resolution procedure.

☐ **Create a Board/Community Advisory Board.** An advisory board can support planning, fundraising, and program design. When recruiting board members, consider their experience to support these tasks and identify resources to deliver coaching on Board operations.

☐ **Begin planning for financial sustainability early.** A collaborative multi-service center is a complex endeavor with a multitude of fundraising and development needs. Hiring an experienced, full-time development professional will best position the Center for long-term sustainability with public and private funding. Also consider how partner agencies can be involved in each other's fundraising efforts.

D. Partnership Operations

☐ **Create written policies and procedures to support clear processes and accountability.** Policies and procedures may include, but are not limited to: clinical procedures; procedures for referrals to and from partner agencies; standardization of data collection; communication and meetings; training; and conflict resolution.

☐ **Ensure regular communication among partner agencies.** Each partner agency has its own organizational culture. While this is not necessarily something negative, it is important that partners are aligned in the areas of cultural humility and communication agreements.

- It is important for leadership from all partner agencies to have meetings on a regular basis to keep leadership up to date and seek input on organizational planning.
- It is important to have regular staff meetings that include frontline staff from partner agencies to discuss the day-to-day work. Smaller subsets of staff, such as a Program Team or Clinical Team, should also meet regularly.

2. Staffing and Training

To fulfill a vision of creating a collaborative hub for the LGBTQ+ community, staff should have 1) knowledge and understanding of issues impacting the LGBTQ+ youth, families, and older adults; 2) experience and passion for serving the LGBTQ+ community; 3) understanding of social justice and cultural humility; and 4) lived experience, cultural identities, and linguistic abilities that are reflective of the county's LGBTQ+ community and enhance the Center's capacity to provide culturally responsive services.

A. Staffing Model

- ☐ **Determine staff assignments.** Whether staff from partner agencies provide services on site at the Pride Center and whether any services are provided outside the Center (either at partner agency locations or satellite locations) shapes the sense of team identity and cohesion, affects workloads, and influences the community's understanding of the Center's model. Consider these factors in the context of your community and partnership and plan accordingly.
- ☐ **Guarantee a competitive compensation and benefits structure** that will attract and retain qualified staff. In addition to competitive compensation, offer benefits such as professional development and opportunities for growth (e.g., promotions, clinical training pathways).
- ☐ **Ensure that staff at all levels are reflective of the community's diversity** at the intersections of sexual orientation, gender identity, race/ethnicity, disability, age, and other diverse qualities. Identify language capacities needed to effectively serve the community.
- ☐ **Consider the number of program staff and the positions required to achieve the desired reach.** In concert with the strategic plan, map out an organizational chart that details each staff position and their role. Ensure that the number and type of planned staff is sufficient to manage program responsibilities with reasonable workloads. If it is not, consider how to narrow down the strategic plan so it is feasible with the available resources for staffing, or consider how to fundraise to support additional staffing.
- ☐ **Hire staff to oversee and support programming** so that these duties do not fall on frontline or direct service staff.
    - Hire a Program Manager(s) to oversee program planning, design, and quality improvement.
    - Hire an Administrative Coordinator(s) to support general Center operations, the clinical team, and the marketing and communications team. For example, this position could coordinate with agency facilities to address on-site needs, forward new client service inquiries, oversee clinical duties including Medicaid/Medi-Cal reimbursement and data collection and data entry processes for clinical data, and assist in distributing marketing and communications materials.

B. Staff Training and Support

- ☐ **Ensure there are processes for staff onboarding and exit**. Solid onboarding makes a huge difference in staff understanding their roles and expectations. Similarly, having processes when staff exit helps to tie loose ends in terms of client services and helps retain institutional knowledge that staff may be taking with them when they leave.
- ☐ **Create a staff training plan that includes cross-training** among partner agency staff. Identifying a staff training plan helps ensure that staff have the information and tools to carry out their roles effectively. At a minimum, the staff training plan must go beyond standard diversity trainings, and should cover topics including anti-racism, cultural humility, anti-oppression, disability and accessibility, and intersectionality.
- ☐ **Promote staff retention through compensation, promotion pathways, benefits, feasible roles, and attention to self-care**. Longevity of staff is vital to developing partnerships and institutional knowledge that facilitate high quality service delivery. As noted in the Staffing Model section, it is critical to offer staff competitive compensation and benefits, ensure that staff's workloads are feasible, and offer options for self-care such as flexible schedules and mental health days.
- ☐ **Identify supportive resources for staff.** Staff are not immune to the challenges that the LGBTQ+ community faces. Identify programmatic resources and/or service referrals and make them available for staff to support their own resilience and wellbeing.

3. Location and Physical Space

For in-person services, having a thoughtful physical space for a Pride Center builds community for LGBTQ+ individuals and impacts accessibility to much needed services.

- ☐ **Select a central location**. A location that is accessible via public transportation is a must.
- ☐ **As much as possible, select a visible location**. While the visibility—whether the Center is located on a main street and building signage/flags—is critical to building a sense of community for LGBTQ+ individuals, consider strategies to reach those who may not feel comfortable attending a visibly LGBTQ+ organization.
- ☐ **Ensure an accessible space**. It is important to have a space that is accessible to all, a physically accessible building for persons with disabilities, as well as accessibility considerations for individuals with chemical and sensory sensitivities, such as fragrance-free products.
- ☐ **Create a welcoming ambiance and feel in the physical space.** It is important to consider how you can use decorations, colors, and furniture to create a welcoming space for all. For example, certain styles may appeal more to youth participants, while other styles may appeal to older adults. Visuals such as art and posters within the space should be reflective of the diverse and intersectional identities within the LGBTQ+ community.

4. Programming

In any multi-service center—sometimes called a "one-stop shop"—there will be many options for programming, and it is important to be intentional and avoid overcommitting. Overall, the recommendation is to start small and then expand once programs are established and there is capacity to add more.

A. Program Planning

- ☐ **Define service types based on community interest.** The Pride Center has services in three areas: clinical services, social and community services, and training and resources. Programming that the Pride Center has not provided, but that other models could incorporate, include social services, such as housing and legal services.
- ☐ **Maximize program accessibility.** Consider how the Center will facilitate access to programs in the areas of program cost, transportation assistance, providing services at partner locations in other regions of the County, services in multiple languages, and in-person and virtual services.
- ☐ **Keep equity and inclusion at the forefront.** Program planning should prioritize equity and inclusion by continuously asking the question, "Who is not here?" The Center should gather data and reflect on which populations programs are reaching; identify potential disparities by race/ethnicity, gender, age, disability, or other characteristics; and seek to understand the reasons for disparities or exclusion.
- ☐ **Engage in self-reflection**. As discussed in the section on Data and Evaluation below, it is important for the Center to engage in critical self-reflection on a regular basis, gather feedback to identify areas for program improvement, and follow through on that feedback by modifying programs to be increasingly relevant, equitable, and accessible.

B. Clinical Services

- ☐ **Define the focal populations and services based on community interest and need.** Identify whether there are certain groups based on need, region, or demographics that the Center intends to serve.
    - Consider the level of mental health need (e.g., mild-to-moderate, serious mental illness) the Center will serve.
    - Ensure the Center can meet the needs of clients who speak languages other than English.
    - Consider whether the Center will include services such as Letters of Support for gender affirming health care.
    - Consider whether the Center will serve parents of LGBTQ+ children.
    - Consider whether the Center will offer group therapy in addition to individual therapy.
- ☐ **Develop clear referral pathways to clinical services** including multiple points of entry (e.g., phone, email, website); referral processes to and from external partners; and a

waitlist system. Consider how the referral and waitlist process may differ for individuals with or without insurance.

  - Assign the role of Intake Coordinator to a Program Manager or a clinician on staff to track requests for services, complete phone screenings, and add clients to a caseload or a waitlist.

- ☐ **Identify responsive clinical staffing composition**. There are a number of strategies to staff responsive clinical services.
  - Clearly define the role of each position, including the expected balance between administrative tasks and direct clinical services and/or supervisory expectations of clinical staff.
  - Ensure staff demographics are reflective of the community the Center seeks to serve.
  - Consider the number of clinical hours needed to serve the population and hire accordingly.
  - Offer full-time employment to clinicians (rather than part-time) to attract more candidates.
  - Consider how the Center will use clinical trainees to factor into a realistic caseload goal for their training term.
  - Consider what level of supervisor is needed for different clinical degrees (MFT, LASW, PCC, PsyD/PhD students/associates/interns) and create a plan to hire clinical supervisors.
  - Offer competitive pay rates for clinical supervisors and clinicians at all levels (associates, psychological interns/assistants, licensed clinicians) such that the Center can attract qualified staff.
  - Offer a competitive pay differential for bilingual staff.
  - Consider whether case management will be included in the clinical service array and how many case managers are needed to meet the need.
  - Consider whether the Center will have a psychiatrist (either on staff or as a consultant on retainer).
- ☐ **Include an external capacity development strategy**. No single Center can meet all of the clinical needs of the LGBTQ+ community. Having a training program is critical to expand culturally responsive clinical capacity across providers.
  - Identify a designated trainer within the clinical team to offer training to other behavioral health service providers.
  - Develop a consultation strategy to offer varying means for clinical providers to receive ongoing support beyond the initial trainings.
- ☐ **Develop an equitable sliding fee scale** that will enable higher income clients to subsidize clients who cannot pay full fee and are not covered by insurance, and periodically re-evaluate the scale. Consider reserving limited slots for pro-bono services.
- ☐ **Plan for the supportive and administrative functions of running a clinical program** including but not limited to: accounting, insurance billing, creating billing statements for clients to submit to private insurance, electronic health record (EHR)

management, information technology, and contracting with external clinical supervisors and/or trainees.

- ☐ **Develop a crisis plan** before beginning clinical services to ensure all clinicians are aware of crisis protocols. Plan for various reasonable scenarios that might occur at a community mental health facility.

C. Social and Community Services

- ☐ **Be intentional about program offerings.** With numerous, intersectional identities in the LGBTQ+ community, there are infinite possibilities for programming. It is critical to consider the ratio of programs to staff and narrow down the list of programs that will be offered, which should be based on a community needs assessment.
- ☐ **Create a balance of programming within and across identities**. There can be benefits to programming for specific groups within the LGBTQ+ umbrella and by certain age or cultural groups. For example, peer support groups for transgender and nonbinary youth, or for Filipinx adults, can provide a needed safe space. Additionally, it can be meaningful to offer opportunities for individuals across identity groups to socialize and build community. For example, intergenerational dinners or book groups can be a way for older and younger LGBTQ+ community members to learn from one another's experiences.
- ☐ **Co-sponsor social events with outside agencies that reach diverse populations.** For example, partner with a local, Black-led organization for an event related to Black and queer liberation.
- ☐ **Consider developing a volunteer program**. Having volunteers can be mutually beneficial as it can engage community members in a meaningful activity and support Center activities. It is important to consider that the volunteer program will need a staff assigned to support it so that there is a reliable contact for prospective and current volunteers.

D. Training and Resources

- ☐ **Identify a designated clinical trainer** with expertise in clinical services to provide training and consultation specifically around providing LGBTQ+ responsive behavioral health services.
- ☐ **Develop a training manual** with clear instructions, steps, and guidance on how to organize and facilitate trainings. The manual should be available to adapt based on changes to the training structure/procedures.
- ☐ **Offer diverse LGBTQ+ training topics** for community groups and service providers that include standard LGBTQ+ 101, and population specific trainings such as trans and non-binary 101 & 201, LGBTQ+ 201, Pronouns 101, etc.
- ☐ **Consider how to make trainings accessible to diverse audiences**. If possible, have trainings available in multiple languages, in-person and virtual formats. Offer closed captioning and other accessibility options.
- ☐ **Support audience in applying new knowledge** by having interactive components such as games and exercises and allotting time to practice newly learned skills.

5. Marketing and Outreach

Marketing and outreach to the community and external partners is key in getting the word out about services. It is a challenge to achieve community-wide awareness and recognition, so involving all partner agencies to help with outreach is important.

- ☐ **Outreach widely in the community**. Partner with communities of color and non-explicitly LGBTQ+ organizations, such as art spaces, racial/ethnic identity groups, libraries, schools, senior centers, faith-based organizations, and health care providers.
- ☐ **Allocate funding for advertising** in the forms of newspapers, ads, flyers, and social media, and staffing resources designated to conduct outreach and advertising.
- ☐ **Tailor outreach strategies for different populations**. Older adults may prefer print advertisement, such as fliers, newspapers, journals, magazines, and places of worship. Younger participants may respond well to online outreach in non-traditional venues, such as Instagram and dating apps. Outreach materials should be in multiple languages to meet the needs of the community and should include image descriptions for individuals who use accessibility technology.
- ☐ **Use social media and technology for outreach**. In addition to Facebook, Instagram, and other social media sites, consider partnering with an agency that could create an app for the Center to list events and programs.

6. Data and Evaluation

Regular data collection and evaluation is vital to support organizational process improvements, understand program outcomes, and report to funders. It is important to set up data collection processes from the beginning. Data collection for a multi-service center will require several ways of measuring participation, as some participants will be one-time or occasional participants, and some will be regular clinical clients. If possible, work with a data and evaluation consultant.

- ☐ **Determine processes to measure *non-clinical* participant reach and demographics.** For participants who attend social events, drop-in groups, and trainings, it will be difficult, or nearly impossible, to get a unique count of the number of people who attend, since people may attend multiple events and activities. However, it is still useful to have a rough count of the number of people the Center reaches via programming. Consider a way to document registration and attendance that balances information-gathering while respecting that one-time or sporadic participants may not want to share a wealth of personal information.
    - Attendance sign-ins should include basic demographic questions (e.g., race/ethnicity, sexual orientation, gender identity) so the Center can assess whether programs are reaching their intended audience.
- ☐ **Determine processes to gather unique data for *clinical* clients.** For clients who receive clinical services, the Center will need a system to gather and record information for each individual client. It will be important to develop an intake process that includes

necessary personal and demographic information as well as clinical assessments of clients' needs, strengths, and mental health status. The Center will likely want a process to collect baseline, follow-up, and exit data to understand changes in clients' mental health during the period they are receiving services.

- ☐ **Determine a data management system and process**. The Center will need a system to store participant data in a protected and confidential manner. It will be important to identify whether the sponsoring agency has an electronic health record (EHR) that can be modified for the Center or whether a new system is needed. The process for collecting and entering data into the system is as important as the system itself—ensure that clear processes are written for when data will be collected, by whom, how frequently, and who is responsible for data entry and quality assurance, and review and refine processes on a regular basis.
    - If there is no current system, consider working with a consultant to develop a data tracking system.
    - Develop and maintain easy-to-use reports that help track participant data.
- ☐ **Set up processes to learn about participant experience and outcomes**. In addition to collecting participant information, it is essential to gather information to understand whether and how the Center is improving people's lives. Consider both of the following opportunities to gather feedback directly from Center participants.
    - **Post-activity feedback**: Determine the events/programs/services for which the Center will collect feedback—likely in the form of a short survey—directly after or shortly after the activity. The Center will have many programs and events and it may not be feasible to gather participant feedback after every activity—select the key activities about which the Center would like feedback.
    - **Point-in-time feedback**: Consider an annual participant satisfaction/participant feedback survey to administer to all participants who have attended programs in the previous year. Outreach and publicity for this survey will be essential to receiving responses from a wide range of participants. Whenever possible, offer incentives (e.g., gift cards or prize raffles) for participation.
- ☐ **Collect data on service requests,** regardless of whether those services are delivered at the time, to measure the capacity of the Center to meet the community's need.
- ☐ **Consider data collection requirements across partner agencies** as partners may have distinct reporting requirements for different funders.

Appendix

Demographic Data – Non-Clinical Participants

Note: Some options on the demographic form were changed in FY2018-19

AGE	FY16-17 (N=36)	FY17-18 (N=400)	FY18-19 (N=199)	FY19-20 (N=426)
0-15	17%	5%	15%	7%
16-25	28%	29%	25%	22%
26-39	22%	30%	24%	38%
40-59	17%	26%	29%	23%
60+	17%	8%	8%	10%
Decline to answer	0	3%	0	0

RACE	FY16-17	FY17-18	FY18-19	FY19-20
White/Caucasian	50%	54%	59%	60%
Hispanic/Latino	65%	23%	23%	21%
Asian or Asian American		20%	19%	17%
Black or African American		5%	7%	6%
Native American or Native Alaskan		3%	5%	2%
Native Hawaiian or Pacific Islander		4%	2%	2%
Other		4%	4%	3%
Decline to answer		2%	N/A	N/A

ETHNICITY	FY16-17	FY17-18	FY18-19	FY19-20
European	Not enough data to report ethnicity breakdown	28%	35%	45%
Mexican/Chicanx/a/o		13%	21%	15%
Other		9%	14%	13%
Chinese		7%	8%	8%

Filipinx/a/o		8%	11%	7%
Eastern European		5%	5%	7%
African		4%	4%	4%
Central American		2%	N/A	3%
Pacific Islander		N/A	N/A	3%
South American		5%	4%	3%
Indigenous Nation		N/A	N/A	2%
Japanese		N/A	N/A	2%
Middle Eastern		3%	N/A	2%
Puerto Rican		N/A	N/A	2%
Vietnamese		N/A	N/A	2%
Decline to answer		9%	N/A	N/A

SEX	FY16-17 (N=38)	FY17-18 (N=400)	FY18-19 (N=193)	FY19-20 (N=193)
Female	76%	61%	59%	55%
Male	21%	31%	40%	45%
Decline to answer	3%	9%	N/A	N/A

GENDER IDENTITY	FY16-17 (N=39)	FY17-18 (N=400)	FY18-19 (N=181)	FY19-20 (N=400)
Cisgender Woman/Woman	44%	39%	40%	39%
Cisgender Man/Man	21%	23%	22%	30%
Genderqueer/Gender nonconforming/Neither exclusively male nor female	3%	9%	9%	13%
Trans Woman/Transgender Female/Trans-feminine/Male-to-Female (MTF)/Woman	36%	3%	10%	9%

Trans Man/Transgender Male/Trans-masculine/Female-to-Male (FTM)/Man		4%	9%	9%
Questioning or unsure of gender identity		3%	5%	3%
Another Gender Identity	N/A	2%	4%	2%
Indigenous Gender Identity	N/A	N/A	N/A	2%
Decline to answer	N/A	18%	N/A	N/A

SEXUAL ORIENTATION	FY16-17 (N=37)	FY17-18 (N=400)	FY18-19 (N=186)	FY19-20 (N=405)
Gay or Lesbian	46%	30%	26%	33%
Bisexual	19%	9%	21%	18%
Heterosexual or Straight	36%	30%	23%	26%
Queer		12%	9%	13%
Pansexual		5%	12%	11%
Asexual		3%	3%	6%
Questioning or unsure of sexual orientation		2%	5%	4%
Another sexual orientation		2%	N/A	2%
Decline to answer		9%	N/A	N/A

DISABILITY STATUS	FY16-17	FY17-18	FY18-19	FY19-20
None	73%	59%	67%	58%
Mental health condition	N/A	N/A	N/A	30%
Chronic health condition	14%	6%	9%	10%
Learning disability		4%	6%	7%
Limited physical mobility		2%	6%	5%
Difficulty hearing or having speech understood		3%	N/A	4%

Another challenge with communication		1%	N/A	4%
Another disability or condition	14%	8%	13%	3%
Difficulty seeing	N/A	5%	4%	3%
Developmental disability	N/A	N/A	N/A	2%

EDUCATION	FY16-17 (N=39)	FY17-18 (N=400)	FY18-19 (N=188)	FY19-20
Less than a high school diploma	18%	7%	15%	N/A
High school diploma or GED, Some college, vocational or trade certificate	15%	22%	35%	N/A
Bachelor's or Associate's Degree	38%	32%	34%	N/A
Graduate Degree	18%	28%	17%	N/A
Decline to answer	10%	10%	N/A	N/A

INCOME	FY16-17 (N=32)	FY17-18 (N=265)	FY18-19 (N=139)	FY19-20 (N=329)
$0-$24,999	34%	16%	41%	30%
$25,000-$50,000	16%	16%	23%	19%
$50,001-$75,000	19%	16%	12%	16%
$75,001-$100,000		13%	10%	12%
Above $100,000	16%	14%	14%	22%
Decline to answer	16%	26%	N/A	N/A

EMPLOYMENT	FY16-17 (N=38)	FY17-18 (N=400)	FY18-19 (N=186)	FY19-20 (N=387)
Full time employment	34%	44%	38%	58%
Student	26%	17%	24%	22%

Part time employment	13%	14%	17%	19%
Retired	26%	5%	6%	5%
Unemployed and looking for work		10%	10%	4%
Unemployed and not looking for work		N/A	5%	4%
Unable to work due to disability or illness	N/A	N/A	N/A	4%
Decline to answer	N/A	11%	N/A	N/A

HOUSING STATUS	FY16-17 (N=36)	FY17-18 (N=265)	FY18-19 (N=188)	FY19-20 (N=414)
Stable housing	69%	79%	77%	85%
Temporarily staying with friends or family	28%	5%	12%	5%
Another housing status		4%	10%	3%
Renting with a subsidy, voucher, or supportive services	N/A	N/A	N/A	2%
Homeless and unsheltered	N/A	N/A	3%	4%
Decline to answer	3%	10%	N/A	N/A

Demographic Data – Clinical Participants

AGE	FY17-18 (N=93)	FY18-19 (N=153)	FY19-20 (N=132)	FY20-21 (N=169)	TOTAL (N=395)
0-15	8%	16%	20%	14%	17%
16-25	34%	31%	29%	36%	32%
26-39	30%	25%	27%	28%	26%
40-59	17%	24%	20%	17%	20%
60+	17%	5%	4%	5%	5%
Decline to answer	1%	0	0	0	1%

RACE	FY17-18	FY18-19	FY19-20	FY20-21	TOTAL (N=394)
White/Caucasian	37%	44%	40%	54%	47%
Hispanic/Latino	34%	29%	29%	24%	26%
Asian or Asian American	8%	16%	11%	11%	11%
Black or African American	5%	6%	8%	5%	6%
Other	3%	5%	6%	5%	5%
Native American or Native Alaskan	2%	4%	5%	2%	2%
Native Hawaiian or Pacific Islander	0%	1%	2%	2%	1%
Decline to answer	15%	5%	12%	7%	10%

ETHNICITY	FY17-18	FY18-19	FY19-20	FY20-21	TOTAL (N=395)
European	32%	35%	32%	39%	36%
Mexican/Chicanx/a/o	17%	10%	15%	13%	13%
Other	12%	16%	11%	9%	11%

Eastern European	8%	7%	11%	16%	11%
Central American	6%	6%	6%	5%	6%
Filipinx/a/o	3%	5%	5%	7%	5%
African	4%	3%	7%	5%	5%
Chinese	3%	5%	3%	3%	4%
South American	3%	3%	4%	5%	4%
Middle Eastern	1%	3%	2%	2%	2%
Pacific Islander	0%	2%	3%	1%	1%
Indigenous Nation	1%	3%	2%	1%	1%
Japanese	0%	1%	0%	0%	1%
Puerto Rican	0%	0%	0%	0%	0%
Vietnamese	0%	0%	0	0%	0%
Decline to answer	19%	14%	18%	13%	15%

SEX AT BIRTH*	FY17-18 (N=15)	FY18-19 (N=50)	FY19-20 (N=114)	FY20-21 (N=131)	TOTAL (N=207)
Female	60%	56%	55%	57%	56%
Male	40%	44%	45%	43%	44%

*Those who stated "decline to answer" were not included in the analysis

GENDER IDENTITY*	FY17-18 (N=87)	FY18-19 (N=145)	FY19-20 (N=127)	FY20-21 (N=162)	TOTAL (N=376)
Cisgender Woman/Woman	23%	28%	17%	23%	23%
Cisgender Man/Man	33%	21%	17%	13%	20%
Genderqueer/Gender nonconforming/Neither exclusively male nor female	11%	13%	13%	9%	11%
Trans Woman/Transgender Female/Trans-feminine/Male-to-Female (MTF)/Woman	14%	17%	22%	21%	18%

Trans Man/Transgender Male/Trans-masculine/Female-to-Male (FTM)/Man	14%	15%	23%	25%	20%
Questioning or unsure of gender identity	5%	3%	6%	6%	5%
Another Gender Identity	0%	1%	2%	4%	2%
Indigenous Gender Identity	N/A	N/A	N/A	N/A	N/A

*Those who stated "decline to answer" were not included in the analysis

SEXUAL ORIENTATION*	FY17-18 (N=79)	FY18-19 (N=140)	FY19-20 (N=186)	FY20-21 (N=156)	TOTAL (N=342)
Gay or Lesbian	46%	27%	29%	32%	32%
Bisexual	6%	17%	20%	18%	14%
Heterosexual or Straight	14%	14%	12%	17%	14%
Queer	18%	20%	20%	30%	19%
Pansexual	9%	12%	12%	17%	10%
Asexual	1%	3%	3%	5%	2%
Questioning or unsure of sexual orientation	6%	7%	10%	22%	12%
Another sexual orientation	1%	1%	1%	1%	1%

*Those who stated "decline to answer" were not included in the analysis

DISABILITY STATUS*	TOTAL (N=252)
None of the above	45%
Mental health condition	28%
Chronic health condition	11%
Learning disability	6%
Limited physical mobility	4%

Difficulty hearing or having speech understood	1%
Another challenge with communication	1%
Another disability or condition	3%
Difficulty seeing	2%
Developmental disability	2%
Decline to answer	17%

*Data was only calculated for the total across fiscal years

INCOME*	FY17-18 (N=15)	FY18-19 (N=43)	FY19-20 (N=85)	FY19-20 (N=115)	TOTAL (N=161)
$0-$24,999	80%	67%	58%	65%	60%
$25,000-$50,000	7%	21%	21%	17%	19%
$50,001-$75,000	13%	5%	10%	11%	10%
$75,001-$100,000	0	7%	11%	3%	8%
Above $100,000	0	0	1%	3%	3%

*Those who stated "decline to answer" were not included in the analysis; data only calculated for ages 16 and older

EMPLOYMENT*	FY17-18 (N=15)	FY18-19 (N=54)	FY19-20 (N=123)	FY20-21 (N=159)	TOTAL (N=239)
Full time employment	7%	17%	25%	23%	24%
Student	20%	30%	37%	31%	33%
Part time employment	33%	22%	12%	19%	15%
Retired	7%	2%	2%	3%	3%
Unemployed and looking for work	20%	15%	11%	13%	12%
Unemployed and not looking for work	N/A	2%	2%	5%	3%
Unable to work due to disability or illness	N/A	15%	11%	8%	8%

*Those who stated "decline to answer" were not included in the analysis

HOUSING STATUS*	FY17-18 (N=15)	FY18-19 (N=53)	FY19-20 (N=120)	FY20-21 (N=154)	TOTAL (N=192)
Stable housing	67%	68%	72%	80%	73%
Temporarily staying with friends or family	N/A	11%	13%	10%	13%
Another housing status	N/A	2%	1%	2%	2%
Renting with a subsidy, voucher, or supportive services	13%	6%	3%	2%	3%
Staying in an emergency shelter or transitional housing program	13%	8%	6%	6%	7%
Homeless and unsheltered	7%	6%	5%	1%	3%

*Those who stated "decline to answer" were not included in the analysis; data only calculated for ages 16 and older

Clinical Assessment Data

ANSA Baseline Data (N=88)

Domain	Avg Score
Functioning Domain	0.61
Strengths Domain	1.67
Cultural Factors	0.53
Behavioral/Emotional Needs	0.67
Risk Behaviors	0.18

Domain/Characteristic	Avg Score
Functioning Domain	**0.61**
Family Relationships	1.38
Physical/Medical	0.67
Employment/Functioning	0.66
Social Functioning	1.07
Recreational	0.61
Developmental/intellectual	0.21
Sexual Development	0.68
Living Skills	0.35
Residential Stability	0.60
Legal	0.25
Sleep	0.71
Self-Care	0.76
Medication Compliance	0.26
Transportation	0.24
Living Situation	0.83
School	0.42
Strengths Domain	**1.67**
Family Strengths	1.77
Interpersonal/Social Connectedness	1.55
Optimism	1.52
Educational Setting	1.87
Job History	1.59
Talents and Interests	1.54
Spiritual/Religious	2.07
Community Connection	1.99
Natural Supports	1.66
Resilience	0.99
Resourcefulness	1.14

Domain/Characteristic	Avg Score
Volunteering	2.39
Vocational	1.72
Cultural Factors	**0.53**
Language	0.10
Cultural Identity	0.90
Traditions and Rituals	0.16
Cultural Stress	1.01
Behavioral/Emotional Needs	**0.67**
Psychosis (Thought Disorder)	0.30
Impulse Control	0.37
Depression	1.47
Anxiety	1.51
Interpersonal Problems	0.73
Antisocial Behavior	0.02
Adjustment to Trauma	1.26
Anger Control	0.32
Substance Abuse	0.44
Eating Disturbances	0.23
Risk Behaviors	**0.18**
Suicide Risk	0.57
Non-Suicidal Self-Injurious Behavior	0.17
Other Self-Harm	0.22
Exploitation	0.31
Danger to Others	0.03
Gambling	0.01
Sexual Aggression	0.00
Criminal Behavior	0.10

ANSA Pre/Post Data (N=61)

Domain	Baseline Avg Score	Follow-up Avg Score	Avg Change
Functioning Domain	0.62	0.61	-0.01
Strengths Domain	1.71	1.59	-0.12
Cultural Factors	0.53	0.50	-0.03
Behavioral/Emotional Needs	0.70	0.68	-0.02
Risk Behaviors	0.20	0.20	0.00

Domain/Characteristic	Baseline Avg Score	Follow-up Avg Score	Avg Change
Functioning Domain	**0.62**	**0.61**	**-0.01**
School	0.61	0.23	-0.38
Family Relationships	1.41	1.19	-0.22
Sexual Development	0.60	0.40	-0.20
Sleep	0.73	0.70	-0.03
Self-Care	0.85	0.72	-0.13
Social Functioning	1.17	1.17	0.00
Recreational	0.58	0.55	-0.03
Medication Compliance	0.32	0.27	-0.06
Transportation	0.22	0.20	-0.02
Living Situation	0.80	0.90	0.10
Residential Stability	0.51	0.55	0.04
Developmental/intellectual	0.25	0.32	0.07
Legal	0.22	0.27	0.05
Living Skills	0.34	0.47	0.13
Employment/Functioning	0.77	0.98	0.21
Physical/Medical	0.63	0.73	0.10
Strengths Domain	**1.71**	**1.59**	**-0.12**
Spiritual/Religious	2.14	1.85	-0.29
Talents and Interests	1.53	1.22	-0.32
Resilience	0.92	0.73	-0.18
Optimism	1.53	1.22	-0.32
Volunteering	2.52	2.34	-0.17
Natural Supports	1.71	1.68	-0.03
Interpersonal/Social Connectedness	1.59	1.52	-0.08
Community Connection	1.95	1.69	-0.25
Resourcefulness	1.15	1.02	-0.13
Family Strengths	1.77	1.77	0.00
Educational Setting	2.26	2.14	-0.11
Job History	1.66	1.76	0.10

Domain/Characteristic	Baseline Avg Score	Follow-up Avg Score	Avg Change
Vocational	1.83	2.02	0.19
Cultural Factors	**0.53**	**0.50**	**-0.03**
Cultural Identity	1.00	0.67	-0.33
Language	0.08	0.08	0.00
Traditions and Rituals	0.17	0.23	0.07
Cultural Stress	0.98	1.05	0.07
Behavioral/Emotional Needs	**0.70**	**0.68**	**-0.02**
Anxiety	1.57	1.32	-0.26
Depression	1.57	1.40	-0.17
Adjustment to Trauma	1.30	1.08	-0.21
Psychosis (Thought Disorder)	0.38	0.27	-0.11
Substance Abuse	0.44	0.48	0.04
Interpersonal Problems	0.83	0.95	0.12
Antisocial Behavior	0.02	0.08	0.07
Eating Disturbances	0.21	0.22	0.01
Anger Control	0.21	0.38	0.17
Impulse Control	0.36	0.52	0.15
Risk Behaviors	**0.20**	**0.20**	**0.00**
Exploitation	0.38	0.31	-0.07
Other Self-Harm	0.25	0.22	-0.03
Suicide Risk	0.66	0.59	-0.06
Gambling	0.00	0.00	0.00
Criminal Behavior	0.12	0.12	0.00
Non-Suicidal Self-Injurious Behavior	0.21	0.27	0.06
Sexual Aggression	0.00	0.02	0.02
Danger to Others	0.02	0.08	0.07

CANS Baseline Data (N=24)

Domain	Avg Score
Functioning Domain	**0.56**
Strengths Domain	**1.33**
Cultural Factors	**0.48**
Caregiver Resources and Needs	**0.33**
Child Behavioral/Emotional Needs	**0.50**
Risk Behaviors	**0.14**

Domain/Characteristic	Avg Score
Functioning Domain	**0.56**
Family Functioning	0.92
Living Situation	0.63
Social Functioning	1.00
Recreational	0.63
Developmental/intellectual	0.25
Job Functioning	0.10
Legal	0.13
Medical/Physical	0.46
Sexual Development	0.71
Sleep	1.00
School Behavior	0.52
School Attendance	0.22
School Achievement	0.74
Decision-making	0.48
Strengths Domain	**1.33**
Family Strengths	0.83
Interpersonal/Social Connectedness	1.43
Optimism	1.13
Educational Setting	1.17
Vocational	1.63
Talents and Interests	1.04
Spiritual/Religious	2.17
Community Life	1.78
Relationship Permanence	1.00
Resiliency	0.83
Resourcefulness	1.43
Cultural Identity	1.52
Natural Supports	1.35

Domain/Characteristic	Avg Score
Cultural Factors	**0.48**
Language	0.17
Traditions and Rituals	0.13
Cultural Stress	1.04
Caregiver Resources and Needs	**0.33**
Supervision	0.22
Involvement with Care	0.52
Knowledge	0.87
Organization	0.30
Social Resources	0.70
Residential Stability	0.17
Medical/Physical	0.13
Mental Health	0.39
Substance Abuse	0.17
Developmental	0.04
Safety	0.13
Child Behavioral/Emotional Needs	**0.50**
Psychosis (Thought Disorder)	0.30
Impulsivity/Hyperactivity	0.30
Depression	1.17
Anxiety	1.35
Oppositional	0.26
Conduct	0.04
Adjustment to Trauma	0.48
Attachment Difficulties	0.61
Anger Control	0.39
Substance Use	0.13
Risk Behaviors	**0.14**
Suicide Risk	0.52
Non-Suicidal Self-Injurious Behavior	0.39
Other Self-Harm	0.13
Danger to Others	0.00
Sexual Aggression	0.00
Runaway	0.04
Delinquent Behavior	0.09
Fire Setting	0.00
Intentional Misbehavior	0.04

CANS Pre/Post Data (N=11)

Domain	Baseline Avg Score	Follow-up Avg Score	Avg Change
Functioning Domain	0.55	0.47	-0.08
Strengths Domain	1.61	1.3	-0.31
Cultural Factors	0.50	0.36	-0.14
Caregiver Resources and Needs	0.35	0.31	-0.04
Child Behavioral/Emotional Needs	0.46	0.45	-0.01
Risk Behaviors	0.11	0.15	0.04

Domain/Characteristic	Baseline Avg Score	Follow-up Avg Score	Avg Change
Functioning Domain	0.55	0.47	-0.08
Recreational	0.45	0.20	-0.25
Decision-making	0.50	0.36	-0.14
Sexual Development	1.00	1.00	0.00
Social Functioning	1.00	0.73	-0.27
Sleep	1.10	0.91	-0.19
Medical/Physical	0.00	0.18	0.18
Living Situation	0.45	0.36	-0.09
School Achievement	0.60	0.55	-0.05
Developmental/intellectual	0.36	0.18	-0.18
School Behavior	0.40	0.27	-0.13
Job Functioning	0.11	0.10	-0.01
Legal	0.18	0.09	-0.09
Family Functioning	0.82	0.91	0.09
School Attendance	0.00	0.27	0.27
Strengths Domain	1.61	1.3	-0.31
Interpersonal	1.70	0.82	-0.88
Natural Supports	1.40	0.91	-0.49
Cultural Identity	2.00	1.18	-0.82
Resourcefulness	2.00	1.18	-0.82
Optimism	1.40	0.91	-0.49
Community Life	2.30	2.00	-0.30
Family Strengths	0.80	0.73	-0.07
Educational Setting	1.50	1.45	-0.05
Talents and Interests	1.10	1.09	-0.01
Relationship Permanence	1.20	1.18	-0.02
Vocational	2.29	2.80	0.51
Spiritual/Religious	2.60	2.73	0.13
Resiliency	0.80	0.73	-0.07

Domain/Characteristic	Baseline Avg Score	Follow-up Avg Score	Avg Change
Cultural Factors	0.50	0.36	-0.14
Language	0.30	0.09	-0.21
Traditions and Rituals	0.10	0.00	-0.10
Cultural Stress	1.10	1.00	-0.10
Caregiver Resources and Needs	0.35	0.31	-0.04
Social Resources	0.70	0.27	-0.43
Organization	0.40	0.36	-0.04
Residential Stability	0.30	0.09	-0.21
Knowledge	1.00	1.00	0.00
Involvement with Care	0.40	0.36	-0.04
Mental Health	0.50	0.45	-0.05
Substance Use	0.20	0.27	0.07
Safety	0.10	0.09	-0.01
Supervision	0.30	0.36	0.06
Developmental	0.00	0.09	0.09
Medical/Physical	0.00	0.18	0.18
Child Behavioral/Emotional Needs	0.46	0.45	-0.01
Anxiety	1.50	1.09	-0.41
Adjustment to Trauma	0.50	0.64	0.14
Depression	1.10	0.91	-0.19
Anger Control	0.20	0.18	-0.02
Substance Use	0.20	0.18	-0.02
Oppositional	0.10	0.09	-0.01
Psychosis (Thought Disorder)	0.20	0.00	-0.20
Impulsivity/Hyperactivity	0.20	0.27	0.07
Conduct	0.00	0.18	0.18
Attachment Difficulties	0.60	0.91	0.31
Risk Behaviors	0.11	0.15	0.04
Other Self-Harm	0.20	0.09	-0.11
Suicide Risk	0.60	0.64	0.04
Non-Suicidal Self-Injurious Behavior	0.20	0.27	0.07
Sexual Aggression	0.00	0.00	0.00
Runaway	0.00	0.00	0.00
Fire Setting	0.00	0.00	0.00
Danger to Others	0.00	0.09	0.09
Delinquent Behavior	0.00	0.18	0.18
Intentional Misbehavior	0.00	0.09	0.09