Patching Holes and Integrating Community: A Strengths-Based Continuum of Care for Lesbian, Gay, Bisexual, Transgender and Questioning Youth

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Patching Holes and Integrating Community: 
A Strengths-Based Continuum of Care 
for Lesbian, Gay, Bisexual, Transgender 
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This article describes an integrated model of service provision called a continuum of care (CoC), and illustrates the application of this approach to working with lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth through a case example. The CoC described in this article includes provision of individual and group counseling, case management, housing/family supports, socialization events, and prevention workshops, along with relevant outcomes. The relevance of a CoC model for LGBTQ youth due to the inclusion of community context and potential to empower service users is explored. Key recommendations for CoC models with LGBTQ youth include a focus on collaboration, provider education, and affirmative practice, and incorporating service user feedback.

KEYWORDS LGBTQ youth, continuum of care, lesbian, gay, bisexual, transgender, questioning youth, community-based research, sexual and gender minority youth

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Lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth experience a range of stressors from social exclusion (Ylioja & Craig, 2014) to familial rejection (Mallon, 1997) and poor academic outcomes (Burton, Marshal, & Chisolm, 2014). Despite these complex challenges, few programs created specifically for LGBTQ youth are fully described in the literature. Such gaps may result in an unequitable service delivery system that could exacerbate the negative health outcomes of LGBTQ youth. To address these concerns this article describes a comprehensive model of service provision and illustrates its applicability for LGBTQ youth through a case example.

A continuum of care (CoC), also called a network of care or system of care, is generally considered a collection of integrated and collaborative services designed to meet the complex needs of a specific population (Matarese, 2012; McBryde-Foster & Allen, 2005). A CoC approach has also been defined as a conceptual ideology beneficial to community-level planning for the prevention of poor health outcomes within vulnerable populations (Stroul, Blau, & Friedman, 2010). CoC are “community-based, family-driven... youth-guided, and culturally and linguistically competent” (Stroul et al., 2010, p. 3) and constantly evolve to adapt to the needs of the specific population, and the accompanying sociopolitical climate (Miller, Blau, Christopher & Jordan, 2012). Although Stroul and Friedman (1986) initially proposed the concept of a CoC to support children and youth with severe emotional concerns, communities have utilized this model to serve many different populations (Stroul et al., 2010). Existent literature describes CoCs for older adults (Palley, 2003), children and youth (Grimes, Kapunan, & Mullin, 2006; Stroul et al., 2010), HIV-positive youth and adults (Christopoulous et al., 2013; Woods et al., 1998; Woods et al., 2002) and specific to HIV prevention education for LGBTQ youth (Cranston, 1992).

While 22 articles pertaining to CoCs were identified and reviewed for this article, only 1 journal article and 1 edited book included LGBTQ youth. Woods and colleagues (1998) described a CoC that focused on HIV prevention. Fisher, Poirier, and Blau’s (2012) edited volume offers an insightful approach to the development and evaluation of CoCs, particularly for specific populations of LGBTQ youth. None of these resources, however, clearly describe a “working” CoC model for LGBTQ youth and few provide detailed examples of services. However, from this extant literature, two models emerged as beneficial illustrations of CoCs.

Grimes, Kapunan, and Mullin (2006) describe a CoC for children and youth, titled the Mental Health Services Program for Youth (MHSPY), which
offers services to youth with severe mental health issues. MHSPY serves children and youth (ages 3 to 17.5) residing in certain counties within Massachusetts, who share the following: they have experienced severe emotional disturbances for a minimum of six months, have an IQ of 70 and over, and have conclusive results from the Child and Adolescent Functional Assessment Scale (CAFAS) that identify a “need for intensive services” (p. 314). This CoC includes services for primary health care, mental health needs, substance use issues, involvement with the criminal justice system, educational support, and community resources (p. 313). After acceptance into MHSPY, a care manager is appointed to each family to offer support and help the family build an interdisciplinary care team comprised of professional and personal supports. The MHSPY emphasizes the role of youth and their families as the “primary decision makers” of their care which aligns with the current definition of CoC suggested by Stroul and colleagues (2010, p. 3).

Similarly, Woods and colleagues (2002) discussed a CoC for youth that are HIV positive or at high risk of acquiring sexually transmitted infections. Key organizational partners included hospitals, public and community health centers, and outreach agencies. Each setting offered unique services, with a few offering key programs (e.g., HIV testing) at multiple venues. The features of this CoC included targeted HIV-related services that integrated the following: mental and sexual health counseling, optional HIV testing, educational outreach by trained peer educators, primary health and dental care, case management by a multidisciplinary team, referrals and resourcing, and follow-up care (Woods et al., 2002). The CoC explicitly included youth throughout service development, implementation and delivery. For example, youth focus groups were created to identify needs and evaluate services, a youth advisory board was formed, and young people were hired as peer educators. Furthermore, this CoC intentionally incorporated prevention, a harm reduction approach, and education into the various interactions with youth.

**COCS: A COMMUNITY RESPONSE**

A CoC can serve as a community response to social problems and broad population needs (Palley, 2003). As a planned and synchronized effort by various agencies and stakeholders (Dentato, Craig, & Smith, 2010), a CoC can actively create and build a network of supports for marginalized groups (Stroul & Friedman, 1986). These efforts are made with the hope of creating efficacious services that consider the strengths and unique needs (e.g., cultural, linguistic, etc.) of the population needing services (Stroul et al., 2010). A CoC could be considered an alternative service delivery model that improves access for populations that have significant health and mental health disparities yet infrequently utilize traditional services, such as the widely
A CoC is a complex network that requires providers to consider critical services and the ease of navigating between them (McBryde-Foster & Allen, 2005). As a result, it is essential to understand the limits of a single organization and the necessity of collaboration across the CoC (Dentato et al., 2010). Woods and colleagues (1998) stress the importance of collaboration between various types of youth services, spanning health and social sectors. Miller et al. (2012) further describe current models of CoCs that integrate child welfare, youth criminal justice, substance abuse, mental health, and educational systems. Furthermore, CoCs are unique to each community and require a wide range of stakeholder involvement. A CoC may include political leaders, funders, or criminal justice services as well as health and mental health organizations. A CoC could have a positive and systemic impact on the overall service delivery environment and may even encourage other providers and agencies to deliver a variety of LGBTQ youth-friendly and queer-positive services. This could serve to create awareness within mainstream services that lead to the creation of welcoming and inviting spaces for LGBTQ youth (Crisp & McCave, 2007) or specialized services to meet their needs (Lazear, Pires, Forssell, & Mallery, 2012).

There are several key characteristics of a CoC that make this framework appropriate for LGBTQ youth. For instance, services typically originate from population needs, require family and community collaboration, and empower users (Stroul et al., 2010). Ideally, a CoC would strive to bridge gaps in service utilization (Stroul et al., 2010; Dentato et al., 2010; Center for Mental Health Services, 1998). Barriers to traditional service use for LGBTQ youth include feeling unwelcome, perceiving the provider to be incompetent, and confusion regarding appropriate and accessible programs (Craig, 2011). When they do obtain services, LGBTQ youth often remain unacknowledged within traditional services and their unique concerns and assets are overlooked (Lazear et al., 2012). This lack of acknowledgment often renders them invisible within health, wellness, and social programs. For example, LGBTQ youth do not always have their concerns met when pursuing counseling services, which often results in low utilization and satisfaction rates.

CoCs are expected to be family driven, as caregivers and families typically make the most important decisions about their child’s care (Stroul et al., 2010). Miller and colleagues (2012) advocate for a consideration of the context of each family as a whole during treatment planning, which allows for the unique strengths and resources of the family unit to be incorporated into care. Similarly, Wilber, Ryan, and Marksamer (2006) advocate for involving families in CoCs for LGBTQ youth. A supportive caregiver or family can be even more important to an LGBTQ youth who is coping with the regular hardships of being a teenager while also contending with stigma and discrimination related to his or her sexual orientation, gender identity, and/or gender
expression. Ryan, Russell, Huebner, Diaz, and Sanchez (2010) describe the benefits that family support has on the lives of LGBTQ youth as young adults, including promoting higher self-esteem, overall health, and a stronger support system. A supportive family environment can also shield LGBTQ young adults from substance abuse, depression, and suicidal ideation and/or attempts, which unfortunately are often present among LGTBQ young adults with unsupportive families (Ryan et al., 2010). While it can be beneficial for both LGBTQ youth as well as their caregivers/families to be included in a CoC, it is imperative that a youth’s emotional and/or physical safety is not placed at risk. Whether an LGBTQ youth’s family is able to be involved or not, it is valuable for care to be provided in such a manner that the youth’s caregiver/family context is identified and considered (Ryan et al., 2010). If families are unsupportive and the LGBTQ youth gives permission, it may be helpful for the provider to meet with the families to provide education and resources to help them fully understand the impact of their behavior on their child. If an LGBTQ youth’s caregiver/family is not able to be involved because of abusive or unhealthy treatment of the youth, the service provider and youth can identify other supportive individuals and/or environments (Wilber et al., 2006).

A final characteristic of CoCs is that they empower service users. For LGBTQ youth, this can mean there are multiple opportunities for them to become involved in programming efforts (Pires, 2002; Pires & Silber, 1991). This can be accomplished by asking service users their vision and expectations of effective services, as well as involving them in planning and, as available, in the delivery of services (Lazear et al., 2012; Matarrese, 2012; Stroul et al., 2010; Woods et al., 1998). Such involvement ultimately creates a pivotal space for youth to exercise self-determination in their lives (Pires, 2002; Pires & Silber, 1991). As there has been a lack of attention paid to the strengths of LGBTQ youth in service models (Craig, 2012; Lazear & Gamache, 2012) and few opportunities for LGBTQ youth involvement in planning their own services (Craig, 2011), a CoC could provide a clear framework for youth engagement.

COCS: COMMON ELEMENTS

Although a CoC framework necessitates that it be unique to the community in which it is created, some common elements have been identified within the literature. A key commonality is the underlying value of community responsibility that shapes how continuums of care are created and adapted to best meet stakeholder needs (Stroul, 2002). Miller and colleagues (2012) boldly suggest that almost all communities have embraced and even implemented some degree of a CoC for certain populations. Thus, it may be useful to constantly examine which components are being addressed
Continuum of Care for LGBTQ Youth

(Minnick, 1997; Stroul, 2002) consistently and competently, as well as where gaps may continue to exist.

McBryde-Foster and Allen (2005) describe a CoC as having four common elements that include “people, environment, events and time” (p. 629). It should be noted that the following examples provided will be specific to the population discussed in this article, namely LGBTQ youth. **People** refers to the youth, their family members, and peers, as well as the providers and stakeholders involved in the CoC. **Environment** refers to the variety of settings in which a youth might be cared for within the CoC, which can include community organizations, schools, hospitals, as well as other agencies. **Events** refer to the “care events” that take place as the youth and his or her provider navigate the CoC, both as a unit and as separate entities (McBryde-Foster & Allen, 2005, p. 629). These care events can range from individual counseling to supportive interventions in schools or treatment within health care settings. A CoC considers the interactions of the various stakeholders as a sequence of “initiating, continuing and concluding care events” (McBryde-Foster & Allen, 2005, p. 630) between organizations that may occur as a youth receives services from multiple care settings. Finally, **time** refers to the amount of time a youth spends within the CoC, which could range from one visit of a short duration, such as one group counseling session, to participation in multiple concurrent services such as individual counseling, case management, and prevention education over a period of several years. Thus, there are endless possibilities for the configuration of a CoC, as a result of the variety of youth and community needs and the types of people, environments, events, and time frames that might be involved (McBryde-Foster & Allen, 2005).

THE STRENGTHS-BASED PERSPECTIVE

A strengths-based perspective fully aligns with key elements of CoCs. For instance, as CoCs are unique to their communities, it makes sense to utilize all the strengths and resources of such communities to develop, implement, and maintain the continuum (Pires & Silber, 1991; Dentato et al., 2010; Stroul et al., 2010). Empowerment can be attained through the logical involvement of service users (Pires & Silber, 1991) in such a way that allows them to assert their strengths, such as asking them about their past or current experiences in programs and adapting programs to better meet their needs (Austin & Craig, in press). Finally a strengths-based perspective is appropriate for the LGBTQ youth population as it provides a chance for their voices to be heard and to underscore such youth as experts (Craig, 2013; Lazear & Gamache, 2012). Incorporating the feedback of LGBTQ youth can ultimately help maintain a CoC (Woods et al., 1998) by ensuring that services provided are appropriate and helpful (Dentato et al., 2010; Miller et al., 2012).
A STRENGTHS-BASED CONTINUUM OF CARE: A CASE EXAMPLE

To provide a specific model of a CoC for LGBTQ youth, an example of one strengths-based CoC found in a large urban city is provided. Originally named The Alliance for GLBTQ Youth, this CoC subsequently became the incorporated name of the nonprofit organization directing the continuum of services. Following an extensive mixed-method community needs assessment (Craig, 2011), a CoC for LGBTQ youth was developed based on the conceptualization of the core components of a CoC found in previous literature (McBryde-Foster & Allen, 2005). People, or service users, included LGBTQ youth, their families, and caregivers. Environment, or network of providers, included a Jewish family and children’s services organization, a telephone counseling and referral agency, a LGBTQ policy advocacy and safe schools organization, a training organization focusing on LGBTQ issues, a LGBTQ hub organization that provided direct services to youth and their families, a school of social work within a university, a nonprofit consulting agency, and a youth drop-in center for LGBTQ youth. Timing, or length of time in care, meant that a youth was a client of the CoC for varying times depending on the number of care events and services. Events, or care events within the CoC, included eight integrated programs for prevention and early intervention at the individual, family, and community level. They ranged from tertiary service provider training to high-intensity direct services for homeless LGBTQ youth.

The seven integrated programs in the CoC are illustrated in Figure 1. Prevention education workshops (1) were designed to increase the awareness of service providers of LGBTQ youth issues and delivered in a variety of community environments. The flexible curriculum included an overview of LGBTQ youth risk, resiliencies, and identity development, strategies for inclusive programming, and an opportunity to discuss inclusivity challenges in the context of organizational or personal barriers. Workshops were tailored to both the type of organization within the CoC (e.g., school,
hospitals, community mental health organizations) and the specific audience (e.g., clinician, administrator, physician, student). **Youth speaker trainings** (2) consisted of public-speaking preparation to empower LGBTQ youth to share their stories in a narrative intervention. Trained youth presented as part of the prevention education workshops to LGBTQ and non-LGBTQ youth, adults, parents, allies, and other community members. **Youth enrichment events** (3) were safe socialization and skill-building programs that encouraged youth leadership development and self-expression. Activities such as LGBTQ youth proms and dances, community field trips, artistic workshops, and educational sessions were delivered through various provider agencies. **Group counseling** (4) consisted of six to eight sessions of socio-emotional and prevention-focused discussions in open-ended school and community-based groups with specifics described elsewhere (Craig, Austin, & McInroy, 2014). These youth groups were usually offered weekly in various locations throughout the county. Topics such as healthy relationships, substance abuse prevention, healthy decision making, and coping skills were discussed within these confidential group settings, led by graduate-level mental health counselors and interns. **Care coordination** (5) consisted of individualized guidance, support, and critical linkage to services in the community. Highly trained case managers assisted LGBTQ youth to navigate a range of challenges on the path toward a healthy adulthood and independence, while underscoring resiliency and using a strengths-based approach (Craig, 2012). Within the context of the CoC, one care coordinator was specifically trained to work with families in the role of a “family specialist” that provided services to parents and caregivers that were struggling with issues related to their LGBTQ child and wished to obtain assistance and support. **Individual counseling** (6) with a mental health professional was offered for youth at CoC provider agencies. Counseling was individually tailored to address the needs collaboratively determined during an initial psychosocial assessment. Finally, **housing or reunification services** (7) consisted of safe and supportive short-term shelter services for homeless LGBTQ youth in a unique collaboration between a youth homeless shelter and care coordinators. It is important to note that all of these services were provided without any initial or ongoing cost to the participants. The hub organization provided direct services (care coordination, a limited amount of individual and group-level counseling and prevention education) and the remainder of services were provided by other collaborating organizations within the CoC.

This CoC for LGBTQ youth has achieved positive outcomes in core programs (care coordination, community-based group counseling, and prevention education workshops). Specifically, in terms of care coordination, the multietnic LGBTQ youth participants ($N = 162$) in the “Strengths First” program experienced statistically significant increases in self-esteem and self-efficacy (Craig, McInroy, Austin, Smith, & Engle, 2012). Similarly, based on an
assessment of the community-based group counseling component, the mul-
tiethnic LGBTQ youth ($N = 263$) that participated in “Affirmative Supportive
Safe and Empowering Talk” (ASSET), the first affirmative group counseling
intervention created specifically to promote resilience in LGBTQ youth, re-
ported significant increases in proactive coping and self-esteem (Craig et al.,
2014). Finally, prevention education workshops involved a diverse sample of
White non-Hispanic (29%), Black/African-American (20%), Hispanic (49%),
and Haitian (3%) adult multidisciplinary professionals ($N = 2,850$) in the
CoCs community-based educational intervention designed to improve ser-
vice provision for LGBTQ youth. As a result of the training, nearly 80% of
participants reported that they intended to take at least one action to improve
the lives of LGBTQ youth. Participants also agreed that their knowledge and
skills increased after the intervention (Craig, Doiron, & Dillon, in press). No-
tably, at least 46% of the youth receiving services within the CoC identified
that they had used at least one other CoC program. In addition, a large ma-
ajority of youth stated that they had learned about the variety of programs
offered through the CoC and would be willing to attend if they identified a
need.

**IMPLICATIONS FOR PRACTICE**

This case example provides several key considerations in the development
of a CoC for LGBTQ youth, including a focus on collaboration among service
providers, training and skill enhancement of practitioners, staff members, and
administrators, and the importance of incorporating service user feedback.

**Focus on Collaboration**

There is no doubt that an effective CoC requires productive collaboration,
effective communication, and trust in order to share knowledge, resources,
and infrastructure. From the initial meeting of service providers to create
a shared vision for a CoC to clinicians coordinating services for an indi-
vidual LGBTQ youth, communication was essential (Dentato et al., 2010).
These considerations also emphasize values of inclusivity and transparency
necessary for continuum building. For instance, the use of consensus build-
ing can help ensure each member of the partnership has a voice in all matters;
and keeping extensive records can promote transparency and equal access
to decisions by all involved. Those working within CoCs cite the benefits of
collaborative planning and shared responsibility for vulnerable populations
as strengths within this framework (Stroul, 2002).

CoCs often include a variety of providers from different disciplines. In
a strengths-based approach, providers recognize the distinct expertise that
each brings to the continuum and highlights that within a collaborative framework. Furthermore, within a CoC, there may be conflicting perspectives on both participant needs and service delivery (McBryde-Foster & Allen, 2005). Without self-reflection and communication with colleagues, as suggested by Minnick (1997), contradictory perspectives between service providers could influence the quality of services received by clients (McBryde-Foster & Allen, 2005). Such concerns should be considered during the inception of a CoC and should be carefully planned for and integrated into ongoing discussions.

Practitioner and Organizational Training and Skills Enhancement

To achieve optimal effectiveness, providers within the CoC should consider training in population-specific care as well as working within the collaborative framework. It is important for service providers to be culturally competent in working with LGBTQ youth. Matarese (2012) suggests ongoing training and professional development for those working with LGBTQ youth in conjunction with the development of LGBTQ antidiscrimination policies. Within the context of a CoC, trainings to ensure culturally competent service delivery should be offered to all organizations serving LGBTQ youth, including service providers, fiscal agents, and funders, among others.

Interdisciplinary groups working in continuums of care can utilize affirmative practice. This framework “celebrate[s], advocate[s] and validate[s] the [LGBTQ] identities” of clients (Crisp & McCave, 2007, p. 405; Crisp, 2006). This could mean supporting and empowering LGBTQ individuals in exploring their identities and/or examining issues within the context of homophobia (Craig, Austin, & Alessi, 2013). Affirmative practice requires three components: specialized knowledge, affirming skills, and supportive attitudes. Acquiring knowledge related to LGBTQ youth may include learning and using preferred identity and gender terms, understanding experiences of diversity and oppression, and having a strong sense of supportive resources. Important skills include the ability to create affirming LGBTQ-positive spaces, the avoidance of assumptions and imposition of labels, and the consideration of a client’s issues within the context of his or her intersecting identities (Crisp & McCave, 2007). Finally, with regard to attitudes, service providers must acknowledge and address their biases to better serve LGBTQ youth (Alessi, 2014). Affirmative practice can be tailored to develop community competence to deliver services to LGBTQ youth within the framework of a CoC. In addition, collaborating agencies should consider an evaluation of their own services, practices, and policies prior to participating in a CoC to determine if they are anti-oppressive and affirmative (Crisp & McCave, 2007; Matarese, 2012; Pawley Helfgott & Gonsoulin, 2012).

Specific programmatic skills are also important. Many of the programs, such as case management, are consistent with services offered by other
continuums of care (Grimes et al., 2006; Palley, 2003; Woods et al., 1998)
and may require a focus on continuing education in effective case management. The inclusion of training programs to facilitate the development of staff competencies in counseling and supporting youth as peer educators is also warranted. Educational initiatives for LGBTQ youth to become peer educators may offer opportunities for them to develop leadership, public speaking, and other transferable skills, which will ultimately be useful for pursuits of education and/or employment.

In the context of allied health, Minnick (1997) suggests several important skills that are critical to working within a CoC, that include the ability to motivate, communicate, and analyze (p. 45). Motivational skills can be used to inspire and encourage individuals and groups to act (Minnick, 1997), which can be applied to organizations and governments of various levels, in encouraging them to deliver services to LGBTQ youth while supporting them in their efforts to secure services and opportunities internal and external to the network. In the context of social workers, motivation could include the empowerment perspective, which entails providing opportunities for individuals and groups to have more control over their daily lives (Boehm & Staples, 2004). Minnick (1997) describes communication as including “system building and application of information system skills,” which means that providers should consider the full CoC when delivering services (p. 45). In addition to communicating among service providers within the CoC, communication skills include explaining the various stages of the CoC to the client (Craig, 2012). Analysis skills can include management of client and administrative concerns, evaluating program effects, and the need for adaptation (Matarese, 2012). In addition, strong evaluation measures to capture the impact of individual LGBTQ services and the CoC need to be developed as such efforts may result in increased utilization by youth (Goode & Fisher, 2012).

Incorporating Service User Feedback

It is asserted that a CoC can improve the quality of life of the population served (Stroul et al., 2010); however there is a notable gap in the CoC literature that articulates the client’s perspective (McBryde-Foster & Allen, 2005). This gap is likely to be even more pronounced for LGBTQ youth who often experience invisibility within services (Lazear et al., 2012). Current CoCs should be “youth-guided” with the engaged involvement of youth in all stages of their care (Miller et al., 2012; Stroul et al., 2010). This includes creating opportunities for youth to provide feedback, such as involving them in needs assessments and program evaluations (Miller et al., 2012). A recent needs assessment discovered that LGBTQ youth had drastically different ideas than the service providers about the types of programs they would ac-
cess or need (Craig, 2011). Such divergent perceptions might create obstacles between clients and providers during the administration of services. Thus, needs assessments in a CoC should be developed through collaboration between providers and youth. In an ideal situation, service users should take a leadership role in the needs assessment process to encourage ownership of the process and to ensure findings are congruent with a youth perspective (Dobell & Newcomer, 2008; Stroul et al., 2010).

Providers should be competent in their interactions and practice with vulnerable populations (Bundock et al., 2011). For LGBTQ youth, providers may consider the various ways to engage with youth who are “out,” those who are not, and those who are questioning their sexual orientation or gender identity (Lazear et al., 2012). Furthermore, Bundock and colleagues’ (2011) study of youth and young adults (N = 60) found that they valued feeling included in the treatment choices that affect them, feeling heard by their provider, and accessing services in a safe space free of discrimination. Thus, in order to ensure the utility of CoCs to LGBTQ youth, it is critical to solicit their perspective throughout the course of development.

CONCLUSION

The collaborative framework, contextual approach, and potential for empowerment of a CoC make it a good option for service delivery for LGBTQ youth. This article examined the current literature surrounding continuums of care and proposed a strengths-based CoC model for LGBTQ youth, illustrated by a case example of a successful CoC that ultimately became a successful nonprofit organization. It is clear that providing services through a CoC can contribute to meeting the immediate needs of the population served, while also serving as a form of capacity building to better support organizations to provide competent services to LGBTQ youth. Community and youth involvement and leadership are crucial in all steps of the design, delivery, and implementation of the CoC services offered, in order to ensure their appropriateness and helpfulness (Dentato et al., 2010; Lazear et al., 2012; Matarese, 2012; Pires, 2002; Woods et al., 1998). Ultimately, social workers and other professionals working with LGBTQ youth must recognize their vital roles as allies and create opportunities for service provision that leverages the community strengths.

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