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Shelley L. Craig

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## **Precarious Partnerships: Designing a Community Needs Assessment to Develop a System of Care for Gay, Lesbian, Bisexual, Transgender and Questioning (GLBTQ) Youths**

SHELLEY L. CRAIG

*Factor-Inwentash Faculty of Social Work, University of Toronto, Toronto, Ontario, Canada*

*This article describes the planning and implementation of a mixed-method community needs assessment with the intent of creating a system of care for gay, lesbian, bisexual, transgender, and questioning (GLBTQ) youths in an urban area. Flowing from qualitative to quantitative research strategies, this needs assessment utilized key informant interviews, focus groups, and survey research in a countywide initiative. Rather than outline each set of findings, this article provides a brief description of the four phases of research activities and the action steps that were completed during each phase. Community context for the needs assessment is described in detail and a final system of care is proposed. Notable barriers and challenges associated with the community needs assessment are also articulated.*

**KEYWORDS** *community-based participatory research, sexual minority youth, lesbian, gay, bisexual, transgender, community needs assessment*

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Address correspondence to Shelley L. Craig, Factor-Inwentash Faculty of Social Work, University of Toronto, 246 Bloor Street West, Toronto, Ontario, Canada M5V 1V4. E-mail: shelley.craig@utoronto.ca

## BACKGROUND

Gay, lesbian, bisexual, transgender, and questioning (GLBTQ) youths are considered a population at risk. They are at increased peril for psychiatric disorders, substance abuse, and suicide (Bontempo & D'Augelli, 2002; Faulkner & Cranston, 1998; Gilman et al., 2001; Herrell et al., 1999; Meyer, 2003); discrimination and harassment from peers (D'Augelli & Grossman, 2001); and rejection from family (D'Augelli, Grossman, & Starks, 2008; National Youth Advocacy Coalition, 2004). Despite these challenges, few programs that target the specific needs of GLBTQ youths exist and little is known about such initiatives. Most research efforts have focused on youth risk factors, yet there is a critical need for inquiry into the ways in which service delivery systems could address these issues, particularly for minority GLBTQ populations. This article examines the stages in the implementation of a community needs assessment (CNA) developed in collaboration with local agencies. The challenges in balancing the perspectives of providers with multiple roles and agendas within this service partnership will be highlighted.

### Community Needs Assessment

A CNA is used to identify the needs of a target population within a specific historical and geographical context (Berberet, 2006). Among other factors, it should involve the evaluation of existing health and mental health service delivery systems and their impact on the target population. Additionally, needs must be clearly defined and understood for truly effective programs and services to be created, implemented, and evaluated (Corona, Gonzalez, Cohen, Edwards, & Edmonds, 2009). Such an undertaking, particularly when it arouses deeply held community norms and values, is a complex and exhaustive task (Slaght & Schopler, 1994). Successful initiatives require research and collaboration between stakeholders (Siegel, Attkisson, & Carson, 1995). GLBTQ communities have not always undertaken CNAs due, in part, to resource scarcity that perpetually plagues organizations that serve marginalized populations. Furthermore, the competition between research and practice dollars is usually trumped by the high levels of community need for direct services. Miami Dade County (MDC) is no exception. MDC has a population of nearly 2.5 million (US Census Bureau, 2009) that is spread over 2,000 square miles and is serviced by a severely inadequate public transportation system. In 2007, MDC consisted of a majority of persons of Latino/Hispanic origin (62%) with significantly lower percentages of Blacks (20%), or non-Hispanic White (NHW) persons (18%). The service delivery system for this complex population is a very diverse mix of organizations, ranging from multimillion dollar institutions to community-based agencies run by volunteers. The GLBTQ population

has been estimated at 123,000 (Olorunnipa, 2009) in MDC alone, and there are approximately 359,000 children and youths between the ages of 5 and 18 residing in the county (U.S. Census Bureau, 2009). MDC also has the fourth largest school district in the United States (Miami-Dade County Public Schools, 2009). This indicates that a great many youths and families that may be affected by GLBTQ-related issues. Although there are over 14 organizations that claim to serve GLBTQ youths in some capacity in MDC, most have budgets of less than \$250,000 and nearly 60% have less than five staff members (Craig & Attonito, 2008). Thus, challenges such as a diverse and sprawling population and limited agency capacity were encountered when conceptualizing and implementing a comprehensive needs assessment.

### Service Partnerships

Service partnerships (SP) are working groups that use techniques of community development and research to create systems of care. Such community-based interventions deliver coordinated and individualized services to address needs while highlighting family and child strengths (National Center for Youth Law, 2003). Frequently comprised of a loosely organized group of community and agency representatives from public and private sectors, SP coalesce around a shared belief that a collaborative approach could have greater impact on a perceived need. Eliminating an identified community health concern such as decreasing substance use in youth (Lubman, Hides, & Elkins, 2008), coordinating services for low income residents in neighborhood-based partnerships (Ahsan, 2008), and less frequently, developing services for a particularly vulnerable population (e.g., Latino youth; Corona et al., 2009) have culminated in SPs. Although GLBTQ community representatives are found within these existing SP, no examples were found of SP that specifically targeted this population. This article outlines the development of a CNA for GLBTQ youth and the concurrent expansion of a SP for this emerging vulnerable population in Miami-Dade County, Florida.

The first murmur of a SP began to circulate when a local funding agency released a request for proposals (RFP) for community planning grants. Six agencies then joined forces to advocate for inclusion of the GLBTQ youth population in the RFP process and to support an initial proposal (Dentato, Craig, & Smith, 2010). These agencies were a mixture of gay service organizations and larger mainstream organizations that had programs specific to GLBTQ youth. To increase the complexity of the process, the participating organizations had a multiplicity of mission-driven mandates such as education, public policy advocacy, mental health, resource and referral, and GLBTQ youth recreational services. As discussed in an earlier

publication describing the initial formation of the SP, these issues represented ongoing challenges in establishing cohesion (Dentato, Craig, & Smith, 2010). Achieving and integrating support from all of these different stakeholders became of utmost importance as the SP progressed through the phases of the needs assessment.

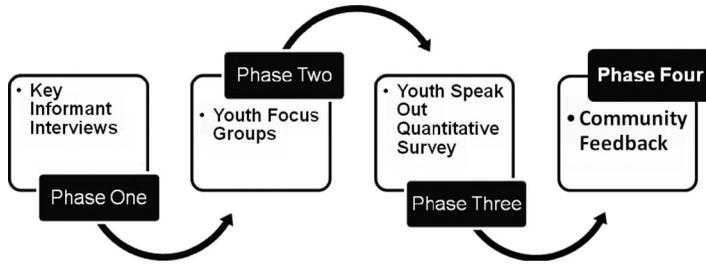
Funding was initially granted to the SP for 1 year to support a combination of research and services. Of the approximately \$210,000 in funding, the primary expenses included the salary of a full-time researcher (23%); research-related costs such as a laptop computer and travel for data collection, as well as gift cards and snacks for participants (7%); indirect costs paid to the fiscal agent (10%); and the delivery of existing services to GLBTQ youths (60%) through the six agencies involved in the SP. Once funded, the SP hired a researcher from a local public university to conduct a CNA from which to develop a system of care for GLBTQ youth. This particular principal investigator (PI) was selected because of her expertise in GLBTQ youth services, which represented an emic (insider) perspective but also had limited knowledge of the history of the local providers, which provided her a simultaneous etic (outsider) perspective (Creswell, 1998). The initial research scan found a profound need for the CNA due to a lack of any available data about GLBTQ youths in general, or service delivery systems particular to their needs. No substantive local data on sexual orientation, gender identity, or even same gender attraction existed. The questions simply were never asked. There were, however, plenty of anecdotes from service providers, a few stories from youth, and a great deal of energy and passion from the community to fuel the research process.

## METHODS

### Research Design

The CNA was based on a community-based participatory research (CBPR) design. CBPR has become increasingly utilized within North America as a result of its effectiveness and innovative approach to investigating the challenges of vulnerable populations (Tandon et al., 2007; Trinh-Shevrin et al., 2007). CBPR has been described as:

a collaborative approach to research that equitably involves, for example, community members, organizational representatives, and researchers in all aspects of the research process. The partners contribute unique strengths and shared responsibilities to enhance understanding of a given phenomenon and the social and cultural dynamics of the community, and integrate the knowledge gained with action to improve the health and well-being of community members. (Israel, Schulz, Parker, & Becker, 1998, p. 3)



**FIGURE 1** Community assessment phases.

The CNA consisted of four primary phases which were relatively sequential and are visually depicted in Figure 1. The entire research process was designed to elicit rich qualitative data to contextualize and develop a comprehensive quantitative survey tool (Creswell, 2009; Denzin & Lincoln, 2008) from which to design an evidence-informed system of care. Such heterogeneous sources and approaches to data collection ensure trustworthiness (Clark, Creswell, Green, & Shope, 2008). Phase one included an environmental scan and key informant interviews (KII), and phase two consisted of focus groups comprised of GLBTQ youths from the community under study. With the information gleaned from the first two stages, phase three involved the development, implementation, and analysis of a survey of the target population called Youth Speak Out. Phase four consisted of solicited community feedback about the results of the CNA. To make this plan actionable, a series of steps (Table 1) were conceived and implemented in coordination with the SP. The entire process took approximately 13 months. Most of the qualitative and quantitative research was facilitated by the PI with the help of a research assistant.

### Phase One: Environmental Scan and Key Informant Interviews

The first phase of the project included an environmental scan of national and local GLBTQ programs (this included eligibility criteria, utilization data, and types and locations of programs). Data about programs was gleaned following e-mails and phone calls to a variety of sources, including national GLBTQ organizations, members of the SP, the MDC Gay and Lesbian Chamber of Commerce, and an online social service resource database. Several local, national, and international organizations that did exceptional work with GLBTQ youth were identified through this research and visited to allow for a broad perspective on the creation of a system of care. Such destinations included Toronto, ON; San Francisco, CA; New York, NY; Boston, MA; Los Angeles, CA; Minneapolis, MN; Atlanta, GA and Washington, DC. The environmental scan served as the foundation for the initial list of potential interviewees.

**TABLE 1** Research Activities: Community Needs Assessment (CNA)

Research phase	Research activity	Description	Plan	Outcome
Phase one	Local key informant interviews	Key informant interviews with community leaders and agency personnel to discuss perspective of GLBTQ needs, service gaps, community assets, and their opportunities for engagement Gather future and current partnership members	Initial goal of 10–20 key informant interviews using standardized protocol	45 key informant interviews completed and analyzed
	National key informant interviews	Identification of communities that are taking steps to create a system of care Assess national trends and build effective intrastate collaborations Identify practice models	Site visits planned: Toronto; Chicago; New York City; Boston; Los Angeles; San Francisco; Washington, DC; Minneapolis; and Atlanta 4–6 focus groups planned with youth	Site visits completed: Toronto; Chicago; New York City; Boston; Los Angeles; San Francisco; Washington, DC; Minneapolis; and Atlanta 10 focus groups completed with youth ( $n = 180$ )
Phase two	Focus groups	Focus groups are a good strategy to gather important context and history for prevention interventions in marginalized communities	Transcribe, collate, and assess results	Generate qualitative report
Phase three	Literature review	Comprehensive literature reviews of risks and needs relative to the target population and tied to the domains addressed in both the needs assessment and focus groups	Literature review via PsychInfo, Webspirs, and PubMed databases	
	GAB (Gay Advisory Board)	Creation of a Youth Advisory Board (now named GAB) to engage consumers in the design and implementation of services	Monthly meetings with 10 core GLBTQ youth leaders from MDC initiated January, 2007	10 monthly meetings convened before CNA was completed and leaders graduated

(Continued)

**TABLE 1** (Continued)

Research phase	Research activity	Description	Plan	Outcome
	Youth Speak Out Survey	Such collaboration and oversight is critical to culturally competent practice Provides a great opportunity to empower young community leaders Creation of a full quantitative needs assessment for GLBTQ youth in MDC, including the following basic domains: Demographics School support Family support Health and mental health Social support Discrimination Service needs Identifying opportunities for community-resource sharing through the convening of all interested service partnerships and resource networks The final draft of the CNA was presented to a full convening of stakeholders and their feedback was integrated into the final plan.	This community board reviews all issues related to the design and implementation of the CNA Survey of needs and protective factors Although online, primarily collected paper surveys Sample of 200 GLBTQ youth targeted Completion time: Approx 30 min	Data collected and analyzed ( $N = 273$ )
Phase Four	Local Service Network Meetings Community Stakeholder Feedback Loops		Building of a service partnership consortium Monthly meetings Full meeting of service partnership research participants and interested community members	Full meeting convened

*Note.* GLBTQ = Gay, lesbian, bisexual, transgender, and questioning. MCD = Miami-Dade County.

During the next step, the KII were planned and initiated. Such qualitative methods are often utilized in prevention research (Patton, 1987, 2002) and are consistent with types of recommended evaluation research into programs that serve GLBT individuals (Kelly et al., 1991). The qualitative nature of KII is ideal for exploratory studies designed to better understand culturally-based beliefs and generate hypotheses for future research (Denzin & Lincoln, 2008). The criteria for participation in KII included: (a) knowledge of GLBTQ youth, preferably in Miami-Dade County; (b) potential access to the population or services; and (c) influence to advance the initiative (Berberet, 2006). Forty-five KII ( $n = 45$ ) were conducted with local service providers, community leaders, and other stakeholders. Sites included mental health agencies, school counseling sites, after-school programs, homeless shelters, and delinquency and substance abuse facilities. The purpose of these KII were to: (a) assess the providers perception of youth needs and service availability, (b) build relationships with gatekeepers who could provide access to the population and programmatic support if needed, and (c) begin to develop the collaborative structure necessary for the development of a system of care (Berberet, 2006). Building these collaborative relationships is critical to the success of a CNA, as these key individuals are often in positions to either advance or impede the project and can also grant access to the target population. A series of open-ended guiding questions were asked in a semistructured format to enable key informants to share their ideas and experiences. Probes were used to encourage additional dialogue and clarification. Each KII lasted from 45 min to an hour-and-a-half. At the end of each KII, participants were asked for suggestions for other potential interviewees. It is notable that 100% of those contacted for KII agreed to participate in an interview. Each KII was transcribed and analyzed for themes using Atlas-Ti software. Findings indicated a need for safe homeless shelter services, education for adults within the youth system, family support, a public education campaign, mental health counseling, transportation, and health care.

### Phase Two: Focus Groups With GLBTQ Youth

In the second phase of the research, focus groups were conducted to deepen relationships with the population of interest and to provide a richer understanding of the true needs of the population by building upon the perspective of the providers. Utilizing the new relationships with KII, the PI identified four sites (one in each region of the expansive county) and conducted focus groups. Youths were primarily recruited through existing gay-straight alliances in the schools or community youth groups. Upon completion of the original groups, both unanswered questions and a demand by the youths at various sites to be included in this project necessitated adding six more groups for a total of 10 focus groups with nearly 200 youth

participants ( $n = 180$ ). Results were transcribed, collated, and content analyzed for themes using Atlas-Ti qualitative software. The specific procedures and findings of these focus groups are reported in a different publication by this author.

### Phase Three: Youth Speak Out Survey

The third phase was the development of a quantitative survey instrument for youth. Based on the domains articulated by the qualitative research, the PI identified the relevant measures from the existing literature. A draft of the survey was constructed for review by the members of the SP. The design of the quantitative instrument was determined during three open meetings with staff from interested social service agencies. With an average number of 15 participants in attendance and 26 different people attending at least one of the meetings, these brainstorming sessions were infused with enthusiasm.

Several meetings were spent adding topics or questions that members wanted to include in the research. At the first meeting, more than 50 additional questions were suggested to the 200 already in the draft presented by the PI. Some agency representatives even requested individual meetings to discuss their specific research concerns. Many of the SP members wanted questions specific to their agency mission included (e.g., the school based programs wanted to ask about bullying). Such involvement led to opportunities to discuss the delicate balance between agency requests, youth needs, and overall feasibility. During the final full group meeting more questions were added and deleted and final consensus was reached on the survey contents.

Throughout this process, each version of the draft survey went to the newly created Youth Advisory Board (later renamed the Gay Advisory Board, by the youth participants). The Gay Advisory Board (GAB) consisted of 10 youths that had applied and been selected by the PI and the SP to oversee the CNA process. The PI felt that the GAB's insider knowledge and expertise as members of the target population was critical to both instrument validity and eventual program adoption. The youth members would review each draft of the survey and provide feedback to the SP. They met for one-and-a-half hours each month and were given gift cards to a local store as a reward for their participation. It should be mentioned that this unusual approach to construct validation caused some tension within the adult SP. As one participant stated, "I have worked with this population for 20 years—I probably know better than a group of 16-year-olds what they need." It is recognized that this process of adults' efforts being evaluated by adolescents should be carefully managed to preserve the relationships within the partnership. Such concerns were addressed through a training from a national expert in youth adult partnerships, but certainly represented a critical challenge to the

construction of the final draft of the survey. Once finalized, the Youth Speak Out survey was implemented. A nonrandom sample of 273 GLBTQ youths from around MDC was collected using venue-based sampling. Building on the relationships established during the first two phases of the research, many of the KII organizations and focus group sites were willing venues for the quantitative survey. As data is understood and triangulated for accuracy, checks on the fidelity of the data are critical, especially from the perspective of the target population (Denzin & Lincoln, 2008).

#### Phase Four: Community Feedback

A key component of CPBR is the solicitation of community feedback on the findings of the CNA, as well as the identification of particular services for implementation. Participants were given opportunities to preview and give feedback through meetings with the SP and GAB, and presented to additional community members during a community wide meeting. Table 1 outlines a description of the plan for each of the specific research activities and related outcomes that were undertaken during the CNA to fulfill the expectations of each phase outlined in Figure 1.

### SERVICE DOMAIN SELECTION

Conducting a needs assessment is an effective method of community empowerment and decision-making in the development of a plan for a system of care (Corona et al., 2009; Warheit, Bell, & Schwab, 1977). For the community members, the process of researching, selecting, and crafting a service system can be an engaging and inspirational process. These experiences are relatively uncommon for GLBTQ youths or youth providers who are often outside the margins of decision-making. The CNA supported the community-building intent of the planning process and ensured greater accuracy of the findings through the identification of youth needs. During all three phases, the data findings were taken back to the GAB and SP for confirmation of accuracy, which facilitated a continuous discussion of potential service domains; such as the need for housing, case management, mental health, medical services, and prevention services for GLBTQ youth. Once the primary service domains were envisioned, confirmed through data collection, and chosen by the planning committee, the selection of specific services was initiated. Even the Youth Speak Out survey was created in a way that allowed youths to prioritize services from a list generated from their qualitative responses (Berberet, 2006). The stakeholders recognized that inclusion of services would be contingent upon priorities, congruency with service domains, economic realities, and overall vision. During a half-day retreat that represented a community feedback loop, many were present

to share their insights into services identified for inclusion in the system of care. At the end of this meeting, a decision was made to proceed with the following system of care.

### A SYSTEM OF CARE: THE ALLIANCE FOR GLBTQ YOUTH

The following programs were identified through the CNA as the critical components of a system of care for GLBTQ Youth. This service continuum included several integrated programs for prevention and early intervention at the individual, family, and community level. Prevention Education workshops were designed to increase the awareness of GLBTQ youth issues and delivered in a variety of community environments. The flexible curriculum included an overview of GLBTQ youth development, direct strategies for program enhancement, and frank discussion of participant concerns. Workshops were tailored to both setting and audience. Youth Speaker Training consisted of public-speaking preparation to empower GLBTQ youth to share their stories. Trained youths then presented as part of the Prevention Education workshops. Youth Enrichment Events were safe socialization and skills-building programs that encouraged youth leadership development and self-expression. Activities such as dances, artistic workshops, and educational sessions were delivered through provider agencies. Care Coordination consisted of individualized guidance, support, and critical linkage to services in the community. Highly trained Care Coordinators helped GLBTQ youths navigate a range of challenges on the path to healthy adulthood. The care coordination philosophy was founded on a strengths-based model. One Care Coordinator was specifically trained to work with families in a Family Specialist role that provided services to the entire county. Community-Based Group Counseling consisted of six to eight sessions of prevention focused discussion. These groups were usually offered weekly in various locations throughout the county. Group counseling has been recognized as an effective means of developing resiliency among vulnerable youths (Thompson, 2005). In a group counseling session, adolescents discussed their experiences, feelings, and ideas facilitated by a mental health professional. Topics such as healthy relationships, substance abuse prevention, healthy decision making, and coping skills were discussed in these confidential group settings. Individual Counseling with a mental health professional was offered for youths at provider agencies throughout the county. Counseling was individualized to address the needs determined during an initial psychosocial assessment. Housing or Reunification Services consisted of safe and supportive short-term shelter services for homeless GLBTQ youths in a unique collaboration between a youth homeless shelter and the Alliance Care Coordinators. This system of care was initially planned for 5 years; however if the initial evaluation

determined that services were necessary for a longer duration because of youth utilization and community feedback, other funding would be sought.

## DISCUSSION

Designing and implementing a CNA that incorporates the perspectives of various stakeholders represents both a daunting task and an incredible opportunity. The ultimate outcome of this CNA was to suggest a model for a service system that was truly rooted in the needs of the GLBTQ youth community. Future articles will evaluate the stages of implementation and the specific programmatic outcomes. However, a brief discussion of some of the challenges in conducting the needs assessment may be useful for other communities undertaking such processes.

### Identifying the Target Population

Although our quest was to learn about the issues impacting GLBTQ youths for the purpose of developing a service system, limiting our research to that population was impossible. This was due to the hidden nature of the population, the developmental identity stages that GLBTQ youths navigate in idiosyncratic ways, and the dependency that youths have on adults within the service delivery system. Even determining sexual minority status became a challenge. All participants in the focus groups, including those identifying as straight allies, were able to provide insight on the needs of GLBTQ youth. In many cases, straight-identified participants provided important evidence based on the experiences of their close friends and family members. As the value of this information was clearly recognized, the researcher decided to include this information. Although the data cannot be considered fully representative of the general population of GLBTQ youths, every effort was made to identify hard to reach subpopulations. Identifying the population was made easier because the funder restricted the scope of the CNA to GLBTQ youths in MDC.

### Identifying Needs

Initially determining what *needs* meant was also a challenge. Needs may vary based on many factors: including age, sexual orientation status, region, culture, and gender identity. Furthermore, there were substantive differences between youth and adult perceptions of need. Many key informants openly stated that they did not understand the current needs of GLBTQ youths, however, also felt that adult-driven services, such as counseling, would fully address any possible youth concerns. Although there was a

wide range of articulated issues, youths in focus groups identified their greatest need as a place for safe socialization. The proposed system of care incorporated both perspectives by suggesting point of entry socialization activities (Youth Enrichment Events) that could meet youth needs but also facilitate access to more intense services, such as counseling, when necessary.

Moreover, there seemed to be an element of projective identification that emerged for some adults that was of interest. Often these adults seemed to believe strongly that they knew exactly what the youths needed. It was helpful to compare these perceptions with the youth data collected during the community engagement process. On some issues, the adult providers were completely accurate about youth needs, at other times their perspectives may have been true of an earlier generation, and occasionally these perceptions seemed to be a projection of their own fears and concerns. For example, some providers spoke about how the youths should always remain closeted in high school for fear that they could jeopardize their future careers. Parental acceptance was also one need that all interviewed adults stressed as a critical focus for program development in the form of parent and family counseling; yet only about half of the youths even mentioned parental acceptance as a potential area of intervention. Many youths stated that “my parents will never accept me;” “it’s a waste of time.” Such contradictory beliefs could constitute a barrier to service delivery for GLBTQ youths, because adults have the power to design and implement programs for youths, and such initiatives may not fully comprehend youths’ true needs, and thus be less successful in addressing them. A system of care that is not solidly based on the true needs of the population could face substantive implementation issues. Adults and youths also differed in their beliefs of the approach to service delivery. Youths strongly articulated that programs should be delivered in field-based locations that they could easily access, which was in contrast to adult service providers who felt that agency-based counseling was the best type of delivery structure.

However, there were issues on which youths and adults concurred. Youths that lived outside the downtown core also articulated a lack of GLBTQ-friendly youth services in their neighborhoods, which were often in higher crime areas. Adults agreed that inadequate public transportation was a challenge for youths trying to obtain services. Both adults and youths also agreed that confidentiality concerns with parents and families can be barriers to service acquisition for youths. As such, strategies to minimize these potential barriers were incorporated into the design of the service continuum in the form of the provision of field-based services and public transportation cards for youths enrolled in the program, as well as training for staff about how to reinforce the confidential nature of services with youths.

## Competing Agendas: Mavericks

There is limited literature on the population of activists that generate and sustain community-based organizations and programs for marginalized populations (Donaldson, 2007; Epstein, 1981). These passionate activists have often had to overcome significant resistance to their efforts to advance social change (Mizrahi & Rosenthal, 1998), a situation that often solidifies their identities as advocates. This approach may be particularly important for populations with limited representation, such as GLBTQ youth, that struggle with high levels of community-based stigma (Epstein, 1999). The advocates involved in the SP often had strong personalities articulating competing agendas, as well conflicting perceptions of needs. Such mavericks often had less experience working on community collaborations because such opportunities were less available to them. In many cases, these individuals had no experience working collaboratively on projects in which they were both part of the leadership and a component of the service delivery system. Although these maverick characteristics represent important and valuable catalysts to community development (Rubin & Rubin, 2008), there are times when competing agendas and personalities create challenges in developing community cohesion (Zald, 1969). To strengthen the SP, it became important to reiterate their individual efforts while stressing the overall research and program vision.

During many stages of research and program planning, the members of the community, many of whom represented particular organizations, would advocate for their agency's preferred approach to service delivery (e.g., the counseling agencies felt that the majority of the needs identified would be rectified through counseling). During these times, a significant amount of skilled facilitation was required. For example, during a SP forum convened to discuss the proposed service delivery plan, a traditional mental health agency brought three representatives, two with limited history of the community process. During the meeting, one of these individuals was incredibly disruptive and disrespectful because of her dissatisfaction with the amount of allocated services that were both adult-directed and mental health focused. This situation required strong limit setting on behalf of the facilitator and the opportunity for feedback from all of the invested parties, which meant that the meeting went over schedule until consensus was achieved. Because the objective was to design a service system for GLBTQ youths that was intended to have multiple levels of service across an expansive county, thus requiring significant interagency participation, extreme care was taken to ensure consensus among those involved. For example, two of the participating agencies had a long history of providing programs for adults to sensitize them about the needs of GLBTQ youth, and both wanted to be the sole agency providing those services for the SP. To address this conflict, several one-on-one meetings were facilitated where clearly defined service boundaries were

articulated so that one agency provided sensitivity training within the school system and the other provided similar training in community-based agencies that were not schools. Such choreographed activities that incorporate the history and agendas of individual agencies while maintaining a vision of the collective potential are important to the slow and shaky development of a SP.

## CONCLUSION

Developing service consortiums and programs designed to provide essential services for vulnerable and stigmatized populations with limited data is a challenge. It is essential to plan a system of care, yet strategies for community engagement in a community planning process need further development. Needs assessments can assist dramatically in the growth of community cohesion and the development and implementation of a system of care based on CBPR. Widespread CNAs for GLBTQ youths have been limited partially due to challenges in obtaining concurrent funding for both research and program development. This graduated CNA utilized both qualitative and quantitative approaches to elicit a significant amount of data about GLBTQ youth needs and available resources. Further, this CNA strove to fully engage both members of the target population and service providers as decision makers in the research to develop an applicable system of care for GLBTQ youth. Such partnerships were often tenuous and possessed significant challenges in both implementing the needs assessment and uncovering the needs of the youth. In many cases, these efforts determined that needs were not being met by existing programs and that many of the needed programs simply did not exist. The CNA did not uncover services that existed yet were not needed, but this could be attributed to the general consensus that there was an overall lack of specific services for this population. Thus, as evidenced in the proposed service delivery model, new programs had to be created to meet the needs. The process of conducting a comprehensive and collaborative CNA is challenging, yet the process is critical to creating systems of care that are relevant for, and sensitive to, marginalized populations.

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